

# Patients and Communities Committee

Mon 03 November 2025, 10:00 - 12:30

## Agenda

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### 10:00 - 10:00 **Meeting Agenda**

0 min

📄 00. P&C Committee - Agenda 3.11.25 FINAL.pdf (2 pages)

### 10:00 - 10:00 **1. Chair's welcome and apologies for absence**

0 min

### 10:00 - 10:00 **2. Declarations of Interest**

0 min

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

### 10:00 - 10:00 **3. Minutes from previous meeting (28.8.25) and matters arising**

0 min

📄 03 NW ICB PC Committee Minutes 28.8.25 Part One - DRAFT.pdf (16 pages)

### 10:00 - 10:00 **4. Action Log**

0 min

📄 04 P&CC Action Log.pdf (1 pages)

### 10:00 - 10:00 **5. Risk Register**

0 min

📄 05i Risk Register cover sheet November 2025.pdf (3 pages)

📄 05ii Patient and Communities Register 30.10.25.pdf (3 pages)

### 10:00 - 10:00 **6. General Update**

0 min

### 10:00 - 10:00 **7. Spotlight on: Waiting Times including patient stories**

0 min

📄 07a Long Waits Elective Care Oct25.pdf (5 pages)

📄 07b Long Waits Data Slides - Oct25.pdf (10 pages)

### 10:00 - 10:00 **8. Access to Primary Care Services**

0 min

📄 08 Patient and Communities Slides - November 2025 - Final.pdf (18 pages)

### 10:00 - 10:00 **9. Comms and Engagement Update**

0 min

📄 09 2025-11-03 - CE update to Patients and Communities Committee - Final.pdf (4 pages)

### 10:00 - 10:00 **10. Community Voices Update**

0 min

📄 10a Cover sheet\_Community Voices update\_3.11.25.pdf (6 pages)

📄 10b Appendix 1 - CV Women's Health NODA Report.pdf (37 pages)

📄 10c Appendix 2 - CV Women's Health Impact Report.pdf (3 pages)

📄 10d Appendix 3 - CV QEH Anchors Report.pdf (15 pages)

📄 10e Appendix 4 - QEH briefing session - Closing the Loop.pdf (11 pages)

📄 10f Appendix 5 - CV evaluation report (final version) Nov 2024.pdf (11 pages)

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**10:00 - 10:00 11. Ageing Well Programme Board Update and Dementia Workstream Update**

0 min

- 📄 11a Ageing Well Update Paper P&C v1.pdf (6 pages)
- 📄 11b Ageing Well Highlight Report P&C Committee v1.pdf (4 pages)
- 📄 11ii P&C Ageing Well Dementia Update Paper v1.pdf (5 pages)

**10:00 - 10:00 12. Healthwatch Norfolk and Healthwatch Suffolk Updates**

0 min

**10:00 - 10:00 13. VCSE Assembly Update**

0 min

- 📄 13 PCC Report VCSE Assembly.pdf (4 pages)

**10:00 - 10:00 14. Population Health and Inequalities Board Update**

0 min

- 📄 14a 2025.10.21 PHI Board Report Cover Sheet v1.pdf (2 pages)
- 📄 14b 2025.10.21 PHI Board Assurance-Escalations v3.pdf (3 pages)
- 📄 14c PHM Annual Report 2024 - 2025 Final Version.pdf (29 pages)

**10:00 - 10:00 15. Items for Escalation to ICB Board**

0 min

**10:00 - 10:00 16. Any Other Business**

0 min

**10:00 - 10:00 17. For Information**

0 min

- 📄 For info - CN Place Update October 2025.pdf (14 pages)
- 📄 For info - GYW Place Update October 2025 FINAL.pdf (6 pages)

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

Monday 3 November 2025, 10:00-12:30hrs

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	10:00-10:15	Chair's welcome and apologies for absence	V	Chair
2		Declarations of Interest	P	Chair
3		Minutes from previous meeting (28.8.25) and matters arising	P	Chair
4		Action log	P	Chair
5	10:15	Risk Register	P	Mark Burgis
6	10:20	General Update	V	Mark Burgis
7	10:30	Spotlight on: <ul style="list-style-type: none"> <li>Waiting Times including patient stories</li> </ul>	P	Judith Sharpe Diane Smith
8	11:00	Access to Primary Care Services	P	Sadie Parker
9	11:15	Comms and Engagement Update	P	Chris Williams
10	11:25	Community Voices Update	P	Shelley Ames
		<b>Standing Items</b>		
11	11:35	i Ageing Well Programme Board Update ii Dementia Workstream Update	P	Dr Frankie Swords Dr Jeanine Smirl

12	11:45	<b>Healthwatch Norfolk &amp; Healthwatch Suffolk Updates</b>	V	Judith Sharpe Andy Yacoub
		<b>BREAK (5 mins)</b>		
13	12:00	<b>VCSE Assembly Update</b>	P	Tim Gardiner
14	12:10	<b>Population Health and Inequalities Board Update</b>	P	Dr Frankie Swords
15	12:20	<b>Items for Escalation to ICB Board</b>	V	Chair
16	12:25	<b>Any Other Business</b>	V	Chair
	12:30	Close		

The following papers are provided for information and will be discussed by exception only

- Place Board Reports
  - Central
  - East
  - West

**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](mailto:rachael.parker9@nhs.net)

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

**Declared interests of the Patients and Communities Committee**

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
Aliona Derrett	Non-Executive Member, Norfolk and Waveney ICB	Norfolk and Norwich University Hospital			X	indirect	My son-in-law, Richard Wharton, is a consultant surgeon at NNUHFT	2004	To date	Will withdraw from any discussions and decision that might directly involve the department or 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

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		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	Hellesden 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
		Norfolk County Council	X				Employed by Norfolk County Council	01/09/2014	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
		Public Health professional		X			Public Health professional interests - Fellow of the Faculty of Public Health, UKPHR registration	01/08/2024	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
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	Norfolk and Norwich University Hospital		X			I hold an honorary contract and work as a consultant endocrinologist / physician approximately one day per week at NNUH	01/07/2022	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
		St Martin's Norwich and private mental health counselling				Indirect	My husband works as a counsellor and undertakes sessions for St Martin's and in private practice	01/01/2023	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
		Long Stratton Medical Centre			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared

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Tracy Williams	Clinical Steward for Health Inequalities / Clinical Steward Central Place	Marriots way 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
		Norfolk and Norwich university Hospital				Indirect	Brother employed by Norfolk and Norwich university Hospital - administrator	01/12/2020	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
		Norfolk and Norwich university Hospital				Indirect	Sister employed by Norfolk and Norwich university Hospital - registered nurse	01/04/2020	Present	
		Norfolk Primary care				Indirect	Former Employee of Norfolk Primary care. Former employed member of staff as clinical lead of the vulnerable adult service	01/07/2020	31/03/2025	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
		Royal college of Nursing		X			RCN member. Subscribed member of the RCN	02/02/1987	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
		Queens Nurse		X			Queens Nurse. Awarded the tile and a member of the queens nurse institute	01/01/2014	Present	Declare at any relevant meetings and will not take part in any discussions or decisions relating to interest
Andy Yacoub	Chief Executive, Healthwatch Suffolk	Nothing to Declare	N/A				N/A	N/A	N/A	
Timothy Gardiner	Partner member - VCSE	Rouen Road Health Centre			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared

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**NHS Norfolk and Waveney Integrated Care Board**  
**DRAFT Minutes of the Patients and Communities Committee meeting**

**Held on Thursday 28 August 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
- Judith Sharpe (JS), Deputy Chief Executive, Healthwatch Norfolk
- Rebekah Collett (RC), Associate Director of West Place, NHS Norfolk and Waveney Integrated Care Board for items 6 and 8
- Emma Bugg (EB), Acting Associate Director of North, Norwich & South Norfolk Place, NHS Norfolk and Waveney Integrated Care Board for item 6
- Jon Punt (JP), Senior Lead, Patient Experience, NHS Norfolk and Waveney Integrated Care Board for items 14 and 15
- Bethany Small (BS), Commissioning Manager, Norfolk County Council and NHS Norfolk & Waveney ICB for item 9
- Susan Balaam (SB), Research Officer, Healthwatch Suffolk for item 7
- Charlotte Dillaway (CD), Chief Operating Officer, James Paget University Hospital NHS Trust for item 7
- Chris Williams (CW), Head of Communications and Engagement for item 15
- Karin Bryant (KB), Associate Director of Commissioning, NHS Norfolk and Waveney Integrated Care Board
- Shelley Ames, Head of Health Inequalities & VCSE Partnering, NHS Norfolk and Waveney Integrated Care Board
- Alison Weston (AW), NHS Norfolk and Waveney Integrated Care Board.
- Liz Joyce (LJ), Head of System Transformation, NHS Norfolk and Waveney Integrated Care Board

**Attending to support the meeting:**

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

1.	<b>Chairs welcome and apologies for absence</b>	
	Cathy Armor (CA) began by welcoming everyone to the Patients and Communities Committee.	

	Apologies for absence had been received from: Emma Ratzer, Alex Steward, Matt Dooley, Paula Boyce, and Andy Yacoub.	
2.	<b>Declarations of Interest</b>	
	None declared.	
3.	<b>Agree Minutes from the Previous meeting and Matters Arising</b>	
	<p>The minutes of the previous meeting were approved as an accurate record with the following correction:</p> <p>Page 9 Item 9ii: Second bullet point should read</p> <ul style="list-style-type: none"> <li>The consultation on the <b>Walk-in</b> Centre and engagement activities for vulnerable adult services is ongoing.</li> </ul>	
4.	<b>Action Log</b>	
	The action log was reviewed and updated accordingly.	
	<p>Before progressing further with the agenda, CA asked Mark Burgis (MB) to provide an overview of the restructure underway within the ICB.</p> <p>MB updated as follows:</p> <ul style="list-style-type: none"> <li>The executive team consultation for the new Norfolk and Suffolk ICB cluster concluded approximately three weeks ago, with interviews and selection currently in progress and expected to finish by 15 September.</li> <li>The launch of the full organisational consultation was originally scheduled for mid-August but has been delayed due to national-level agreement issues related to redundancies, affecting not only the local area but the entire country.</li> <li>Despite the delays, background work continues to ensure the organisation will be fit for purpose moving forward, although the postponement has placed additional pressure on staff.</li> <li>The executive team acknowledges and appreciates the continued dedication of staff in maintaining day-to-day operations during this period of uncertainty.</li> <li>Stakeholders are encouraged to raise any questions regarding the ongoing process.</li> <li>Healthwatch and other partners were invited to provide any additional updates or comments following recent communications and posted materials.</li> </ul> <p>In addition, Tim Gardiner made the following comments in respect of the impact the ICB changes will have on the voluntary sector.</p> <ul style="list-style-type: none"> <li>The voluntary sector is experiencing significant uncertainty due to ongoing structural changes within the ICB, which also affects local authorities and Healthwatch colleagues.</li> <li>Strong relationships are essential for the voluntary sector to navigate this period of flux and to maintain its role within the wider system.</li> <li>There is widespread sympathy and support across the sector for all colleagues impacted by these changes.</li> </ul>	

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	<ul style="list-style-type: none"> <li>The sector is seeking clarity on future developments to move forward collaboratively and continue strengthening existing partnerships.</li> </ul> <p>Tricia D’Orsi (TD) added the following comments</p> <ul style="list-style-type: none"> <li>The committee serves as the public’s voice, emphasising the importance of effective communication with the community during periods of organisational change.</li> <li>There has been a notable lack of communication nationally and locally regarding recent developments, which has contributed to uncertainty.</li> <li>The public may be less interested in the specific roles or identities of commissioners but are concerned about the impacts on service delivery and quality.</li> <li>Ongoing systemic changes present a significant risk to quality of care across the system.</li> <li>It is important to proactively manage messaging to the public, as this has not been sufficiently prioritised to date.</li> </ul> <p>Judith Sharpe (JS) added there has been a notable level of public awareness and support regarding recent announcements, particularly concerning the potential loss of Healthwatch. Feedback from social media and community engagement activities indicates that the public is actively commenting on and engaging with these developments.</p> <p>CA acknowledged the updates and comments, adding that by the next meeting there will hopefully be greater clarity and more direction on these matters.</p>	
5.	<p><b>Risk Register</b></p>	
	<p>Mark Burgis (MB) introduced the item and updated that the relevant teams have reviewed existing risks related to health inequalities, and an ageing population, updating these as necessary to reflect current circumstances.</p> <p>MB added two new risks were proposed:</p> <ul style="list-style-type: none"> <li>Hospice Funding: Raised by the Planned Care Team. This risk concerns the impact of funding mechanisms on patient care and service delivery within hospices. The initial risk score was proposed as 16.</li> <li>Community Support Service: Identified by the UEC Board. This risk pertains to the ongoing funding and sustainability of the community support service, which facilitates patient discharge from acute care and prevents unnecessary admissions. The committee was advised to reassess the risk score in light of recent developments.</li> </ul> <p>The committee was invited to review and accept these risks for inclusion on the risk register and consider actions for escalation or further response to address the identified risks.</p> <p>Comments and questions from members of the committee.</p> <ul style="list-style-type: none"> <li>FS highlighted, in relation to the proposed risk regarding hospice funding, the specific concerns are about the sustainability of the sector and its impact on long-term service planning and patient care. FS clarified that whilst sustainability is a quality-related issue affecting patients, the primary reason for escalating the risk to this committee is its broader impact on the sector’s future viability.</li> </ul>	

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	<ul style="list-style-type: none"> <li>• FS shared uncertainty regarding the appropriate committee for addressing a risk related to the Community Support Service, particularly whether it should be managed by the Commissioning and Performance Committee.</li> <li>• MB acknowledged the importance of appropriately assigning risks to the correct committee. He supported the suggestion that risks concerning general patient care may be better managed by the Commissioning and Performance Committee, while noting that this committee has the authority to make such recommendations.</li> <li>• FS queried the proper ownership of risks originating from the UEC Board, suggesting these typically route to the Commissioning and Performance Committee.</li> <li>• TD agreed that certain risks, especially those of a commissioning nature, should be transferred to the relevant committee. She proposed escalating the sustainability concerns regarding hospice funding to the Regional Quality Group for broader discussion. Karin Bryant (KB) agreed to collaborate with TD on preparing the paper for the Regional Quality Group, confirming coordination across relevant teams.</li> <li>• Tracy Williams (TW) stressed that the hospice funding risk is closely linked to the Ageing Well Programme and the voluntary sector, recommending it remain within the current committee's remit. She also requested assurance that both quality and equality health impact assessments had been adequately undertaken. MB confirmed these had been completed, providing reassurance on due process.</li> <li>• TG emphasised that most hospices are charitable organisations reliant on fundraising. He noted that sector sustainability and resilience are already tracked by the VCSE Assembly risk register and referenced ongoing work to support these services.</li> <li>• KB highlighted broader concerns regarding the sustainability of the voluntary sector beyond hospices, questioning the committee best suited to address these issues.</li> <li>• MB proposed that, to ensure risks are not overlooked, the hospice funding risk should remain on the current committee's risk register until there is confirmation of appropriate mitigating actions or alternative ownership, with an update to be provided at the next meeting.</li> </ul> <p>The update was noted.</p> <p><b>Action: The committee agreed that, for the time being, Risk 84 should remain on the P&amp;CC risk register, whilst Risk 105 should be transferred to the Commissioning and Performance Committee (MB)</b></p>	
6.	<p><b>Spotlight on: NHS Changes</b></p>	
	<p>Rebekah Collett (RC) provided an overview of Neighbourhood Health Service Implementation, highlighting the following points:</p> <ul style="list-style-type: none"> <li>• The 10 Year Health Plan places the neighbourhood health service at the forefront of NHS transformation, aiming for preventative, patient-centred care that reduces reliance on hospital admission as the default option.</li> <li>• The neighbourhood health model is designed to provide more personalised and coordinated care, particularly supporting individuals with long-term or complex needs who interact with multiple health and care services.</li> </ul> <p>Strategic Shifts and Objectives</p>	

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- The plan seeks to deliver three strategic shifts: transitioning from hospital-based to community care, focusing increasingly on prevention, and harnessing digital solutions for care delivery.
- Initial implementation will prioritise improving access to general practice and urgent care, preventing avoidable hospital admissions, and reducing long-term placements in residential or nursing care.
- Care should be delivered as locally as possible, leveraging digital resources, neighbourhood health centres, and hospitals only when necessary.
- General practice and community mental health services are identified as critical components.

#### Contracting and Population Coverage

- Two types of neighbourhood provider contracts will be introduced: a single neighbourhood contract for populations of 30,000–50,000 and a multi-neighbourhood contract for populations of approximately 250,000.
- These contracts will enable benefits of scale, including streamlined back-office functions and enhanced data analytics

#### Collaboration and Integration

- Effective delivery requires integrated working between health, social care, and VCSE partners at the neighbourhood level, moving toward collaboration as the norm.
- Existing progress in place-led collaboration, health inequalities, prevention, and population health management was noted

#### National Implementation Programme

- The National Neighbourhood Health Implementation Programme will launch in September 2025, with 42 sites selected to accelerate implementation and share solutions across the country.
- A national task force and enabler groups will address barriers related to data, digital, finance, estates, and workforce.
- Great Yarmouth and Waveney have submitted an application to join the first wave, with the outcome expected by early September 2025

#### Guiding Principles and Next Steps

- Neighbourhood working is both a mindset and a method, requiring care to be locally informed, community-led, and coordinated across systems.
- Successful implementation will depend on building trust, strong relationships, and leveraging community insights, with services co-designed in response to local needs and contexts.

#### Comments and questions from members of the committee.

- CA asked why the system had only submitted one application for the National Neighbourhood Health Implementation Programme.
- MB provided the following response:
  - The neighbourhood health initiative is an integral part of the 10-year plan, representing a strategic shift in health system operations.
  - The national pilot involves 42 sites. Its purpose is to test new approaches aligned with the 10-year plan's objectives.
  - Within the Norfolk and Waveney region, extensive consultation with directors and partner organisations determined that only one application—focused on Great Yarmouth and Waveney—would be submitted for the pilot.

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-Lack of additional funding necessitated consensus and collaboration across all local partners before submission, ensuring that the bid was co-signed by executive leaders from involved organisations.

-Areas not included in the pilot (Central and West Norfolk) will act as 'fast followers,' continuing to prioritise local initiatives such as the Marmot work and collaborating as the programme evolves.

-The strong cross-organisational commitment to change was evidenced by the broad support and leadership sign-off for the bid.

- MB expressed his appreciation for the Great Yarmouth and Waveney team's efforts and emphasised that the neighbourhood work is an exciting development, marking the beginning of a significant journey. He noted that while the overall feedback has been positive, there are some concerns regarding the lack of detail in the current proposals. MB highlighted that the 10-year plan provides flexibility for local adaptation, enabling services to be designed around the needs of the population rather than traditional care pathways. MB stressed the importance of leveraging this flexibility to ensure locally tailored service design.
- Suzanne Meredith (SM) welcomed the initiative, stressing the importance of community-centred transformation and integration between health and social care. She highlighted the need for a stronger focus on prevention and data, urging swift action to determine future data requirements and support from BI and PHM teams.
- Karin Bryant (KB) supported SMs comments and raised practical issues regarding commissioning and contract timelines, noting two major contracts (NCH&C and ECCH) end in March 2027. She emphasised the need for joint commissioning, possible interim arrangements, and a system-wide approach to strategic planning and delivery.
- TD commented neighbourhood health initiatives are being strengthened through cross-sector collaboration and integrated working, with notable progress in addressing health inequalities via effective partnerships. The emergence of national contract opportunities presents a chance to further reinforce neighbourhood health and integrated care. To maximise these benefits, strategic planning for upcoming contracts is essential, enabling the development of innovative and integrated approaches.
- TD further added national birth rates have declined significantly (now at 1.4% compared to the 2.1% needed for population sustainability) requiring a strategic re-evaluation of community support with a focus on self-care and frailty. Substantial progress has been made in collaborative initiatives for children and young people, supported by ongoing discussions and presentations to enhance integrated neighbourhood team models. MB continues to ensure that children and young people are prioritised in strategic planning. Furthermore, Charlotte Dillaway's (Chief Operating Officer, JPUH) recent involvement brings valuable expertise in integrated neighbourhood teams, offering the opportunity for practical insights and effective, rapid implementation through discovery interviews.
- FS highlighted the significance of using data-driven approaches to identify the most pressing needs within neighbourhoods. FS referenced a study from northeast Essex, noting that around 5% of the population accounts for 50% of cost-weighted need in primary, emergency, mental health, and social care, emphasising that approximately 50% of this need could be addressed through preventative, community-level interventions, especially targeting low-level anxiety, depression, unpaid carer breakdown, and social isolation. FS stressed that impactful neighbourhood health improvements often rely more on coordinated local resources rather than high-cost medical interventions.

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	<ul style="list-style-type: none"> <li>• TG stressed the importance of the voluntary sector in proactive neighbourhood work and called for a shift from clinical to holistic, social models of care. TG pointed out that much of the demand on GP services arises from social needs rather than clinical issues. TG advocated for integrating voluntary sector data into decision-making processes and increasing investment in preventative, community-based services to build resilience and address social determinants of health.</li> <li>• MB endorsed the focus on social determinants of health, referencing the statistic that 80% of health outcomes are linked to social factors. He described ongoing initiatives to develop a strategic roadmap for neighbourhood working and provided a practical example where a modest investment (£64 out of a £10,000 budget) in personal living conditions led to reduced health and social care usage, illustrating the value of targeted, preventative interventions. MB emphasised maintaining children and young people as a central focus and welcomed further insights from colleagues.</li> </ul> <p>CA expressed gratitude to the committee for the thoughtful and engaging discussion adding the committee looks forward to receiving updates on the outcome of the bid submitted at the next meeting, as well as ongoing progress with the important work taking place across the area.</p>	
7.	<p><b>Waiting for Hospital Care Report</b></p>	
<p>Parker Rachael 30/10/2025 14:15:50</p>	<p>Susan Balaam (SB) (Healthwatch Suffolk) presented the elective care report, highlighting the significant distress experienced by patients on waiting lists. She emphasised three main areas for improvement: communication, protection from the impact of waiting, and offering choices to patients.</p> <p>Key findings included the need for clearer communication, tailored information and support, and better awareness of patient rights, such as the option to change hospitals after long waits.</p> <p>Charlotte Dillaway (CD) acknowledged the report's findings, describing it as thorough and sobering. She recognised the operational challenges faced and confirmed the hospital's commitment to reducing wait times and improving communication with patients.</p> <p>Comments and questions from members of the committee.</p> <ul style="list-style-type: none"> <li>• TD raised concerns about communication barriers, especially for those with learning disabilities. She advocated for rapid system-wide improvements in communication, particularly regarding phone access and support for individuals with sensory deficits. She also highlighted the importance of transparent consent processes for patients who have experienced prolonged waits and deconditioning, suggesting that some may choose not to proceed with treatment if they fully understood the risks and benefits.</li> <li>• TW supported the need for reasonable adjustments in communications for specific communities. She requested further analysis on whether certain demographic groups, such as ethnic minorities or Core20Plus communities, experience longer waits or poorer outcomes, and suggested learning from projects focused on women's health and gynaecology.</li> <li>• SB responded that the report did capture some inequalities experienced by different groups, noting that longer waits correlated with greater negative impact, but acknowledged that more in-depth research would be beneficial. TG highlighted the challenge patients face in understanding their care pathway while waiting, particularly regarding timelines and next steps. He</li> </ul>	

	<p>suggested that clearer depiction of the patient journey would help manage expectations and support informed decision-making.</p> <ul style="list-style-type: none"> <li>• SB agreed, reiterating that most people wanted better communication regarding their place on waiting lists and expected wait times.</li> <li>• FS outlined ongoing initiatives targeting “waiting well,” including efforts to optimise patient health before procedures and improve the information provided at the point of referral. She explained the complexities involved in providing accurate waiting times and described a pilot project in West Norfolk to support long-waiting orthopaedic patients. She suggested that the Elective Care Group and Scheduled Care Board review the Healthwatch report and coordinate a response. KB agreed to take forward the action of sharing the report with the relevant group.</li> <li>• JS commended the report and raised concerns about the availability and accuracy of waiting time information on hospital websites, urging improvements in transparency for patients.</li> <li>• CD responded positively, committing to publishing average wait times by speciality on the James Paget Hospital website and signposting to relevant resources as an immediate action.</li> </ul> <p>The update was noted.</p> <p><b>Action: Elective Care report to be shared with the Scheduled Care Board (KB)</b></p> <p><b>Action: Waiting time information to be shared on JPUH website including signposting to waiting well information (CD)</b></p>	
<p>8.</p>	<p><b>Place Board Updates</b></p>	
	<p>Rebekah Collett (RC) provided an update from the West Place Board, highlighting three main items:</p> <ul style="list-style-type: none"> <li>• The interim Marmot report will be published shortly and presented at the ICS Conference in November.</li> <li>• Collaboration is ongoing with the Queen Elizabeth Hospital and multiple organisations to develop the outline business case for the new hospital as part of the new hospital programme.</li> <li>• The team is actively engaged in the development and testing of the West Winter plan, which will require sustained focus over the coming weeks.</li> </ul> <p>The committee noted the update for the East Place. A <a href="#">link</a> was shared in the meeting which demonstrated practical examples of current work in the area.</p> <p>A brief update for the Central Place Board had been circulated prior to the meeting which was taken as read. Emma Bugg (EB) highlighted the most significant development which was the agreement by ICS EMT regarding the formalisation of place-based partnership working, including representation from North Norfolk, Norwich, and South Norfolk.</p> <p>A Senior Responsible Officer from Norfolk and Norwich University Hospital (Tracey Bleakley) has been designated to help formalise arrangements across Central Norfolk. The remit includes assessing support mechanisms and infrastructure for integrated neighbourhood teams, with providers leading this initiative rather than the ICB. EB emphasised the need for ambition and provider-driven solutions, referencing earlier conversations on the topic.</p> <p>CA thanked colleagues for their updates and invited further commentary, specifically regarding the video focusing on Great Yarmouth and Waveney.</p>	

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	<p>MB commented that the video offers practical insight into work addressing inequalities and population health management.</p> <p>MB further emphasised the considerable effort required to effect change in the central region, given its historical complexity and diversity of views.</p> <p>The update was noted.</p>	
9.	<p><b>All Age Carers Strategy for Norfolk and Waveney</b></p>	
	<p>Bethany Small (BS) outlined the development and scope of the All-Age Carers Strategy for Norfolk and Waveney, noting its alignment with Suffolk's strategy and the unique position of Waveney.</p> <ul style="list-style-type: none"> <li>• Explained the integrated approach, with the strategy endorsed by the Integrated Care Partnership for the next five years and focused on seven priority areas for supporting carers.</li> <li>• Emphasised the importance of co-production, sharing that carers were directly involved in designing and testing engagement surveys, which informed the strategy's core themes.</li> <li>• Described extensive engagement, including surveys sent to 1,500 carers and 80 carers groups, and outreach to council members and ICS organisations.</li> <li>• Confirmed strategy sign-off in December 2024 and discussed the ongoing process of establishing baseline measures and accountability, led by Philippa Gregory.</li> <li>• Stressed that the strategy requires active monitoring, with regular assessment of actions and outcomes related to carers' support.</li> </ul> <p>Shelley Ames (SA) provided an update on the work within her team to collect baseline data across the organisation and places, ensuring alignment with the strategy's objectives. SA highlighted collaboration with the quality team on equality and health inequality impact assessments (EHIAs). SA also described a partnership with Carers Voice to develop webinars supporting completion of EHIAs, beginning with a session focused on carers and extending to other communities. SA reported that ongoing gap analysis will inform future actions to fully address the strategy's requirements.</p> <p>MB expressed strong support for the strategy and highlighted the significance of the figures previously highlighted regarding carers and reinforced the system-wide importance of supporting carers and their families and recognised ongoing challenges.</p> <p>TW fully endorsed the strategy and its areas of focus, emphasising the need for concrete actions to support carers and improve health outcomes for both carers and those they care for. TW queried the alignment between Norfolk and Waveney's strategy and Suffolk's, given the integrated context of the ICB.</p> <p>BS confirmed strong alignment with Suffolk's approach, particularly in identifying and supporting young carers and improving information and advice.</p> <p>It was noted that Suffolk had progressed to baseline activity and is measuring carer registration with GPs, while Norfolk and Waveney are in the process of establishing similar benchmarks. BS highlighted cross-county working groups ensuring strategic alignment.</p>	

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	<p>KB thanked BS for sharing the strategy, linking it to the Better Care Fund and the importance of embedding carer support within commissioning pathways. KB stressed the need for all commissioners to prioritise carers in their work.</p> <p>CA thanked BS, SA, and the wider team for their contributions.</p>	
<p>10.</p>	<p><b>Healthwatch Updates</b></p>	
	<p>Judith Sharpe (Healthwatch Norfolk) updated as follows:</p> <ul style="list-style-type: none"> <li>• Expressed support and empathy for partners and colleagues amid ongoing uncertainty regarding Healthwatch’s future.</li> <li>• Announced successful award of a new contract – two years with the option to extend to four, including a 12-month termination notice period.</li> <li>• Highlighted strong support from stakeholders, partners, and the public, including letters to the Secretary of State for Health and Norfolk MPs expressing concern about the possible loss of Healthwatch's independent patient voice.</li> <li>• Outlined continued statutory remit to gather public feedback on health and social care services in Norfolk, with trustees exploring long-term future options in light of potential changes to branding and legal entity.</li> <li>• Noted that 53% of the previous year’s income was derived from independently commissioned contracts, affirming appetite for continued independent operation.</li> <li>• Emphasised Healthwatch Norfolk’s 12-year history and established relationships as key assets for maintaining a truly independent public voice.</li> <li>• Provided updates on ongoing surveys: <ul style="list-style-type: none"> <li>- Rehabilitation care survey for NCH&amp;C, targeting post-discharge patients, with limited engagement to date.</li> <li>- Pride survey following attendance at Norwich and King's Lynn Pride events, focusing on issues such as misgendering and inappropriate services offered to LGBTQ+ individuals, and the need for better training in primary care.</li> </ul> </li> <li>• Reported on the engagement team’s involvement in the Crucial Crew initiative, reaching over 4,000 Year Six pupils to highlight the importance of young people's voices in health and social care.</li> <li>• Described successful establishment of the Queen Elizabeth Hospital Youth Council, now with 10 members and handed over for future development.</li> <li>• Mentioned publication of several reports: <ul style="list-style-type: none"> <li>- Digital tools and NHS app usage, highlighting design and awareness issues among younger users.</li> <li>- Walk-in centre consultation findings, including feedback on the naming and logo of the "Vulnerable Adult Service," and survey design lessons.</li> <li>- Safeguarding report for adults with learning disabilities, produced in partnership with "Opening Doors" and other organisations, identifying barriers to reporting concerns and understanding safeguarding processes.</li> </ul> </li> <li>• Follow-up work on the hearing loss charter, with results on GP practice adoption expected soon.</li> <li>• Commended the complaints report, emphasising its value in highlighting key issues such as access to primary care, dentistry, waiting lists, and communication, especially for minority communities.</li> </ul> <p>Comments and questions from members of the committee.</p> <ul style="list-style-type: none"> <li>• MB expressed appreciation for JS update and emphasised Healthwatch’s value as a coordinated, truly independent voice for patients and the wider</li> </ul>	

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	<p>community. MB further highlighted the importance of dedicated resources to champion patient voices and address health inequalities.</p> <p>The update was noted.</p> <p>Healthwatch Suffolk provided a written update as follows:</p> <p>There have been 3 Engagement &amp; Community Officer visits to the Waveney area (Bungay, Beccles and Aldringham) in July and August. 75 people were spoken to. A key issue we hear about is one that is covered by this example, from a visit to a Beccles community coffee morning, attended by mainly older residents: it's becoming increasingly more and more difficult to get 'in-person GP Practice appointments'. They felt they had been "fobbed off" or information submitted through online systems had not been read fully.</p> <ol style="list-style-type: none"> <li>1. Our 'waiting for elective care' research has been well received by N&amp;W ICB, and actions to bring about changes are underway <a href="https://healthwatchsuffolk.co.uk/news/elective-impact/">https://healthwatchsuffolk.co.uk/news/elective-impact/</a></li> <li>2. Trans and non-binary national survey (local report summary): <a href="https://healthwatchsuffolk.co.uk/news/trans-and-non-binary-people-facing-hurdles/">https://healthwatchsuffolk.co.uk/news/trans-and-non-binary-people-facing-hurdles/</a></li> <li>3. We're calling for feedback about adult social care services and contact with Suffolk County Council (relevant to Waveney residents): <a href="https://healthwatchsuffolk.co.uk/news/asc-suffolk/">https://healthwatchsuffolk.co.uk/news/asc-suffolk/</a></li> <li>4. Annual report was published in July, detailing our latest impact and outcomes: <a href="https://healthwatchsuffolk.co.uk/news/impact25/">https://healthwatchsuffolk.co.uk/news/impact25/</a></li> <li>5. We'll soon launch an opportunity for people to tell us about their experiences, if they are living with a visual impairment – an extension of our Your Care, Your Way campaign to influence better accessible care from the NHS and social care.</li> <li>6. We'll soon publish a report about people's experiences of getting support for ADHD (following changes to prescribing practice locally).</li> <li>7. We continue to work with Suffolk User Forum to gather people's experiences of accessing help from Suffolk A&amp;E departments when experiencing a mental health crisis or concern.</li> <li>8. Information about the impact of My Health our Future (schools/colleges programme) might be of interest: <a href="https://healthwatchsuffolk.co.uk/news/mhofimpact-25/">https://healthwatchsuffolk.co.uk/news/mhofimpact-25/</a></li> </ol> <p>And there are our official statements regarding the future of the Healthwatch network too:</p> <ol style="list-style-type: none"> <li>1. Petition: <a href="https://healthwatchsuffolk.co.uk/news/healthwatch-petition/">https://healthwatchsuffolk.co.uk/news/healthwatch-petition/</a></li> <li>2. Open letter: <a href="https://healthwatchsuffolk.co.uk/news/our-future/">https://healthwatchsuffolk.co.uk/news/our-future/</a></li> <li>3. Our original statement: <a href="https://healthwatchsuffolk.co.uk/news/healthwatchnetwork/">https://healthwatchsuffolk.co.uk/news/healthwatchnetwork/</a></li> </ol>	
<p>11. Parker Rachel 30/10/2025 14:13</p>	<p><b>VCSE Assembly Update</b></p> <p>Tim Gardiner (TG) provided an update on the voluntary sector, highlighting the launch of a monthly newsletter intended to improve engagement with the sector and communication around key initiatives, including the 10-year plan. He announced an upcoming sector webinar in October to encourage broader participation.</p>	

	<p>TG also discussed collaboration with Suffolk colleagues, future-proofing strategies, and the continued existence of separate Norfolk and Suffolk assemblies. He emphasised involvement in neighbourhood health applications and the Marmot Advisory Group, noting the recruitment of a remunerated voluntary sector representative for the Marmot steering group. TG described ongoing efforts to streamline the Voluntary Sector Assembly Board and strengthen its steering group. He presented an action plan addressing risks identified in the sector’s risk register and called for endorsement and resourcing from the ICB.</p> <p>Comments and questions from the committee:</p> <ul style="list-style-type: none"> <li>• CA requested clarification regarding the process required for the ICB to endorse and take forward the presented action plan. MB responded that it would be appropriate to consider the action plan for formal support, possibly at Board level. He acknowledged prevailing uncertainties but reassured that resource provision for ongoing voluntary sector work remains a priority.</li> <li>• TW expressed strong support for the action plan, emphasising the essential role of the voluntary sector in neighbourhood health initiatives, community engagement, prevention efforts, and addressing inequalities. TW congratulated TG on his achievements as Assembly Chair.</li> <li>• FS confirmed that the VCSE Assembly is referenced within the Population Health and Health Inequalities Oversight Group reporting structures and welcomed the action plan’s inclusion.</li> <li>• SM commended TG for his efforts in raising the profile of the voluntary sector across the Integrated Care System (ICS), noting his vice-chair roles on the ICP and the Well-being Board as evidence of growing recognition for the VCSE's contributions across health, social care, and local authorities.</li> <li>• CA sought TG feedback on partner perspectives regarding the VCSE assembly’s impact.</li> <li>• TG responded that awareness of the VCSE assembly is increasing within the sector, particularly due to enhanced communications such as the newsletter. He indicated that continued engagement activities, including the upcoming event in October, will help further assess and strengthen understanding and participation.</li> <li>• SA reinforced TG comments, noting a significant increase in understanding and visibility of the assembly since TG assumed his role. SA highlighted the newsletter as an effective mechanism for communication and engagement within the sector and with system partners, including public health colleagues.</li> <li>• CA acknowledged these points and encouraged TG and SA to continue their efforts in fostering sector-wide understanding and communication.</li> </ul> <p>The update was noted.</p>	
12.	<p><b>Ageing Well Programme Board Update</b></p>	
	<p>Dr Frankie Swords (FS) provided an update on the four central work streams for the Ageing Well programme as follows:</p> <ul style="list-style-type: none"> <li>• <b>Frailty Attuned Care:</b> Introduction of a frailty-based assessment system across trusts, replacing previous age cut-offs and resulting in reduced lengths of stay and improved comprehensive geriatric assessments. The system is now considered standard practice, with current focus shifting to implementing frailty scoring in primary care.</li> </ul>	

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	<ul style="list-style-type: none"> <li>• <b>Prevention:</b> Highlighted the 'Warm and Well' campaign and the 'Health Connect' initiative, both aimed at proactively identifying and supporting at-risk populations to prevent health deterioration.</li> <li>• <b>Quality in Care Homes:</b> Reported targeted support for care homes with high usage of emergency services, which has reduced unplanned admissions. Introduced a new dashboard for monitoring and tailoring care home support initiatives.</li> <li>• <b>Dementia Work Stream:</b> Announced the launch of a Dementia Information Pack, intended to provide clear guidance and support pathways for individuals and carers at the point of diagnosis.</li> </ul> <p>FS also highlighted the following:</p> <ul style="list-style-type: none"> <li>• The importance of accurate coding in primary care to identify and support patients proactively, referencing the FrEDA (Frailty, End of life, Data, Analysis) model for enhanced frailty management and wraparound care.</li> <li>• Shared recent successes in population health management, such as leading national referrals to the NHS Digital Weight Management Programme and achieving an average weight loss of 3.9kg among participants.</li> <li>• Emphasised ongoing efforts in health inequality work, including the development of a health inequality advocate network and targeted interventions to reduce hospital admissions, with particular focus on cardiovascular disease, respiratory health, and vaccinations.</li> </ul> <p>Comments and questions from members of the committee.</p> <ul style="list-style-type: none"> <li>• TW requested clarification on the integration of primary care and PCN perspectives into the programme's frailty and prevention workstreams and queried if further action was needed to strengthen those links.</li> <li>• TD acknowledged the contributions of Queen's Nurses and highlighted significant support provided by multiple agencies to care homes. TD outlined ongoing efforts to assess and optimise local assets, supplementing dashboard-driven quality initiatives within care homes.</li> <li>• TD recommended a presentation from Dr. Sarah Zaidi, citing her expertise in health management and risk stratification models.</li> <li>• CA confirmed future meeting plans to include Dr. Zaidi's presentation and acknowledged the progress of the programme since its inception.</li> <li>• CA sought clarification on weight management achievements, confirming the high national referral rate was a positive outcome.</li> <li>• MB supported plans to include relevant presentations and acknowledged the programme's positive developments.</li> </ul> <p>The update was noted.</p> <p><b>Action: Invite Dr Sarah Zaidi to a future meeting to present their work on health management and risk stratification models (RP)</b></p>	
13.	<p><b>Population Health and Inequalities Board Update</b></p>	
	<p>Dr Frankie Swords (FS) reminded the committee that there are three major workstreams under the Population Health and Inequalities Board:</p> <ul style="list-style-type: none"> <li>• Population Health Management (PHM)</li> <li>• Health Inequalities</li> <li>• VCSE work</li> </ul>	

	<p>FS highlighted two PHM projects:</p> <ul style="list-style-type: none"> <li>• Restarted efforts to increase NHS Health Checks, targeting early identification of health issues, especially among those experiencing inequalities</li> <li>• Focused on referring overweight individuals to the national digital weight management programme, with Norfolk and Waveney leading the country in referrals</li> </ul> <p>From a Health Inequalities perspective:</p> <ul style="list-style-type: none"> <li>• The NHSE Statement of Information Report has been published, marking progress</li> <li>• Although the next cohort of Core20PLUS ambassadors is not proceeding, a health inequality advocate network is being developed to extend the work</li> </ul> <p>From the VCSE perspective:</p> <ul style="list-style-type: none"> <li>• The action plan has been agreed (though not yet received)</li> <li>• Marmot, Place and volunteering support initiatives are highlighted as particularly positive, including training for carers and exploring support for people involved in the criminal justice system</li> </ul> <p>FS further highlighted the collaboration with Eclipse (PHM software provider) to identify impactful health interventions to prevent hospital admissions, with priorities including:</p> <ul style="list-style-type: none"> <li>-Cardiovascular disease prevention</li> <li>-Improving respiratory health (COPD)</li> <li>-Vaccinations, noted as the most significant intervention for reducing inequalities and overall demand. Emphasised the importance of optimising vaccination uptake and outlined ongoing gap analysis to determine next steps</li> </ul> <p>FS clarified that being the highest national referrer to the weight management programme is a positive achievement, reflecting proactive identification and support for at-risk individuals, not simply a higher prevalence of obesity in the area. FS reported that, on average, participants in the digital weight management programme lose 3.9 kilos, representing a significant population health improvement if achieved at scale FS expressed pride in these achievements and mentioned discussions with SNEE regarding potential collaboration.</p> <p>The update was noted.</p>	
14.	<p><b>Complaints Report</b></p>	
	<p>Jon Punt (JP) reported an overall upward trend in patient contacts, which has continued into the current financial year. He emphasised that the increase is broad-based, likely reflecting pressure on services. Outstanding cases from the previous year have been reduced from 16 to two, with the remaining cases being complex or pending provider information.</p> <p>JP identified three key themes for the committee’s attention:</p> <ul style="list-style-type: none"> <li>• Access to primary care services: Highlighted as an area of increasing activity and public interest, particularly with upcoming changes to GP contracts in October. Anticipated higher levels of patient feedback and the need for adaptability in response.</li> </ul>	

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	<ul style="list-style-type: none"> <li>Continuing Healthcare (CHC): The team is experiencing high demand and staff vacancies, which may impact communication with patients and families.</li> <li>Access to weight management services: There has been a rise in contacts regarding access to weight loss injections, particularly in the context of recent changes enabling more provision via primary care.</li> </ul> <p>Cathy Armor invited questions and feedback from the committee.</p> <ul style="list-style-type: none"> <li>TW asked about the implications of GP contract changes in October and recommended a proactive approach regarding communications and engagement to support general practices and public understanding.</li> <li>JP agreed with the need for tailored, local communication strategies to support practices, suggesting the use of social media and local platforms.</li> <li>TW proposed providing a toolkit to practices to support effective communication.</li> <li>MB commended the team's work and suggested that the committee incorporate programme planning around key patient priorities, such as primary care and dentistry, into its forward plan. He highlighted the success in increasing urgent dental appointments (35,000 across 23 practices last year) and noted very low DNA rates (0.2%) but emphasised the need for balanced capacity to include preventative services, especially for young people.</li> <li>JP noted a shift towards more routine dental care requests and agreed with the importance of addressing routine capacity in addition to urgent needs.</li> <li>TD stressed the importance of public education on navigating primary care pathways, self-care, and additional roles, noting that CHC is perceived as financially driven and often generates complaints when funding is denied due to policy adherence.</li> </ul> <p>The updated was noted.</p>	
15.	<p><b>Policies for Review</b></p>	
	<p>The following policies were presented to the committee, providing assurance that each had undergone review in accordance with the annual schedule, and that all content remains current and pertinent.</p> <p><b>Complaints Handling Policy and Procedure</b> JP confirmed that there were no substantive amendments to the policy and requested committee approval to proceed, unless members had any queries or concerns. He proposed a two-week period for committee members to submit any feedback or comments.</p> <p>CA endorsed the suggested deadline as appropriate. JS identified a specific editorial issue relating to the clarity of a bullet point on page six of the policy document and offered to address the wording outside the committee meeting.</p> <p><b>Media Policy and Approach to Engagement with People and Communities</b> Chris Williams (CW) reported that the media policy had also been reviewed, with no amendments deemed necessary at this time. He noted, however, that ongoing developments within Integrated Care Partnerships (ICPs) may necessitate a revised approach for Norfolk and Suffolk in the future, rather than further revisions to the existing policy.</p>	

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16.	<p><b>Items for Escalation to ICB Board</b></p> <p>No formal new escalations were identified for submission to the Board at this time. Nevertheless, the following points are recommended for inclusion in the updated report to the Board:</p> <ul style="list-style-type: none"> <li>• A summary of the discussion regarding risk areas identified during the current meeting.</li> <li>• An outline of priorities for forthcoming sessions, with emphasis on the commitment to continuous improvement.</li> <li>• Updates from both Healthwatch and the Complaints Team to be incorporated into the Board report.</li> <li>• Consideration of the All-Age Carers Strategy report, highlighting performance metrics and recommended mitigation measures. Furthermore, acknowledgement of TG’s leadership within the voluntary sector and the ongoing development of the assembly is recommended for Board awareness.</li> </ul> <p><b>Positive Highlights</b></p> <ul style="list-style-type: none"> <li>• The system is currently ranked highest nationally for referrals to the digital weight management programme—a notable achievement that merits recognition by the Board.</li> <li>• Successful quality improvement nurse-led initiatives have had a demonstrable positive impact on care homes, reflecting effective teamwork and collaboration.</li> <li>• Significant progress has been made on the Voluntary, Community and Social Care (VCSC) action plan, including its relaunch, introduction of a newsletter, completion of a gap analysis, and the implementation of targeted initiatives to address identified needs.</li> </ul> <p>Together, these items reflect both the challenges and positive outcomes discussed, offering assurance of ongoing efforts and achievements within the system.</p>	
17.	<p><b>Any Other Business</b></p> <p>No items were raised.</p>	
<p><b>Date, time, and venue of next meeting: To be confirmed</b></p>		

**Minutes agreed as accurate record of meeting:**

Signed: ..... Date: .....  
Chair

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



## Norfolk & Waveney ICB Patients and Communities Committee Action Log

No	Meeting date added	Description	Owner	Action Required	Action Undertaken / Progress	Due date	Status	Date Closed
26	25.11.24	Mental Health Referrals	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. <b>Update 28.8.25: Briefing to be circulated by 5.9.25</b>	28.7.25 <del>19.5.25</del> <del>24.3.25</del> <del>27.1.25</del>		
38	28.8.25	Hospice Funding Risk	TD / FS / MD	Escalate risk to the regional quality group, and confirm by the next meeting whether mitigating actions are in place and if the risk should remain on the committee's register.	Update 30.10.25: Currently no escalation to region required due to an agreed plan to recommission services within the local budget as phase 1, with phase 2 to address additional resource needs.	3.11.25		
39	28.8.25	Community Support Service Risk	MB	Risk relating to the Community Support Service to be removed from P&CC risk register and transferred to the Commissioning and Performance committee.	Update 28.10.25: Action complete	3.11.25		
40	28.8.25	Healthwatch Suffolk Elective Care Report	KB	Share the Healthwatch Suffolk elective care report with the Scheduled Care Board	Update 28.10.25: Report shared at meeting on 16.10.25	3.11.25		
41	28.8.25	James Paget Hospital Waiting Times Information	C Dillaway	Publish average wait times by speciality on the James Paget Hospital website and signposting to relevant resources	Update 28.10.25: Action complete	3.11.25		
42	28.8.25	Ageing Well	RP	invite Dr Sarah Zaidi to a future committee (once future committee dates are set) to present her work on health management and risk stratification models.		1.12.25		

Made by Rachael  
 30/10/25 14:15:50

Agenda item: 05

<b>Subject:</b>	<b>Patients and Communities Committee Risk Register</b>
<b>Presented by:</b>	<b>Mark Burgis, Executive Director of Patients and Communities</b>
<b>Prepared by:</b>	<b>Rachael Parker, Executive Assistant</b>
<b>Submitted to:</b>	<b>N&amp;W ICB Patients and Communities Committee</b>
<b>Date:</b>	<b>3 November 2025</b>

**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. Since August’s meeting the mitigated score has reduced from 12 to 9 as several of the contributing risks to the overall BAF score have reduced, thus reducing the overall score as a reflection of the remaining risk.

**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.

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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.

There have been no changes to scoring since August's meeting.

More detailed information regarding both risks can be found in Appendix 1.

In addition, the following risk is still being reviewed and will remain on the risk register until mitigating actions and alternative ownership have been agreed.

**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 PEO LC 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

Since the last meeting in August a new risk has been added in relation to the Shrewd contract.

**Risk 106 - Shrewd Contract:** The Shrewd contract, which is crucial for the System Coordination Centre's data feed, is at risk of ending in March 2026. This is the data platform that enables full oversight of all key live UEC metrics e.g. ambulance arrivals, handover times, emergency department figures, OPEL status, etc. This poses a significant risk to the coordination and management of system-wide data, potentially affecting the ability to monitor and respond to system pressures effectively. This risk is being escalated to the joint EMT for urgent attention and resolution.

### Recommendation to the Committee:

The committee is asked to:

- Note the update and the new risk identified (risk 106).
- Consider whether any additional actions should be identified.

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

## Governance

<b>Process/Committee approval with date(s) (as appropriate)</b>	
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Risk ID	Risk Title	Risk Description	Risk Owner	Risk Committee	Operational Lead	Risk Identified	Target Date	Unmitigated score	Mitigated Score	Target Score	Controls	Action	Action Owner	Start Date	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 2022	31 Mar 2026	16	9	8	<p>Community Voices gathering insights into HI and connecting with local communities to help address.</p> <p>Datahub Population Health dashboards in place to support reporting and population health management approaches.</p> <p>External factors that impact on "Plus groups" (such as the moving of hotels for asylum seekers which impacts on the services they receive) are raised by the HI team to be managed across the ICP.</p> <p>Health and wellbeing partnerships and place boards overseeing local work programmes.</p> <p>Health Inequalities &amp; VCSE Partnering team appointed to lead health inequalities work programme development.</p> <p>The HI Strategic Framework for action and the PHM strategy have been published. Implementation plans under development.</p> <p>The Health Improvement Transformation Group (HITG) focusses on Primary Prevention: smoking, physical activity and Healthy weight, report to ICP.</p> <p>ICS groups set up for Inclusion health groups, vaccines inequalities, Core20plus5 programme group, NHS Anchors group, access and support programme group, reporting to HIOG</p> <p>Refresh of the VCSE Assembly and partnership working reporting into the PH&amp;I Board. New Assembly Chair appointed.</p> <p>Specialty advisors are leading on HI, PHM and the Core20Plus5 clinical areas.</p> <p>ICP supported proposals for a strategic group and co-ordination group to formally oversee delivery of the Health Inequalities Framework for action. Co-ordinating multi-partner health inequalities group now in place. SROs established for Lifestyle factors and Healthcare Inequalities</p>				

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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 2024	31 Mar 2028	20	12	12	Increased focus upon early intervention (identify and intervene)	Ageing Well Programme Blueprint developed to establish priorities and align workstreams and agreed at Programme Board	William Lee	04 Nov 2024	31 Mar 2026
											Increased focus upon upstream prevention and remaining active	Develop appropriate system Dashboard with all core workstream metrics	William Lee	04 Nov 2024	19 Feb 2026
											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; recent examples such as the NHS-wide pay increases for staff which did not result in further funding for hospices to mitigate this. Without this funding feeding through to charitable organisations it has meant these organisations that serve a large patient group within the PEOC space are becoming 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.	Olga Emmerson	Patients and Communities Committee	Zoe Nash	20 Sep 2024	31 Mar 2026	12		8	To ensure commissioning arrangements are in alignment.	Work with stakeholders to redesign the model of care for palliative care in Norfolk and Waveney: Plan for x 3 workshops between Oct 25 and Jan 26 to define the requirements for the new model of care and to inform the refreshed specifications. Involvement of Healthwatch and a strong service user voice.	Zoe Nash	29 Oct 2025	30 Jan 2026
											Work with stakeholders to redesign the model of care for palliative care in Norfolk and Waveney to define what good looks like to inform revised commissioning/funding arrangements. This shall involve developing new evidence-based care setting specifications.	Work with ICB PH data analyst colleagues to identify the capacity needed to meet the needs of the local population as per National recommendations.	Maggie Tween	29 Oct 2025	28 Nov 2025
											To identify the capacity needed to meet the needs of the local population as per National recommendations.	Work with BI colleagues to refresh the palliative care dashboard to monitor the outcomes-based delivery of palliative care services and to be in alignment with Suffolk.	Zoe Nash	29 Oct 2025	30 Jan 2026
											To monitor the outcomes-based delivery of palliative care services and to be in alignment with Suffolk.	Review of commissioning and funding arrangements and agreement of contracting/procurement next steps at Oct and Nov CTPOG meetings.	Zoe Nash	29 Oct 2025	28 Nov 2025
											Review of commissioning and funding arrangements: Gap analysis and review of commissioning and funding arrangements to identify opportunities to reduce variation and improve access. Agreement of most appropriate contractual and procurement route to address these issues.				

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106	Shrewd Contract	The SHREWD contract, which is crucial for the System Coordination Centre's data feed, is at risk of ending in March. This poses a significant risk to the coordination and management of system-wide data, potentially affecting the ability to monitor and respond to system pressures effectively.	Mark Burgis	Patients and Communities Committee	Ross Collett	17 Jul 2025	31 Mar 2026	20	9	8		This risk is being escalated to the joint EMT for urgent attention and resolution.	Rebecca Richards	08 Jul 2025	31 Mar 2026
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Agenda item: 07

<b>Subject:</b>	<b>Elective Care Performance</b>
<b>Presented by:</b>	<b>Diane Smith, Head of Collaborative Commissioning and Performance</b>
<b>Prepared by:</b>	<b>Diane Smith, Head of Collaborative Commissioning and Performance</b>
<b>Submitted to:</b>	<b>N&amp;W ICB Patients and Communities Committee</b>
<b>Date:</b>	<b>3<sup>rd</sup> November 2025</b>

**Purpose of paper:**

To provide the committee an update on the referral to treatment (RTT) times for the Norfolk and Waveney Population and an overview of the work to meet national 2025/26 planning ambitions.

**Executive Summary:**

NHS Norfolk and Waveney, and the three acute provider Trusts within the geography of Norfolk and Waveney, are currently behind plan to deliver on objectives for elective care as set and agreed for 2025/26. There are robust governance arrangements and system-level work underway to support recovery. Plans to deliver to the commitments made for 2025/26 are reliant on key factors such as availability of skilled workforce, implementation of productivity programs and delivering new ways of working.

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## Report

### 1. Waiting times

The following provides a view of the current position against plan, and improvements to date.

#### 1.1 Plans

Annual performance is agreed through the annual planning cycle, following guidance from NHSE. The 2025/26 annual plans have recently been reviewed and providers asked to re-profile trajectories to return to the 2025/26 plans in December 2025. Both the Norfolk and Norwich University Hospital NHS Trust and the Queen Elizabeth Hospital Kings Lynn have trajectories that return to original plan by end of December 2025, and maintain original targets submitted to the 31<sup>st</sup> March 2026. Further work is required at the JPUH to establish plans that support a return to the original planned delivery at 31<sup>st</sup> March 2026.

#### 1.2 65-week RTT

Following expectations of 65-week waiting times being eliminated prior to the 2025/26 financial year, providers in Norfolk and Waveney set plans to eliminate these waits by 30<sup>th</sup> June 2025. At the end of June, the combined provider position was a total of 150 people waiting, a significant improvement from 2,892 people waiting 65 weeks in June 2024.

The August position grew to 277 (261 in Norfolk and Waveney provider Trusts) due to general capacity issues and challenges delivering in certain clinical specialties, as well as a group of referrals being identified to move to waiting lists late in the referral pathway process.

#### 1.3 52-week RTT

NHS Norfolk and Waveney submitted a plan to achieve no more than 1.7% of people on the total waiting list waiting over 52-weeks by 31<sup>st</sup> March 2026. This fell outside of the planning guidance.

At the end of August 2025, achievement was behind the planned position by 1.1 percentage points. This equates to 2,090 more people waiting than planned. The position has been improving continuously for 2-years, with almost 3,500 less people waiting compared to August 2024, and over 5,700 less people waiting compared to August 2023.

#### 1.4 18-week RTT

NHS Norfolk and Waveney submitted a plan to achieve 60.5% of people on the total waiting list being receiving treatment within 18-weeks of referral by 31<sup>st</sup> March 2026. This aligned with the NHSE planning guidance.

At the end of August 2025, 55% of people received treatment within the standard, this was 1.6 percentage points off plan. There have been improvements in 18-week

performance since September 2024, however July and August 2025 saw a drop in the improvement trend.

## 2. Delivery of 2025/26 plans

### 2.1 Governance

Performance is assured through NHSE process of ‘tiering’ Trusts. Meetings are held with each Trust fortnightly to track progress against planned performance.

Trust tiering positions/changes for Elective and Diagnostic services are as follows:

	QEH		NNUH		JPUH	
	Q1	Q2	Q1	Q2	Q1	Q2
Diagnosics	T2	T1	T1	T1	T2	T1
Elective	None	None	T1	T2	T2	T1

Further, contractual arrangements and system-wide Commissioning and Performance Committee - which has delegated authority from the ICB Board – are routes of assurance and escalation.

All Trusts that were behind their planned position, or trajectory, in September 2025 have rephased their plans and submitted these to NHSE. Where plans have been outside of the 2025/26 objectives, appropriate contractual oversight and assurance has also been sought.

### 2.2 Improvement plans

All Trusts have in place plans to continue improvements to the end of 2025/26 – noting that planning has begun for 2026/27 and forthcoming financial years.

Improvement plans are centered around:

- **Productivity** – ensuring that services are maximising use of available resources, for example through use of the Patient Engagement Portals to reduce missed appointments and efficient use of operating theatres. This is often grouped by area, such as ‘outpatient improvement’, and may be supported by external specialists.
- **Financial** – use of available finances and/or additional funding through specific bids or recovery funds, to support additional capacity.
- **Workforce** – challenges remain within some clinical areas of ensuring the workforce with the appropriate skills are available to deliver services. Where workforce is of a critical nature, alternative routes can be used to address short-term shortages, such as bank, agency or insourcing.
- **Validation** – all Trusts have engaged in the national waiting list validation exercise, to ensure that all who are on a waiting list are still in need of elective care and that it is being offered as per agreed criteria.
- **New ways of working** – new community-based or dedicated centres, new innovations or clinical options that support services to be offered in less-invasive ways which may not require admission or may speed up pathways are developed where possible.

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- **Norfolk and Waveney Hospitals Group** – the development of the ‘group’ affords opportunities to collaborate where efficiencies can be gained and/or clinical expertise can be shared. This is being explored in certain specialties where there is anticipated to be key gains.
- **Operational oversight** – according to need, Trusts employ an appropriate frequency and intensity of oversight to the management of waiting lists.
- **Flow** – continual work is underway to support flow through hospitals, ensuring people remain in hospital only when they clinically need to be there. Elective care is also dependent on effective delivery of diagnostic services.
- **Demand** – the ICB is working with providers to review demand, ensure it is appropriate and is routed the most appropriate pathway of care/treatment. This area of work is important for current delivery and future planning.

Within this, priority may be given to longest waiting patients, those with an urgent need and/or those waiting on [suspected] Cancer pathways. As we head into winter, the plans to manage seasonal pressures are also imperative to the ongoing recovery of elective care services.

**Recommendation to the Committee:**

To note the contents of the report, and work with system partners to support the continued recovery of elective care services.

<b>Key Risks</b>	
<b>Clinical and Quality:</b>	There are clinical risks associated with long-waits for elective care – the impact of long waits is reviewed within Trusts and reported to the ICB.
<b>Finance and Performance:</b>	Delivery of all performance areas outlined is currently challenging and will require ongoing grip and oversight of all areas of mitigation. Financial risks are contained within the deployment of insourcing/outourcing.
<b>Impact Assessment (environmental and equalities):</b>	Waiting lists are reviewed for any potential inequalities in access
<b>Reputation:</b>	Under delivery of elective care risks the reputation of Trusts and the ICB.
<b>Legal:</b>	Nil
<b>Information Governance:</b>	Nil
<b>Resource Required:</b>	Nil
<b>Reference document(s):</b>	Nil

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<b>NHS Constitution:</b>	The NHS constitution contains expected waiting time standards.
<b>Conflicts of Interest:</b>	Nil
<b>Reference to relevant risk on the Board Assurance Framework</b>	BAF risk 07

### Governance

<b>Process/Committee approval with date(s) (as appropriate)</b>	Nil approval sought
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Improving lives **together**

Norfolk and Waveney Integrated Care System

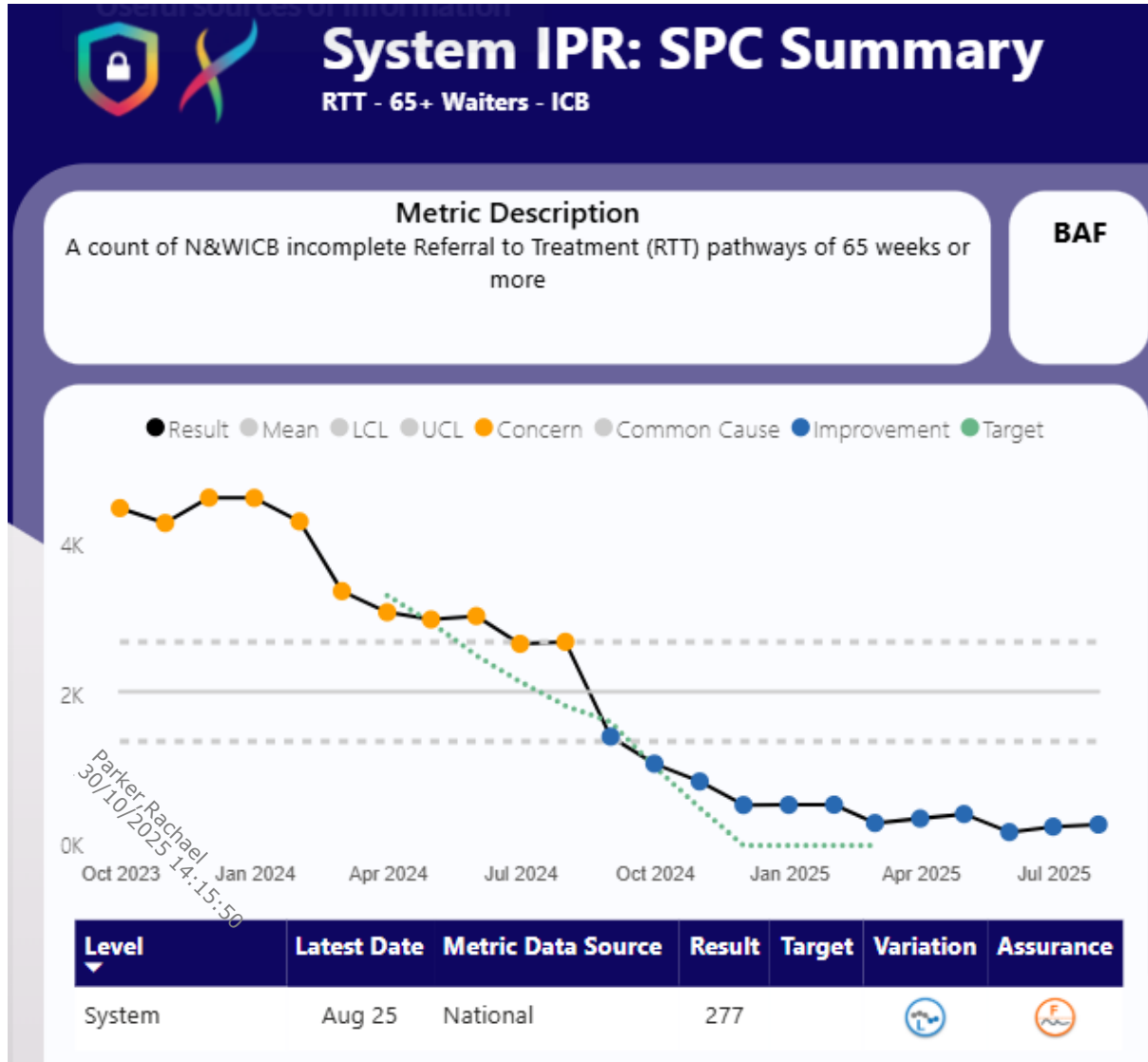
# Long Waits Data

Created: 17<sup>th</sup> October 2025

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# 65-week waits – System position

This is the position for all providers to Norfolk & Waveney population, in and outside of Norfolk & Waveney geography.



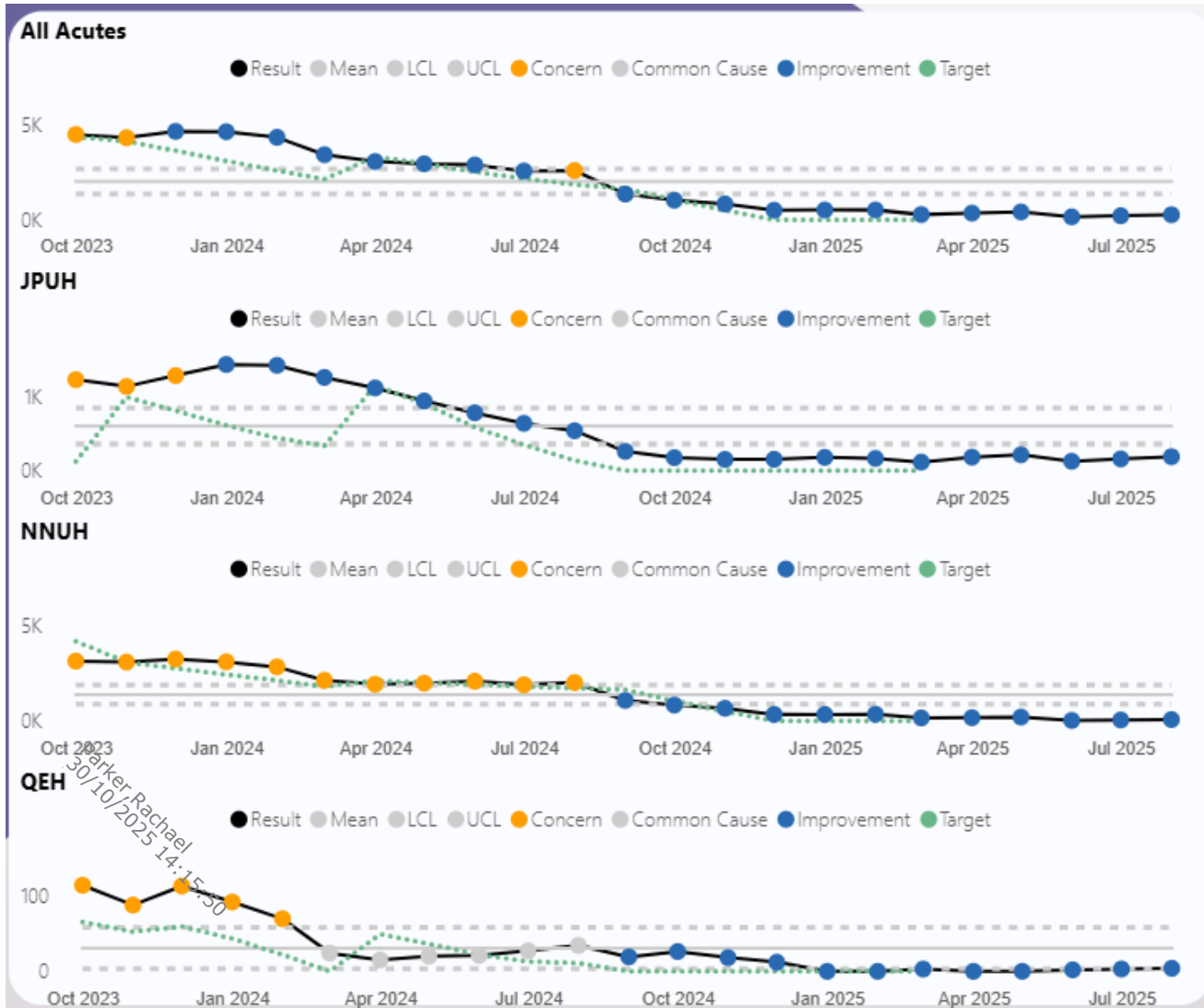
65-week waiting times continue to improve and are in Special Cause Improvement, however 65-week waiting times should have been eliminated by this point. At the end of August 277 people continued to wait 65 weeks or more, from referral to treatment.

Remedial plans have been received from the Trusts and are being monitored for delivery by the ICB and NHSE. Some specialties are more challenged in delivering '0' 65-week waits.

System approaches and support are being pursued to reduce long waits as far as possible.

# 65-week waits – Provider position

This is the position for providers within Norfolk & Waveney geography only. The 'all acutes' performance will be different to the ICB performance shown on the previous slide.



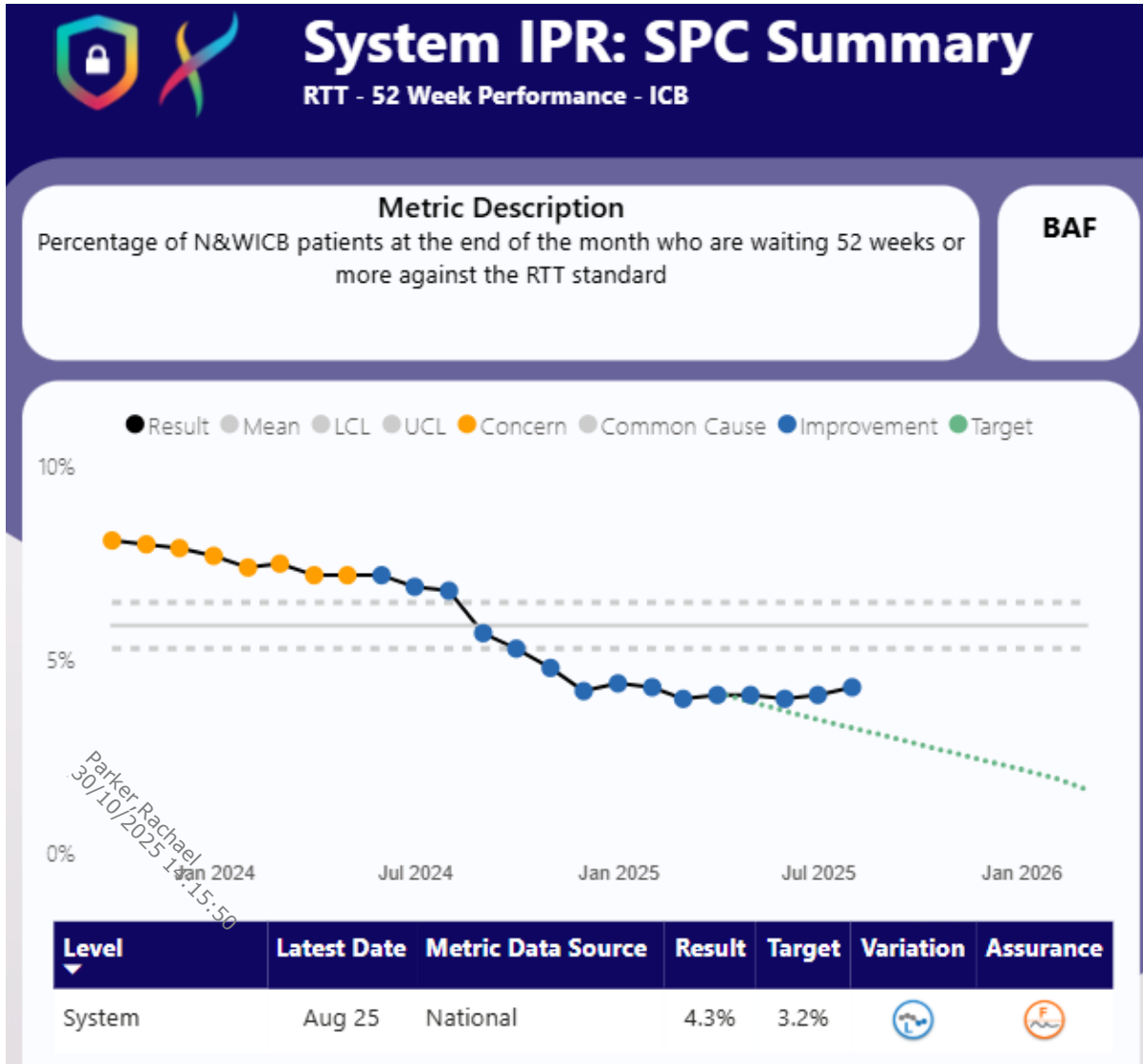
The Statistical Process Control chart continues to show an improvement of special cause, however the performance assurance has 'failed' as the '0' target has not been met.

At a provider level, the JPUH faces the greatest challenges. The Norfolk and Waveney Hospitals Group model is being utilised to maximise opportunities to eliminate these long waits.

Level	Latest Date	Metric Data Source	Result	Target	Variation	Assurance
QEH	Aug 25	National	4	0		
NNUH	Aug 25	National	68	0		
JPUH	Aug 25	National	189	0		

# 52-week waits – System position

This is the position for all providers to Norfolk & Waveney population, in and outside of Norfolk & Waveney geography.



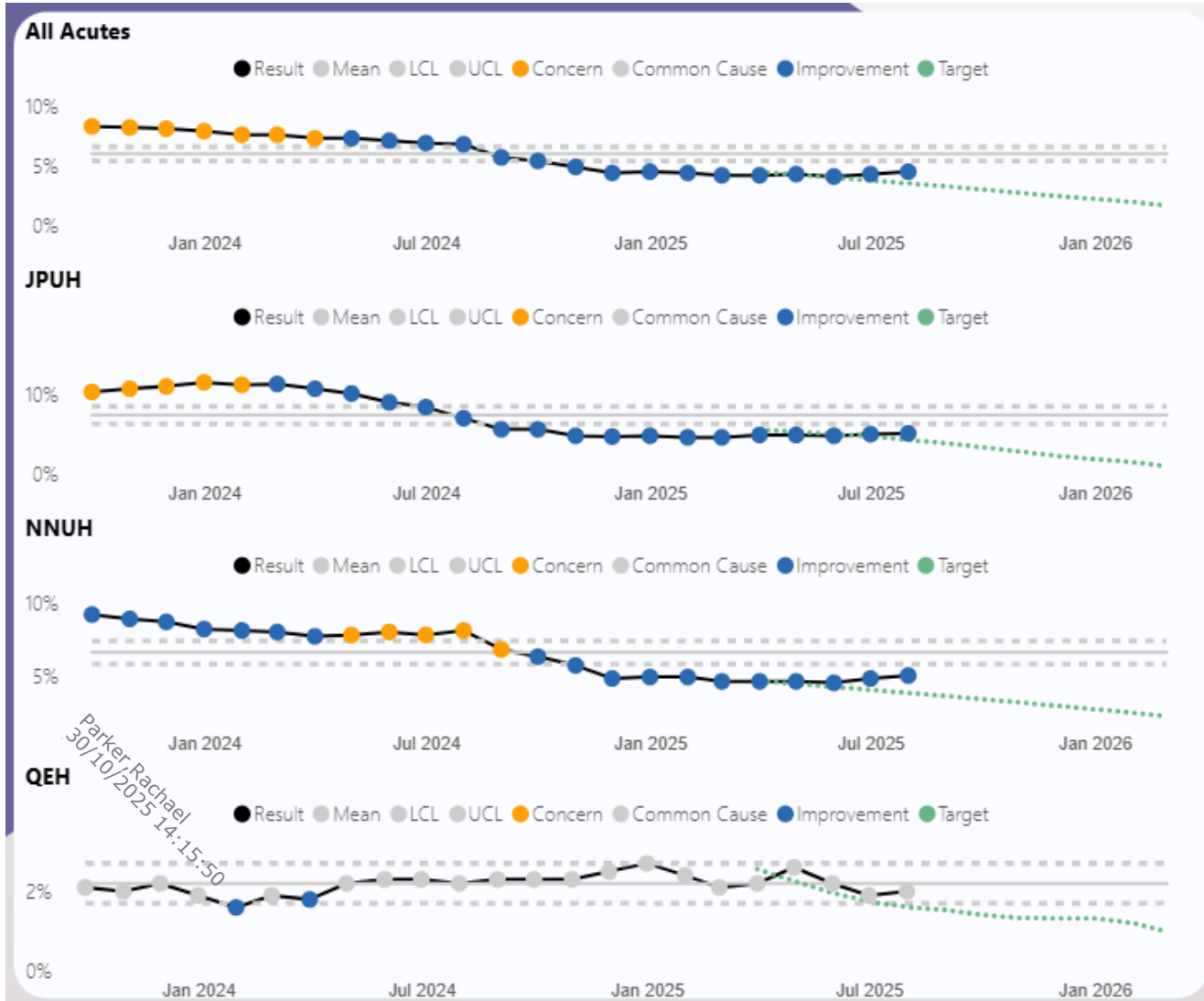
52-week waiting times continue to improve and are in Special Cause Improvement, however the system is off plan in August. (NB low numbers are good in this metric)

Focus on treating people waiting or about to have been waiting 65-weeks or in urgent need, and, for some specialties, a focus on Cancer referrals has impacted this performance.

Various interventions have/are being implemented to improve the position (see accompanying paper).

# 52-week waits – provider position

This is the position for providers within Norfolk & Waveney geography only. The 'all acutes' performance will be different to the ICB performance shown on the previous slide.



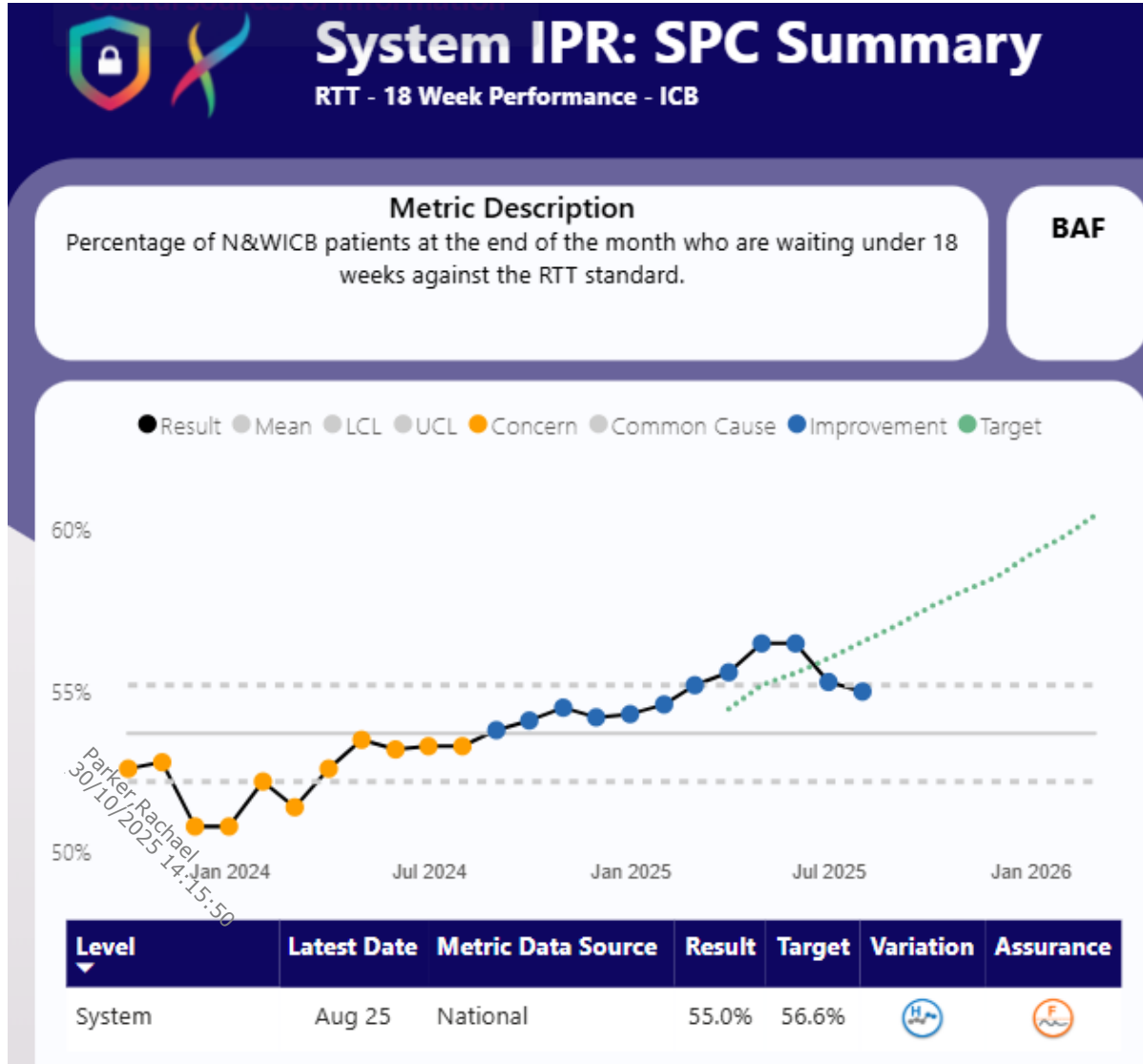
All Trusts are off plan in August. NNUH and JPUH remain in Special Cause improvement. While QEH shows common cause variation, performance at QEH is closer to plan and plan in August is closer to the national ambition for 31<sup>st</sup> March 2026.

All Trusts have remedial plans in place and have shared new trajectories to 31<sup>st</sup> March 2026. At present the JPUH plan does not return to the plan originally submitted for 2025/26.

Level	Latest Date	Metric Data Source	Result	Target	Variation	Assurance
QEH	Aug 25	National	2.0%	1.6%		
NNUH	Aug 25	National	5.0%	3.8%		
JPUH	Aug 25	National	5.1%	4.3%		

# 18-week waits – System position

This is the position for all providers to Norfolk & Waveney population, in and outside of Norfolk & Waveney geography.



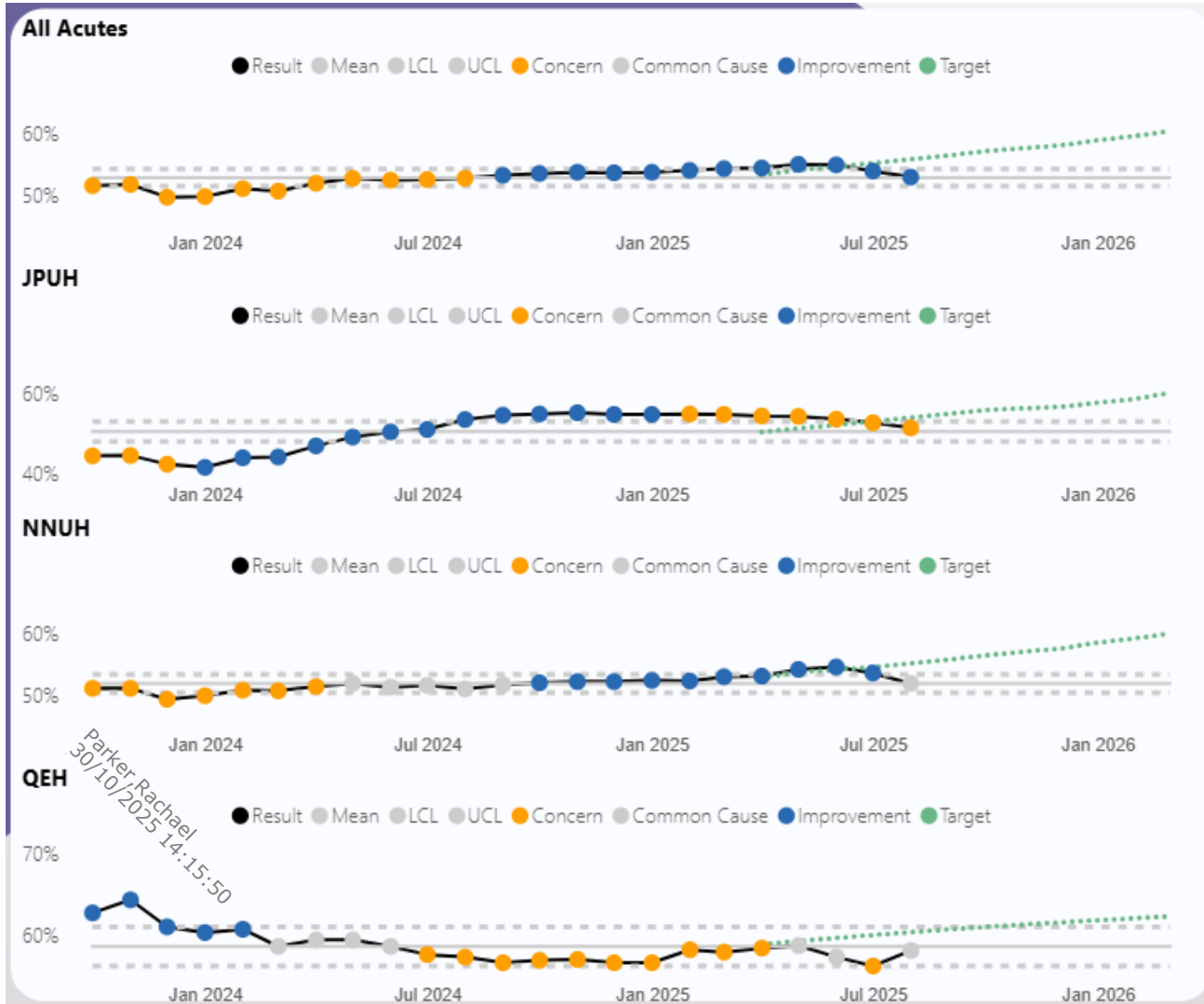
18-week waiting times continue to improve and are in Special Cause Improvement, however performance is under plan for August.

A focus on eliminating / reducing people with longer waiting times or in urgent need, and, for some specialties, a focus on Cancer referrals has impacted this performance.

Various interventions have/are being implemented to improve the position (see accompanying paper).

# 18-week waits

This is the position for providers within Norfolk & Waveney geography only. The 'all acutes' performance will be different to the ICB performance shown on the previous slide.



18-week waiting times are under plan at all three acute Trusts.

All Trusts have remedial plans in place and have shared new trajectories to 31<sup>st</sup> March 2026. At present the JPUH plan does not return to the plan originally submitted for 2025/26.

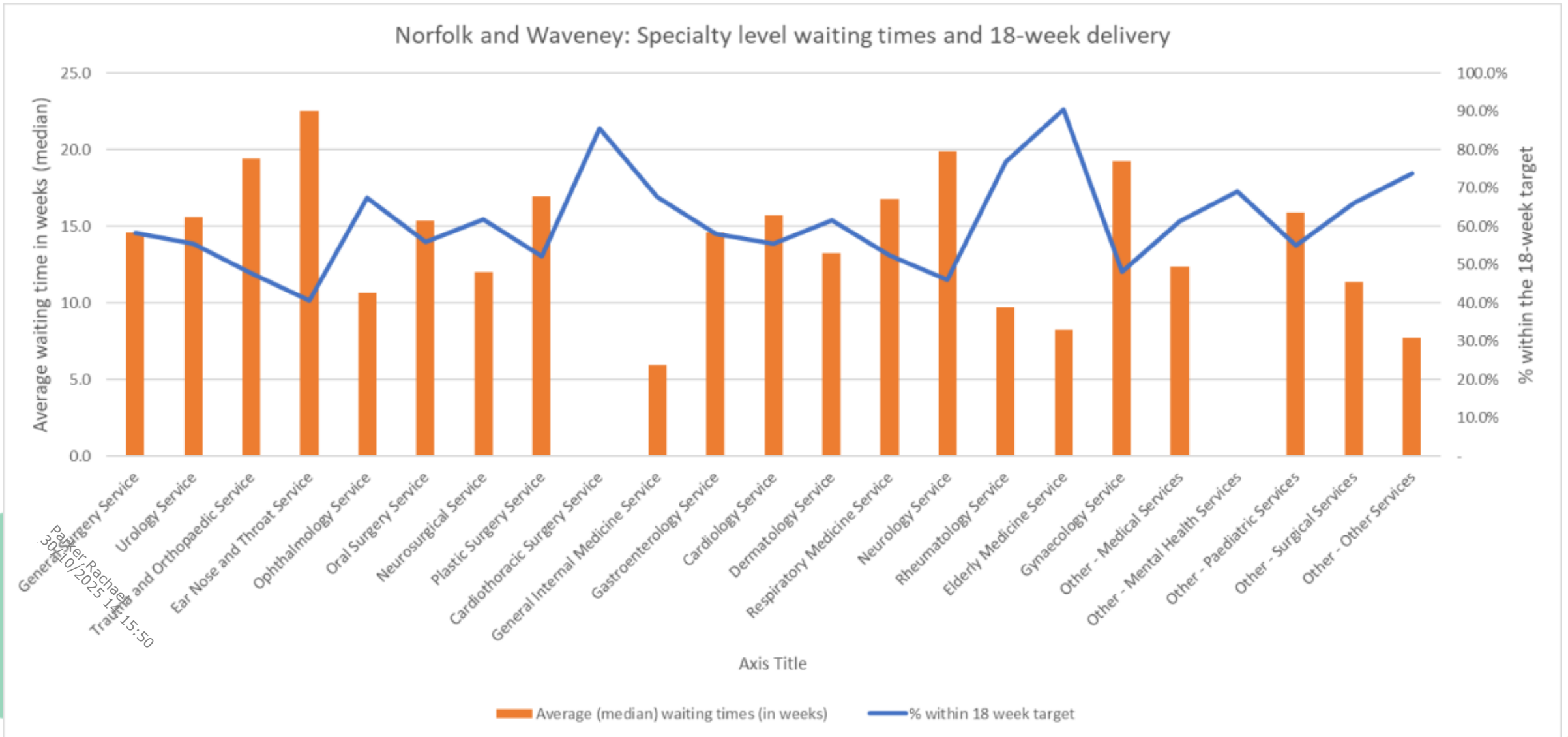
Level	Latest Date	Metric Data Source	Result	Target	Variation	Assurance
QEH	Aug 25	National	58.1%	60.3%		
NNUH	Aug 25	National	51.9%	55.2%		
JPUH	Aug 25	National	51.3%	53.9%		

# Specialty detail

Reporting to August 2025

Data source: [Acute Referrals Dashboard 2526 M05 - N&W ICB - Contract Report Sharing - Futures](#)








Norfolk and Waveney: Specialty level waiting times and 18-week delivery






# Appendix – Statistical Process Control interpretation

Parker Rachael  
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## Variation/Performance Icons

Icon	Technical Description	What does this mean?	What should we do?
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is <b>currently not changing significantly</b> . It shows the level of natural variation you can expect from the process or system itself.	<b>Consider if the level/range of variation is acceptable.</b> If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	<b>Something's going on!</b> Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	<b>Investigate</b> to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	<b>Something's going on!</b> Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	<b>Something good is happening!</b> Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. <b>Celebrate</b> the improvement or success. Is there <b>learning</b> that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	<b>Something good is happening!</b> Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	<b>Something's going on!</b> This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	<b>Investigate</b> to find out what is happening/ happened. Is it a one off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

## Assurance Icons

Icon	Technical Description	What does this mean?	What should we do?
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies <b>within</b> those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies <b>outside of those limits in the wrong direction</b> then you know that the target cannot be achieved.	<b>You need to change something in the system or process if you want to meet the target.</b> The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies <b>outside of those limits in the right direction</b> then you know that the target can consistently be achieved.	<b>Celebrate the achievement.</b> Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

# Primary Care Access Patient & Communities Committee

**3 November 2025**

Parker Rachael  
30/10/2025 14:15:50

# Primary Care Access

## Community Pharmacy, Dentistry, General Practice & Optometry

Access to integrated primary care services remains a core priority for our system — not in the sense of being all things to all people, but in ensuring that every person can reliably access the right care, at the right time, in the right place

To improve health and wellbeing outcomes for individuals and communities, our local commissioning and transformation programmes focus on equity, responsiveness, and continuity, whilst recognising that access must be shaped by **local needs, workforce capacity, and sustainable models of care**. These priorities do not always neatly align with those of others, and can be complicated by funding streams, national targets and individual organisational priorities

We want to work with communities and contractors to understand and balance these, using a data-driven approach supported by lived-experience to support the development of a strong, integrated primary care system across Norfolk & Waveney

# Access to Strong Primary Care Systems

Primary care providers are often the first point of contact in local healthcare systems and play a key role in:

- **Preventing illness** through vaccinations, screenings, and lifestyle advice
- **Detecting conditions early**, which leads to better treatment outcomes
- **Ongoing relationships** between patients and providers, which builds trust and supports adherence to treatment
- Addressing **health inequalities**, serving diverse populations, including deprived and rural areas
- Offering **more equitable access** to healthcare, especially when services are embedded in neighbourhoods or tailored to local needs

Strong primary care systems are associated with **lower mortality rates, better management of chronic diseases** like diabetes, hypertension, and asthma and **improved mental health support**, especially when integrated with community services

Cost effective primary care supports **more efficient use of NHS resources**, especially when care is person-centred, proactive and community-based

# Primary Care – discussion points

**Access as a foundation, not for everything:** access is not about offering every service to every person at every moment — it's about making sure people can get what they need when they need it, especially those who face the greatest barriers

**Tailored to population need:** prioritising access where it matters most — in communities with the greatest health inequalities, and in ways that reflect the diversity of need across Norfolk and Waveney

**Sustainable and realistic:** building models of care that are sustainable for our workforce and system — recognising that access must be balanced with quality, continuity, and clinical appropriateness

**Collaborative and evolving:** access is not static — it evolves with our population, our workforce, and our digital capabilities.

**HOW MIGHT WE UNDERSTAND, DISCUSS AND RESPOND  
TO ACCESS NEEDS AND CHALLENGES BETTER TOGETHER ?**

# Dentistry Overview

The ICB's Long Term Dental Plan was approved May 2024 and focuses on children and young people and reducing health inequalities. National contract reform will take effect from April 2026 following public consultation in August 2025. There have already been revisions to the national contract.

We are responsible for primary, community and secondary care dental services, including high street dental practices, orthodontic providers, Level 2 enhanced services (minor oral surgery), secondary care oral surgery, orthodontics and Maxillo Facial services

Improving Access:

- We made an investment of £1.5m in 2024/2025, 98,000 new patients seen last year.
- We are currently tendering for a new contract in Thetford to start in 2026
- Increased access in Out of Hours in Norwich and Lowestoft on Saturdays, with work ongoing to open in King's Lynn, which would give us 7-day service for urgent care appointments across N&W
- Further increased capacity in North Norfolk and South Norfolk this year
- Improving rates of pay for dentists through a local uplift targeted at rural, coastal and areas of deprivation

# Dentistry – locally commissioned services

Other locally commissioned services:

- Child Focused Dental Practices – 7 providers across N&W area working in collaboration with Community Dental Services to deliver oral health care to vulnerable children and young people in primary care
- Shared Care Pathway for individuals with medical needs without a regular dentist, e.g. receiving cancer treatment or cardiac care
- Urgent Dental Care: More than 29k appointments have been provided since 1 April 2025. The ICB has commissioned 23 local providers to offer urgent dental care, utilisation rate is 96.7% and Did Not Attends 0.4%. A new national scheme to incentivise urgent dental care alongside local schemes was launched in October 2025 – 28 local providers participating. Signposting to both schemes via NHS 111
- Trauma pathway
- TMJ (Temporomandibular Joint) services

# Dentistry - delivery of share of 700K activity

- ICB target is an additional 21,520 appointments over our baseline of 48,898 giving a total of 70,418 appointments.
- July data shows a slippage of 1,037 against a revised trajectory– end July of 19,844 appointments
- Key risks
  - Workforce and recruitment. ICB is investing £1.5m in schemes this year including a local version of Golden Hello for dentists
  - Ongoing active engagement by local providers participating in the scheme
  - Revised trajectory
- ICB has developed a comms and engagement plan based on the national guidance. To rollout in a phased manner to ensure urgent care providers (and specifically their clinical and admin teams) can respond to any additional demand.
- Exploratory discussions with GP Front Door provider as to how they can support
- Continuous monitoring of activity and analysis of NHS 111, GP Front Door, OOH and Emergency Department data

# Pharmacy First Contractor Engagement

## Direct Email Campaign

Following the successful development of the ICB Pharmacy Dashboard we share performance with our contractors monthly, with direct emails offering support and guidance to any pharmacy not reaching the threshold of 30 PF appointments needed for maximum reimbursement. These emails are separated into three groups, contractors with 0 activity, contractors with 1-19 and contractors with 20-29 with the support being tapered for the individual needs of these groups

As part of our work to understand the success and barriers to Pharmacy First access, the pharmacy commissioning team have undertaken 47 site visits, which equates to 28% of our contractors, since February 2024. These visits are planned around Pharmacy First and locality performance which allows the team to gain valuable insights and to offer direct, face to face support to colleagues; they also link to visits to the general practice visit programme to encourage shared understanding and collaborative working on the ground between individual contractors

# Pharmacy First Integration Project

This collaborative project with SNEE ICB ended at the end of September with a final project report to be presented at Primary Care Commissioning Committee

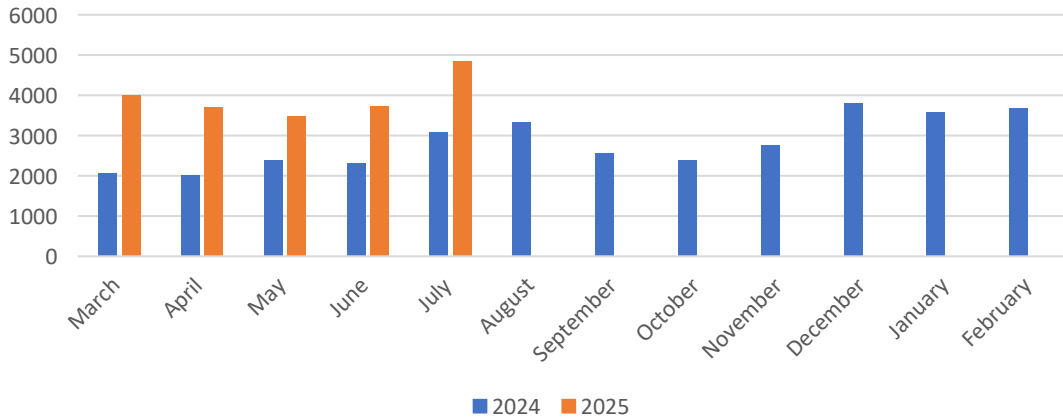
This project commissioned Community Pharmacy Norfolk and Suffolk (CPNS) to support referrals to pharmacies, and activity increases in key service lines such as the Discharge Medicine Service, Pharmacy First, Hypertension and Contraception

Support has been provided across various platforms such as contractor webinars and face to face training events

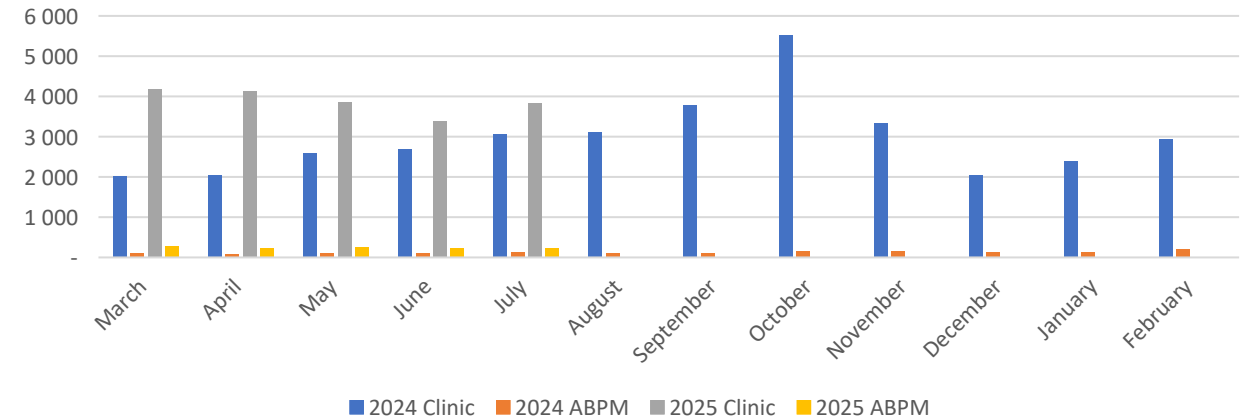
There has also been a focus on patient awareness through several social media campaigns. Initial results are showing a growth in all service lines above that of the national average

# Pharmacy First Performance Data

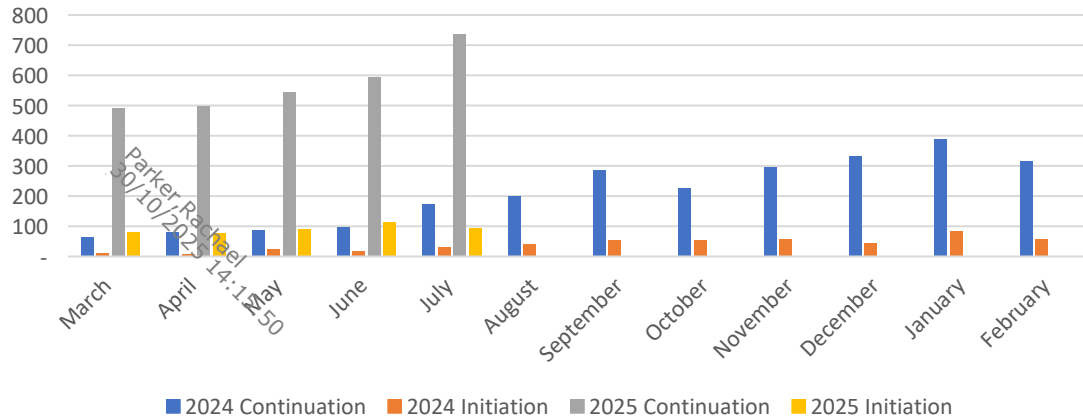
### Clinical Consultations YOY



### Hypertension YOY



### Contraception Service YOY Comparison



We continue to progress our work on Pharmacy First by direct engagement with, and support to, our contractors. We are also working close with our ICB locality and NHS 111 teams to help support an increase in the volume of patients that are being referred (electronically or via signposting) into the service by General practice and other key stakeholders

We are seeing significant year on year growth for the period of March - July in Clinical Consultations (66.8% increase) Hypertension (58.8%) and Contraception (451.4%)

Norfolk and Waveney has seen the highest YoY increase in EOE for Clinical Pathways in the last three months (May, June, July) at 56.83%, and the second highest year on year increase in all three elements for the same period at 41.7%

# Pharmacy First Winter Campaigns

Pharmacy contractors are required to take part in two national health campaigns and two local health campaigns (the latter agreed by ICBs and LPCs at a local level), both of which will focus on and promote the Pharmacy First service to the public

**Monday 20 October 2025 to Sunday 9 November 2025**

Promotional materials will be displayed in pharmacies and social media to coincide with a national advertising campaign

**All contractors must ensure they take the appropriate action to meet this contractual requirement**

A further pharmacy health campaign will run from **Monday 2 February 2026 to Sunday 22 February 2026.**

# General Practice Appointment Data for August 2025

**553,922 appointments were recorded**

Area	Appointments	Population	Appointments per 1k patients
South Norfolk	<b>116,370</b>	244,783	<b>47</b>
Great Yarmouth & Waveney	<b>119,772</b>	243,742	<b>49</b>
Norwich	<b>115,132</b>	248,803	<b>46</b>
West Norfolk	<b>106,195</b>	186,364	<b>57</b>
North Norfolk	<b>96,453</b>	177,285	<b>54</b>

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# General Practice Appointment Data Recorded Year to Date

## Year to date 2024 - 2025

Area	YTD Apr–Aug 2024	YTD Apr–Aug 2025	Change	% Change
South Norfolk	638,373	643,496	+5,123	+0.8%
Great Yarmouth	644,094	647,974	+3,880	+0.6%
Norwich	605,813	637,919	+32,106	+5.3%
West Norfolk	571,203	578,200	+6,997	+1.2%
North Norfolk	509,275	526,556	+17,281	+3.4%
Total	2,968,758	3,034,145	+65,387	+2.2%

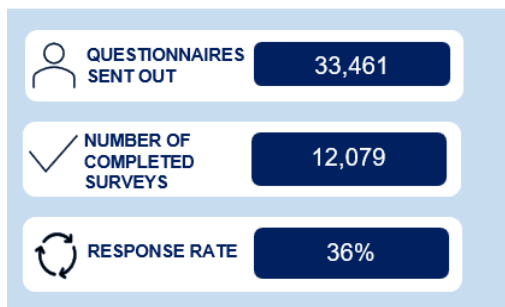
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# 2025 Patient Survey Results

## Summary

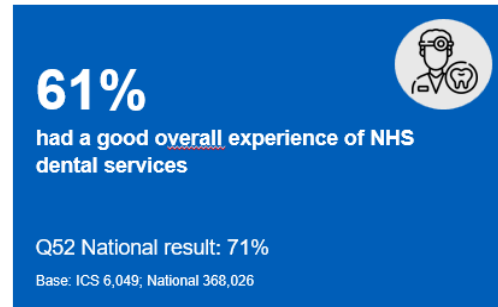
NORFOLK AND WAVENEY INTEGRATED CARE SYSTEM

GP PATIENT SURVEY



Data shows variation in experience, and outcomes

The GP Action Plan is a national tool which helps the ICB identify, understand and address unwarranted variation



In terms of overall GP Practice experience, N&W scored 3% higher than the national average (75%)

N&W scored 1% below the national average for pharmacy services and 10% below for dental services, albeit overall satisfaction with these services increased this year

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# GP Patient Survey – online uptake

The GP Patient Survey shows that many people in Norfolk and Waveney are making use of online services, the most common use is ordering repeat prescriptions, with nearly half of patients (46%) using this service

Around 4 in 10 patients (41%) have booked an appointment online, which is just below the national figure, while about a quarter have used online forms to share information about a health issue or to access their medical records

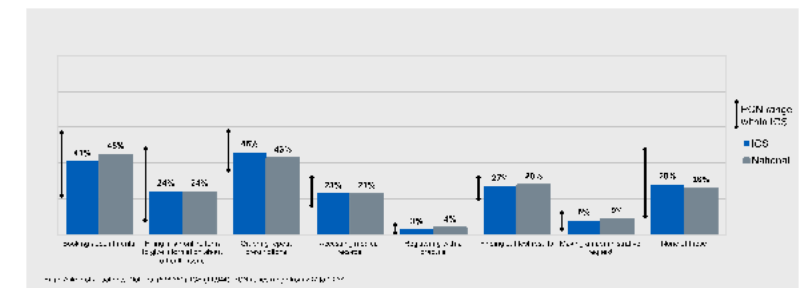
Fewer people use online services for tasks such as finding out test results (27%), making administrative requests (8%), or registering with a new practice (3%)

More than a quarter of local patients (28%) reported not using any online GP services in the last year. This suggests that while online access is becoming a normal part of how many patients interact with their GP, there are still barriers for some people, whether due to awareness, confidence, or access to digital tools

Use of online GP services in the last 12 months  
NORFOLK AND WAVENEY INTEGRATED CARE SYSTEM

GP PATIENT SURVEY

Q5. Which of the following online GP services have you used in the last 12 months?



1. The data in this chart is based on the GP Patient Survey data for the last 12 months.

10. Ipsos. All figures are based on the GP Patient Survey data.

# General Practice Digital Transformation Highlights

## Automation & Cloud Telephony

- Robotic process for repeat prescriptions has issued over 300,000 scripts
- A new robotic process for patient registration is being developed
- Practices have recently had new networks and full coverage wi-fi installed

## Notes Digitisation

- 6 practices currently digitising records: Lionwood, Elmham, Orchard, Theatre Royal, Mattishall, Shipdham
- 18 additional practices agreed in principle to start project
- Digitised notes uploaded to the National Document Repository (NDR)

## NHS App Adoption

- 60% of eligible Norfolk & Waveney residents have the NHS App
- Supporting practices to:
  - Enable notifications for messaging
  - Run campaigns using toolkits and tablet devices
  - By attending NHS App Events
  - Resources and Guidance created and available on Connect NoW

## Online Consultation / Video Consultation (OC/VC)

- All GP practices in N&W have an online access systems
- Supporting transition to total triage models

# Primary Care Workforce

## GP and Nursing:

- Coaching, mentoring, Continuous Professional Development Programmes in place across all professional groups
- GP Action Plan - Lowest negative workforce variation across East of England for GP and addressing data quality issues with 5 practices
- Newly Qualified GP, Nurse and Nursing Associate Incentive launched
- Changing demographics across both staffing groups, however consistent slow growth seen in workforce business intelligence modelling

## ICB plans for increase of ARRS Newly Qualified GPs

- 54% increase in ARRS GP roles since March 2024/25
- In April 25 PCNs submitted ARRS recruitment intentions for 2025/26. Forecast of 22.82 WTE – we are sitting at 50% of this target as of July 2025
- ARRS budget utilisation across all roles is currently forecast at 108%, signalling PCNs' intent to fully utilise the ARRS budget financial envelope with additional investment being made by PCNs



**Newly Qualified Nurse Incentive 2025-26**  
An opportunity to earn an extra £10,000 per annum for newly qualified nurses in primary care. The incentive is available for nurses who have completed their training and are registered with the Nursing and Midwifery Council (NMC) as of 1st April 2025.

**Newly Qualified GP Incentive 2025-26**  
An opportunity to earn an extra £10,000 per annum for newly qualified GPs in primary care. The incentive is available for GPs who have completed their training and are registered with the General Medical Council (GMC) as of 1st April 2025.



# Primary Care Workforce

## Dental:

- 8 dedicated workforce and training programmes to be delivered during 2025/26, budget £1.5M
- Dental Dashboard created to support workforce retention programmes, activity delivery to support resourcing and system priorities
- Approval of an additional Foundation Dental Training Practice, 11 now approved across the system
- 11 Dental Nurse Apprenticeships and 1 non-clinical dental apprenticeship
- Approved the Golden Hello N&W offer: 12 Nurses, 13 Therapists, 19 Dentist
- 3 new Dental Fellows focusing on: Level 2 services, Mini Mouth Matters and Workforce and Retention Programmes (including expansion of Foundation Training Practices and Terms of Agreement Practices)
- 5 Dental workforce programmes in September (Greener Dentistry, First Five, learning expansion, continuous professional development)
- Latest workforce dental position, figures show a workforce returned to 2020 levels. 2.7% increase in dentists per 100,000 population as of December 2024



**Newly Registered Optometrist Incentive 2025-26**  
Are you working or have recently been recruited as a newly registered Optometrist role within Warrington and Halton between 1st April 2025 - 31st March 2026?  
The Primary Care Workforce Team offer a £2,000 incentive for optometrists completing an Optometrist role for the first time in Warrington and Halton between 1st April 2025 - 31st March 2026.  
The Incentive will be subject to:  
• Being a newly qualified optometrist  
• Completion of a 12-month probation period  
• Completion of a 12-month probation period  
• Completion of a 12-month probation period  
To qualify you must complete an Expansion of Existing Role, confirming:  
• The Optometrist has qualified within the last 3 years  
• The Optometrist is employed for a minimum of 12 hours per week  
• Commitment to work at the Practice for 12 months  
Please note this offer is subject to a cap of 3 incentives and funding is limited to the available amount.  
[Click here to apply](#)

**Dental Nurse APPRENTICESHIPS**  
Are you interested in recruiting or upskilling a staff member to become a Dental Nurse?  
**Support is available**  
• £2,000 incentive  
**CONTACT US TO FIND OUT MORE**  
nwcb.primarycareworkforce@nhs.net

Agenda item: 09

<b>Subject:</b>	<b>Communications and engagement update</b>
<b>Presented by:</b>	<b>Chris Williams, Head of Communications and Engagement, NHS Norfolk and Waveney ICB</b>
<b>Prepared by:</b>	<b>Amy Metcalf, Deputy Head of Communications and Engagement, NHS Norfolk and Waveney ICB</b>
<b>Submitted to:</b>	<b>Patients and Communities Committee</b>
<b>Date:</b>	<b>3 November 2025</b>

**Purpose of paper:**

To provide an update on the communications and engagement activity of the ICB.

**Executive Summary:**

Since March 2025, a significant focus of the Communications and Engagement Team has been on supporting staff through and informing stakeholders about the national changes being made to ICBs, working closely with NHS Suffolk and North East Essex ICB (SNEE).

Current and recent work has included communications and engagement activity about staying well this summer and now preparing for winter, reducing medicines waste, the Ten-Year Health Plan, and ADHD Awareness Month. Future activities include a continued focus on organisational change communications and a targeted cervical cancer screening campaign.

**Report:**

**1. Organisational change programme and closer working with NHS Suffolk and North East Essex ICB**

In March 2025, significant changes were announced to the organisation of the NHS in England, including the role, functions and budgets of Integrated Care Boards (ICBs). A central priority for the Communications and Engagement Team has been to support staff through these changes with clear, timely internal communications, alongside keeping stakeholders informed. We have worked closely with colleagues at SNEE ICB to ensure a coordinated approach and consistent messaging.

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In addition to joint working about the organisational change programme, the communications and engagement teams from the two ICBs are also collaborating on other pieces of work. This has provided a really good opportunity to learn from each other and to make the best use of our collective resources.

We have introduced a new blog from the chief executive as a way to raise their profile in Norfolk and Waveney. It is framed around the three shifts in the Ten-Year Health Plan, highlighting work we are doing to move care from hospital into the community, how we are harnessing digital innovation, and our focus on prevention.

We also ran our first joint communications campaign with Suffolk and North East Essex over the summer. The campaign aimed to encourage residents and visitors to stay well during the summer months, raise awareness of heat-related harm, and support system resilience by signposting people to appropriate NHS services. The campaign achieved strong results, for example in Norfolk and Waveney we more than doubled the number of people looking at the section on our website compared to last year.

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## 2. Current and recent work

Here's a snapshot of some of the other current projects and recent work that has been done:

- **NHS 10-Year Plan engagement:** Led an inclusive engagement programme to gather views on prevention, digital access, and moving care closer to home. Local feedback is influencing service design and was fed into the development of the national Ten-Year Health Plan.
  - **Annual Report 2024–25:** Produced and published the ICB's Annual Report, providing transparency on performance, priorities and achievements.
  - **Winter campaign:** This is the biggest campaign we run during the year. It is planned with Norfolk County Council and delivered by system partners. The focus is on supporting communities and system resilience, and includes vaccinations, Pharmacy First, NHS 111 and NHS Talking Therapies.
  - **Wasted medicines campaign:** Launched a local campaign addressing an issue that costs the NHS around £300m annually. Encourages people to only order the medicines they need, helping both environmental sustainability and saving the NHS money.
  - **ADHD Awareness Month (October 2025):** Supported ADHD UK's theme "*The Many Faces of ADHD*", raising awareness and tackling myths. Promoted a video by ADHD UK's first Junior Ambassador, Summer, highlighting lived experience.
- Equality Delivery System (EDS2) engagement:** Engagement activity underway with partner organisations around children and young people's mental health, community translation services and frailty services.

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**Community Voices** continues to deliver an important part of our engagement activity but is not referenced in this report as it is covered in a separate agenda item.

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### 3. Planned work

**Future work includes:**

- **Organisational change communications:** Continued close working with SNEE colleagues to support staff through and inform stakeholders about the changes being made to ICBs.
- **Cervical cancer screening campaign:** Significant communications and engagement campaign being planned alongside a population health management approach to increase uptake of cervical screening. A social media campaign will be coupled with community outreach and engagement via the Wellness on Wheels bus and in community settings.

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**Recommendation to the Committee:**

Members of the Patients and Communities Committee are asked to note the report.
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<b>Key Risks</b>	
<b>Clinical and Quality:</b>	Communications and engagement activity can and does contribute to improved clinical care and quality of services.
<b>Finance and Performance:</b>	Communications and engagement activity can and does help patients and communities to understand and influence NHS finances and performance.
<b>Impact Assessment (environmental and equalities):</b>	We are mindful when planning our communications and engagement activity of the impact on the environment and equalities.
<b>Reputation:</b>	Communications and engagement activity helps to inform and involve patients and communities in our work and that of the Integrated Care System, supporting the organisation’s reputation by being transparent about what we are doing and why we are doing it.
<b>Legal:</b>	We are mindful of the legal requirements around our communications and engagement activity, including our duty to involve and the accessible information standard.
<b>Information Governance:</b>	N/A.
<b>Resource Required:</b>	N/A.
<b>Reference document(s):</b>	N/A.

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<b>NHS Constitution:</b>	Communications and engagement activity is vital to many of the rights and pledges set-out in the NHS Constitution, not least people's right to be involved in the planning of healthcare services commissioned by NHS bodies.
<b>Conflicts of Interest:</b>	N/A.
<b>Reference to relevant risk on the Board Assurance Framework</b>	N/A.

## Governance

<b>Process/Committee approval with date(s) (as appropriate)</b>	N/A.
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Agenda item: 10

<b>Subject:</b>	<b>Community Voices</b>
<b>Presented by:</b>	<b>Shelley Ames, Head of Health Inequalities &amp; VCSE Partnering, NWICB</b> <b>Carly West-Burnham, Director of Strategy and Integration, QEH</b> <b>Laura Tooth, Clinical Programmes Manager, NWICB</b>
<b>Prepared by:</b>	<b>Shelley Ames, Head of Health Inequalities &amp; VCSE Partnering, NWICB</b> <b>Laura Tooth, Clinical Programmes Manager, NWICB</b> <b>Keighley Evans, Strategy Lead, Queen Elizabeth Hospital</b>
<b>Submitted to:</b>	<b>N&amp;W ICB Patients and Communities Committee</b>
<b>Date:</b>	<b>3 November 2025</b>

**Purpose of paper:**

To provide an update on Community Voices, focusing on two recent projects and including the key findings, outcomes and impact. To request ongoing support for this and impactful programme, that supports positive VCSE and local government partnering ambitions, as we move into organisational change.

**Executive Summary:**

This paper provides an update on the Community Voices programme, highlighting its evolution and recent initiatives that are making a measurable difference in addressing health inequalities. Community Voices has developed into a comprehensive framework partnering with over 50 VCSE and local government organisations. The programme leverages the expertise of these partners to engage seldom-heard communities, building health literacy and supporting access to essential services through trained “trusted communicators.” Insights from community engagement are centrally collected and independently analysed, with findings shared with key system leaders to inform strategic decisions and future planning. The report spotlights two recent projects: the Women’s Health Hub and the Quality Employment in Healthcare (QEH) project, both of which used community-driven insights to co-design services and training with VCSE organisations. As a result, these projects have contributed to system change, reduced health inequalities, and

Parker  
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improved outcomes for underserved populations, directly influencing commissioning, service delivery, and workforce development across Norfolk and Waveney.

## Report

### Background

Community Voices is a programme established during the COVID-19 pandemic, initially with a focus on addressing barriers to uptake of the COVID-19 vaccination.

Since then, the programme has evolved into a robust system framework that has worked with over 50+ VCSE and local government organisations to ‘tap into’ their expertise in engaging with communities that experience the greatest inequalities, and are often seldom-heard. Appendix 1 demonstrates the range of VCSE organisations now involved in the programme.

The programme provides training to ‘trusted communicators’ around a variety of topics so that they can develop ‘health literacy’ in communities and support access to a range of services. These topics have included heart health, smoking, vaccinations, cancer screening and more.

The insights gathered through these community conversations are routinely captured in a central insight bank to be analysed, often by the Norfolk Office of Data Analytics (NODA) at Norfolk County Council, who provide independent reports of the findings.

These findings are presented to the ‘project commissioners’ often those in ICB strategic teams, public health, or NHS providers via ‘Closing the Loop’ webinars and discussions. The recommendations from the reports are used to influence strategic decision making, future planning, strategies and commissioning arrangements.

More recently, a number of Community Voices projects have moved into a ‘phase 2’, facilitating codesign of services/training with the VCSE sector organisations involved.

### Introduction

This paper summarises two recent Community Voices initiatives in Norfolk and Waveney: the Women’s Health Hub project and the Quality Employment in Healthcare (QEH) project. Both projects harnessed community-led insight to drive system change, reduce inequalities, and improve outcomes for underrepresented groups. The findings have directly shaped commissioning, service delivery, and workforce development across the region.

### Community Voices – Women’s Health Hub

The full NODA project report can be found in Appendix 1, with the below summarising the key highlights.

#### Aim:

To reduce health inequalities in women’s health by engaging women aged 40–60, especially those from diverse, rural, deprived, and marginalised backgrounds.

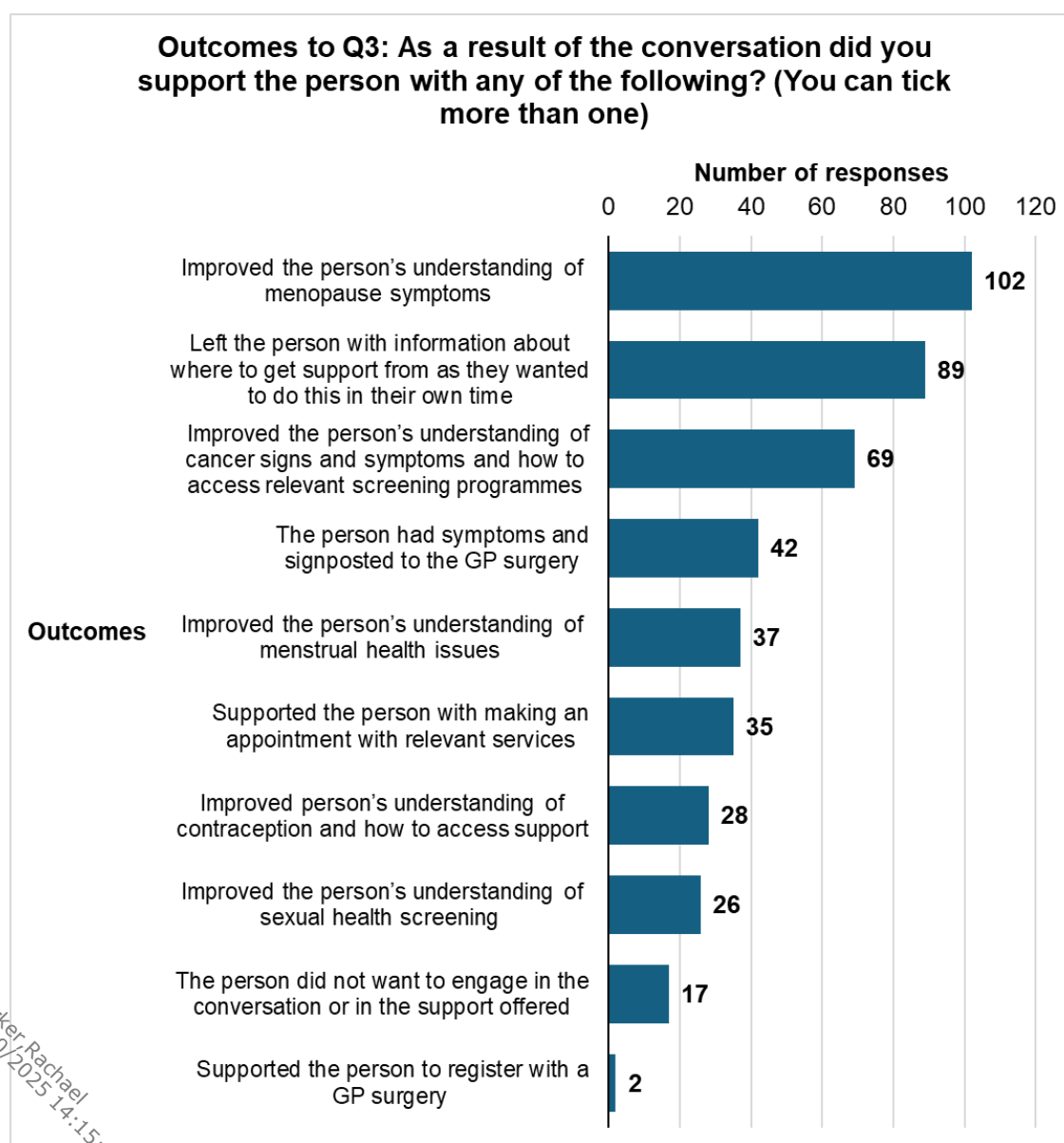
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**Method:**

- 766 in-depth conversations with women across Norfolk and Waveney.
- VCSE partners commissioned to reach diverse communities including Access Community Trust, Asperger East Anglia, Feathers Futures, Age UK Norfolk, Involve Razem, The Feed, The Daisy Programme, The Zainab Project, Women Like Me, Women’s Domestic Abuse Forum and The Magdalene Group.
- Trusted Communicators trained in women’s health topics including menopause, menstrual health, contraception and cancer screening.

**Outcomes:**

The chart below describes the support given and outcomes achieved via the conversations undertaken by the trusted communicators:



Parker Rachael  
30/10/2025 14:15:50

## **Key Findings**

The following summarises the key findings from the insights gathered by the Trusted Communicators:

- Fragmented care and navigation difficulties.
- Feeling dismissed or unheard.
- Cultural and linguistic barriers.
- Low confidence and health literacy.
- Trust and safety concerns.

## **Actions Taken:**

As a result of the findings of the report, the following have been commissioned as part of the Women's Health Programme, more details of which can be found in Appendix 2:

- PCN-Based Women's Health Hub Model to provide local access to specialist services.
- Workforce Training for primary care teams, reflecting the learning from the insights gathered.
- Compassionate Care Training co-developed with VCSE partners and women with lived experience.

## **Community Voices – QEH Employment Project**

The full NODA project report can be found in Appendix 3, with the below summarising the key highlights:

### **Aim:**

- To address employment inequalities at Queen Elizabeth Hospital (QEH), West Norfolk, particularly for individuals from deprived and underrepresented ethnic backgrounds. The project sought to understand barriers and enablers to securing employment at QEH, using the Trusted Communicator model.

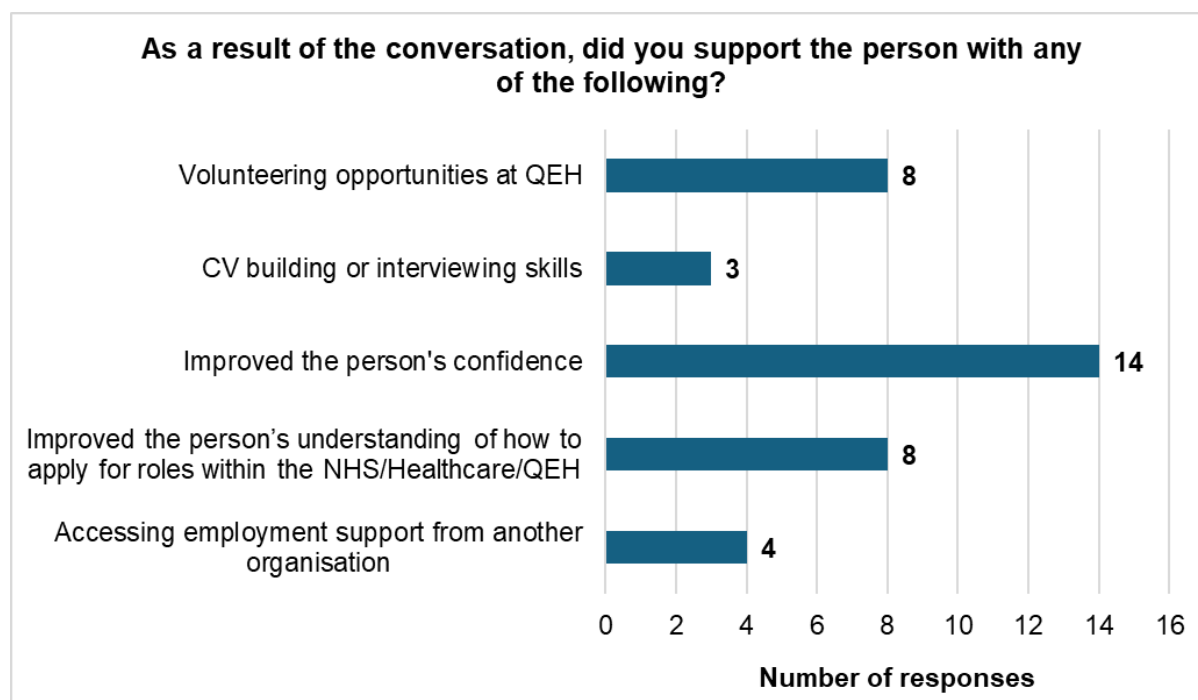
### **Method:**

- 49 structured conversations with unsuccessful applicants or those recruited into lower-grade positions.
- VCSE partners commissioned to reach diverse communities, including Hanseatic Union and Gateway Church.
- Trusted communicators equipped to lead engagement with local community organisations and discuss a range of topics.

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## Outcomes:

The chart below describes the support given and outcomes achieved via the conversations undertaken by the trusted communicators:



## Key Findings:

### Enablers:

- Straightforward and fair recruitment processes.
- User-friendly online platforms.
- Support from family, friends, and community networks.
- Positive interview experiences.
- Access to English language support and recruitment agencies.

### Barriers:

- Language challenges.
- Attitudinal barriers and lack of confidence.
- Confusion about roles and requirements.
- Process-related barriers including interview and communication issues.
- Perceived disadvantage for non-English nationals.
- Practical barriers such as transport and caring responsibilities.

## Actions Taken:

As a result of the findings of the report several recommendations were made to the QEH Strategy and Transformation Executive Group, as described below. The Group have approved implementation of the first two recommendations initially.

1. Community-based recruitment support – partner with local community organisations and trusted communicators to delivery ‘employment navigation workshops’ focused on job roles, application guidance and interview preparation.
2. Redesign recruitment communication – develop applicant communication protocol, including automatic status updates, personalised feedback and realistic timelines for each stage of the recruitment journey.
3. Inclusive role design – co-produce part-time, flexible and entry-level healthcare roles with input from residents, especially those with caregiving responsibilities or other structural constraints.
4. Local ‘Talent into Healthcare’ initiative – set internal targets for hiring from underrepresented communities and create entry-level apprenticeship or paid work experience pathways tied to progression opportunities.
5. Multilingual recruitment pathway – introduce role-specific language requirements aligned to actual need and tiered English-language support, potentially in partnership with ESOL providers.

## Conclusion

Both projects have led to tangible changes in service design, workforce development, and organisational culture. These initiatives demonstrate the power of community-led insight to drive system transformation, reduce inequalities, and deliver more inclusive, responsive services.

The Community Voices programme continues to provide a flexible and impactful framework for engaging seldom heard communities, improving health literacy and access and supporting positive VCSE & local government partnering ambitions, as demonstrated by the evaluation undertaken by the ICB Research & Innovation team, included as Appendix 5.

The Community Voices programme was featured as an example of best practice for tackling health inequalities at this years National NHS Confed Expo in June, generating significant interest from other systems and organisations about its potential to scale and replicate, including NHS England.

## Recommendation to the Committee:

Note the progress and impact of the Community Voices programme and support its continued sustainability aligned to strategic commissioning and the new operating model.

Parker Rachael  
30/10/2025 14:15:50

# Community Voices Women's Health Project

## Key findings

### Overview and general health:

Four topics were covered in the conversations (breast, bowel and cervical cancer, menstrual health, menopause, and sexual health) but **menopause was the most frequently discussed topic** - signs, symptoms and the impact on women's lives were described.

Issues described as having most significant effect on day-to-day health and wellbeing are:

- impact of the menopause
- impact of prevention on general health and wellbeing
- impact of other health conditions and illnesses
- impact of poor mental health
- financial and economic factors

### Five cross-cutting themes emerged from the conversations:

- attitudinal barriers (shame, embarrassment, fear) particularly for women who are vulnerable or who have experienced sexual violence
- negative experiences with health professionals, leading to potential disengagement with services
- women not feeling listened to or lacking a 'voice' in their medical care
- cultural aspects of women's health care
- impact of an individual's protected characteristics on their health care

### The factors which enable women to secure appropriate health care are:

- personal motivation and ability to engage
- outreach and community-based services and support
- appropriate and accessible information (leaflets, online help)
- access to appropriate services
- being supported by family and friends and support from medical practitioners

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### **Factors which prevent women accessing appropriate health care are:**

- feelings of embarrassment, shame or concern about discussing 'personal' matters or being worried about 'bad news' such as cancer diagnosis
- lack of information, too much, or competing information
- issues with getting support in preferred language or issues with interpreters
- negative interaction with a medical professional
- physical or mental disability, neurodiversity, mental health issues, age or lack of support from family or friends
- lack of 'voice', feeling 'unheard' or dismissed

### **Women's experiences could be improved through:**

- accessible information in preferred format or help with IT
- professional, appropriate and empathetic support from medical practitioners
- improved opportunities for the patient voice to be heard; feeling listened to by health professionals
- better availability of medical services such as tests and routine checks
- support including help with accessing, navigating or arranging health care by people such as trusted communicators, intermediaries, or peer support workers
- community based or outreach medical services and services in variety of places
- better availability of interpreters or leaflets in first or preferred language

### **Outcomes of the conversations include:**

- the person or group's understanding of women's health issues was improved (through conversation, receiving leaflets or being signposted to further support)
- people were supported to access treatment or seek further medical advice about women's health issues
- preventative interventions (check-ups and screening) were promoted
- the menopause was discussed in a supportive environment which made it easy for people to share their experiences, support one another and encourage further engagement and action

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## Background

This report provides analysis and a summary of conversations captured as part of the Community Voices Women’s Health Project during January-May 2025. Grants were made through Norfolk Community Foundation and Suffolk Community Foundation to nine organisations to carry out conversations with women in under-served communities. Conversations between Trusted Communicators and participants were recorded on the Community Voices Insight Bank. Analysis was undertaken by the Norfolk Office of Data and Analytics (NODA) in the Insight and Analytics Team at Norfolk County Council. The conversations covered multiple topic areas: cancer (breast, bowel, cervical), menstrual health, menopause, sexual health, and general health and wellbeing. Any quotes included in this report are given verbatim from the Insight Bank.

## Process

NODA was commissioned to analyse eight qualitative questions covering the themes of cancer (Breast, Bowel, Cervical) signs and symptoms, menstrual health, menopause and sexual health. Questions also explored factors which enable people to seek support, and the barriers they experience. Conversations included a general question about issues which affect people’s health and wellbeing.

A sample of comments was read, and a coding framework developed, tested, and refined. Each comment was coded, and codes were quality assured for consistency and accuracy. Analysis of quantitative elements of the project was out of scope although the qualitative elements of Q3 and Q33 are included in this report.

The phrase ‘Trusted Communicator’ is used throughout as a way of describing people who lead the Community Voices conversations and is not intended to reflect a specific role.

## Discussion

Five cross-cutting themes emerged from responses across all questions. These themes highlight why women’s health relating to cancer, menstrual health, the menopause, and sexual health are distinct from other medical issues. The five cross-cutting themes are:

1. Attitudinal barriers (shame, embarrassment, fear) particularly for women who are vulnerable or who have experienced sexual violence
2. Negative experiences with health professionals, leading to potential disengagement with services
3. Women not feeling listened to or lacking a ‘voice’ in their medical care
4. Cultural aspects of women’s health care
5. The impact of an individual’s protected characteristic on their health care

## 1. Attitudinal barriers

**Shame and embarrassment about discussing breasts, bowel, sex, or reproductive systems and fear of ‘invasive’ preventative services particularly cervical screening, were frequently mentioned in the conversations.**

*"I find the whole bowel [bowel] subject very difficult to speak about, I am not sure why but I cant seem to describe the symptoms without feeling dirty".*

These feelings could be magnified in the presence of a male practitioner: *"Barrier number one is being embarrassed to talk to a professional about women's health topics. **These subjects are still quite delicate and stigmatized.** She would not want to talk about them with a stranger IE a doctor. **Worst case scenario would be a male doctor too.**"*

Even when the value of preventative services is acknowledged, uptake can be limited by anxiety: *"It [cervical screening] was something that was invasive that **she did not want to do and was easier to ignore**".*

Victims of sexual violence face additional barriers: *"She was raped as a teenager and does not like having her breasts touched" and "her past experience of smear tests and her **sexual assault both prevented her from attending her smear tests.**"*

## 2. Negative experiences with health professionals

**The impact of lack of professional care and empathy on individuals was raised many times throughout the conversations. The impact of negative interactions included reluctance to attend future appointments, anger, loss of confidence and anxiety.**

*"Discussion on body image and breast cancer, the impact of how a woman feels after a mastectomy. An attendee knows of a situation where a patient once asked ' does this mean men wont fancy me?' and the health professional replied 'yes probably' **this could have lead to that person not wanting to have the operation that would have ultimately save their lives.** This shows a need for more compassion within women's health and consideration to the language and responses used to patients."*

*This lady said she went for a smear test at the doctors practice and the nurse completing the smear mad it a terrible experience. The lady said that the nurse was "putting their whole hand in there, taking it in and out, and couldn't complete the smear test". **The said the nurse tried for over 45 minutes and then told her there was so***

*much discharge that she either had an STI or cancer! This lady was so upset! She went home and had an argument with her husband as both accused each other of having an affair. Then they got upset that she had cancer. All testing was carried out and everything was negative. The lady said she was fuming with the nurse and has since moved practises. She also had the smear test done at the hospital, and it was completed quickly and easily within 10 minutes and no issues. She now always requests that her smear tests be carried out at the hospital.”*

*“She reported that she has a coil fitted but when she went for her smear test they couldn't find it. The nurse spent a while looking for it which she said was very embarrassing, the nurse was moving her light around and muttering under her breath, making her feel awkward and like it was her fault she couldn't find it. She then left her on the bed, exposed, and said she was going to find someone else. She came back in with another lady who didn't introduce herself but went straight down to look between her legs. She said she had no idea who this person was but she couldn't find anything either. They asked her if she checks her string is there and when she last checked, she felt this was said in a way that was blaming her, but she said she just didn't think to check them. They were also asking while one had a speculum in her vagina and was looking inside, so she didn't really feel very comfortable being asked at that point. They told her to get dressed and that they would refer her to the hospital. **She is reluctant to go to the hospital as no-one has explained what will happen next. She doesn't know now if she is protected when she has sex as if they couldn't find the coil she wonders if it is still working**, but she was too embarrassed to ask as there were two of them in the room who had just been looking at her intimately. She had prepared herself for the smear test knowing how important it is to go, but had not prepared for this and now feels on reflection it could have been handled a lot better.”*

### **3. Women not feeling listened to, heard, or understood by medical professionals was also raised.**

*“One of the biggest barriers to her health was the lack of communication (understanding) and trust with her doctor, which has left her feeling dismissed and isolated in managing her treatment. She expressed, “It's like they don't listen. I try to explain what's happening, but they just brush it off. I don't feel like they care enough to get to the bottom of it.” **This lack of trust has led her to avoid seeking help even when she's clearly struggling with side effects”.***

*“In addition, there was significant concern around **feeling "gaslit" by GPs**, for eg., we heard in the group that it took one woman 18 months, one woman 2 years, and one woman 15 years to "fight" for HRT and convince GPs of their "worthiness" to take it.”*

*“We held a women's focus group about menstrual health and the menopause. **General feedback was that the majority of women felt dismissed by healthcare***

**professionals about their menstrual health.** While they could recognise heavy periods, 3 women reported that these were dismissed by their GPs as normal. In addition, one woman reported that other symptoms such as anxiety and heightened anger around her period were dismissed as heavy periods. Women felt that they were pushed toward hormonal contraception options and desired more holistic conversations around how symptoms could be managed through diet.”

#### 4. Cultural aspects of women’s health care

**The importance of offering culturally sensitive and appropriate women’s health services which recognises different perspectives and ensures equitable access to care was discussed.**

*“The individual highlighted that in their culture women that discuss sex, including contraception were considered 'loose' and promiscuous and therefore women were discouraged from discussing matters around sex. She highlighted that sex was something that men spoke about, and **it was considered improper for women to discuss sex.** The individual herself did not necessarily subscribe to these beliefs but highlighted that this was her environment.”*

*“Another attendee said 'no one speaks about this [**menopause**], its a **taboo subject** socially even amongst women.”*

*Given that she relied on medication from Poland and initially had a different understanding of HRT than what she later heard from her UK GP, **access to bilingual or culturally tailored resources could have supported her in navigating differing medical opinions with more clarity and confidence.**”*

*“**The person came from a culture where menopause was not discussed publicly.** The person has never learnt about menopause in a professional or personal environment. Women's health topics such as menopause and menstrual health are not discussed and there is shame around the topics. **Therefore, these mental and personal barriers must be overcome even before other barriers to access care.**”*

*“The conversation was about cancer Breast, Bowel and Cervical. When we talked about signs and symptoms and screenings the Client said “Although I have good understanding and go to all of my cancer screenings not everyone does” and “**I find that there is a lack of understanding (of signs and symptoms) and knowing where to go in ethnic minorities**”.*

#### 5. Impact of protected characteristics in accessing support for Women’s Health

**The conversations revealed how age, disability, gender or ongoing health issues affect how women’s health services are experienced.**

## 5.1 Age

*'Some women our age (mid 50s), still feel like we are making a fuss when we are struggling with health problems that women have'.*

*"The barriers for this woman were her autism and her age. She was told repeatedly that "it's just the menopause." It wasn't ; was stage 4 cancer."*

*"The person wanted to have a bowel screening but was told by her GP they don't do this. She went online and found out from NHS site she could request over the phone wish she did and a test was posted out to her. **'People need to know that if they are over the age limit they can contact NHS direct and ask for a test'.**"*

*"Age was something that came up a lot. "I think younger people are much more clued up on sexual health, taking tests prior to having a new partner etc, it's a shame older people aren't" "I do think that this imbalance needs to be addressed."*

## 5.2 Gender

***"Women's health is just not treated the same way as Men's health in this country, if men went through what we go through things would be very different."***

*"The woman has experienced attitudes which are dismissive of women's health issues, having heard comments like **'are you doing this because you are a woman'** and she questioned **'why does everyone say 'oh it's just your age' to women' if they have a health complaint"**.*

## 5.3 Disability and health conditions

Disclosure of whether the respondent has physical or mental conditions that reduce their ability to carry out day to day activities was optional. Therefore, this information may not have been captured for all respondents. For those that did disclose this, responses are summarised in **Table 1** below.

**Table 1: Summary of respondents with physical or mental conditions which reduce their ability to carry out day-to-day activities**

Option	Number of respondents
Yes	52
No	146
Prefer not to say	13

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## Physical and neurological health issues

*“This lady because of her autism finds it difficult to make the initial appointment as she finds making phone calls very difficult and then attending the appointment will make her very anxious. **Also because of a physical disability she has to rely on someone giving her a lift as her autism makes her too anxious to use taxi services**”*

*“the client has epilepsy and isn't sure of what she can take with her current epilepsy medication and sometimes **getting to GP would be difficult as she doesn't drive** . I have offered to help with supporting this if she needed support to go to GP”*

## Neurodiversity

*“They were able to access Cognitive Behavioural Therapy but this was not tailored to neurodiverse people so was not helpful, this type of therapy was not available in Norfolk and Waveney. The woman was able to access an Autism and ADHD assessment through the NHS which went through a third party and this was very organised, a diagnosis of both was subsequently made 'I thought the clinicians were brilliant they went above and beyond' . **Taking a holistic approach would be more beneficial - being neurodiverse and in menopause can increase mental health problems and become overwhelming. More understanding would be good regarding older women and late Autism/ADHD diagnosis, mental health and menopause and other treatments and support to suit this.**”*

*“The biggest impact on this woman's health is probably her autism and the lack of knowledge and therefore lack of appropriate care that she received. She and her husband compiled 2 boards which they placed above and behind her bed giving health staff detailed information about how best to care for her in terms of her autism but most of the time this was ignored. One nurse even said disparagingly" apparently she's autistic, that's why she's behaving like that!" Not very caring, not very kind. **This woman said that without her husband advocating for her she would probably never have coped with her hospital stay at all. She also queried why disability passports were for in patients only and not out patient appointment She also said that the support of the disability support nurse was invaluable to her but had no idea of her existence. Knowledge of this person earlier would have helped make her hospital experience more positive.**”*

Other ways in which neurodiversity was reported to have impacted some women's experience of care were:

Lack of knowledge about the offer of a Disability Support Nurse who could support them through their medical appointments and navigating the healthcare system

- Stress and anxiety for autistic people attending an appointment is potentially greater than for neurotypical people
- Support for autistic individual during the appointment dismissed despite filling out pre-appointment forms to notify professionals

### Mental health issues

*“During Drop-in session, this lady was relaying that her Drs do not take her seriously. That **everything is dismissed because of her previous "poor mental" health and what she is experiencing is all "in her head".**”*

*“Long term trauma and domestic abuse that has impacted on her life choices, including a period of time addicted to drugs. **She feels that the addiction is always present when seeing anyone to do with her health and that she is judged. She would rather avoid going to any appointments than feel the way some health professionals have made her feel.**”*

*“Previous substance misuse issues that **she does not want to go back to and worried if results were bad she would lapse as a coping strategy.** Hasn't always had positive experiences with health appointments, **feels judged by her past and that they see an ex addict before the current problem so she would rather not go than be judged and feel bad when she comes out.**”*

### 5.4 Ethnicity

Disclosure of ethnicity was optional, therefore data relating to respondents' ethnicity may not have been captured for all respondents. For those that did disclose their ethnicity, these are summarised in **Table 2** below.

**Table 2: Summary of respondents' ethnicity**

Ethnic Group	Number of Respondents
English, Welsh, Scottish, Northern Irish or British	133
Irish	2
Any other White background	52
White and Black Caribbean	1
White and Asian	2
Any other Mixed/multiple ethnic background	2
Any other Asian background	2
African	3
Caribbean	3
Any other Black/African/Caribbean background	1
Any other ethnic group	1

The most commonly reported ethnic groups were ‘English, Welsh, Scottish, Northern Irish or British’ and ‘any other White background’. The high representation of respondents from any other white background may reflect Community Voices’ engagement with the Hanseatic Union which supports communities in King’s Lynn and West Norfolk often including those whose first language is not English.

Being from an ethnic minority background may have impacted some women’s experiences of care:

***“They felt that other ethnic minorities make struggle because of their beliefs and language barriers and may be put [off] by dismissive GPs”***

**Finally, one Trusted Communicator noted the impact of living in a deprived area on perceptions of health services.**

*“Women in the group identified feeling "gaslit" by GPs and this seemed to reflect a wider sense of mistrust in healthcare as an organisation. Our hub sits within one of the most deprived areas of the city, and there was a sense that healthcare, including the NHS, can be seen as representative of the government in general and therefore, seen as an institution that is untrustworthy.”*

## **Analysis of questions**

This report is structured into three sections which mirror the themes of the discussions:

Part 1: Overview of conversations and people’s general health (Q2 and Q32)

Part 2: Enablers and barriers (Q4, Q5 and Q6)

Part 3: Outcomes of conversations (Q3, Q33 and Q34)

### **Part 1: Overview of conversations and people’s general health (Q2 and Q32)**

**Q2. Please provide a summary of your conversation. Prompts: Was the conversation about cancer (Breast, Bowel, Cervical) signs and symptoms, menstrual health or menopause, sexual health? Include person’s awareness of signs and symptoms about the health topics. Did you talk the person through what to look out for, how to access support?**

There were **301** responses to this question.

### 1.1 Menopause

The topic mentioned most frequently was the **menopause**. Symptoms were described as physical signs (“sweats and flushes”) and emotional changes (“mood swings and depression”).

- **Understanding about the signs and symptoms of the menopause varied** from “*we discussed many of the menopause symptoms - she knew them and she said she has most of them*” to limited or no awareness “*she felt that education about Menopause should start earlier so women are forewarned about the signs and symptoms. she had not started the menopause yet but still felt very much in the dark about it*”.
- **Source of information about the menopause** included medical professionals, friends and media: “*She said it was talking to friends and watching the Davina McCall tv programme which really educated her in the symptoms and treatments*” / “*The lady was aware of the signs and symptoms of the menopause (including perimenopause stage). She was aware of them all because she talked a lot about it with her mum*”.
- Some conversations recorded the **physical impact** of the menopause: “*Talked about menopause symptoms - experienced excessive sweating and struggling to work at care home as needed to help people move physically and was embarrassed*”.
- The **emotional impact** of the menopause was also described: “*This lady is going through Menopause. She is struggling with Insomnia, low mood and finding their mood swings really to be quite debilitating, affecting her daily routines and putting pressure on her friendships*”.

Conversations about the menopause included discussion about **hormone replacement therapy (HRT)**. As with discussion around the menopause, people’s knowledge of the signs and symptoms and their attitude towards HRT varied.

- “*Is not phased by hrt as understands the benefits of taking it.*”
- “*She said she didn't want to go on HRT as she has heard bad things about it.*”

Positive and negative examples of people’s experience of using HRT were cited.

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- *“The woman was already on hormone replacement therapy (HRT), but she was struggling with the side effects, including irritability, fatigue, and mood swings.”*
- *“Currently experiencing menopause and is taking HRT which they say has drastically improved their health and wellbeing.”*

## 1.2 Cancer

Sources of information about the signs and symptoms of cancer included:

- **Public health programmes** - *“The poo on a stick test”*.
- **Private health care providers** – *“General health check with private health care provider and given information about signs and symptoms.”*
- **Family and friends** - *“My mother had breast cancer so she taught me the importance of getting things checked out”*.
- **Media** – *“She said the media coverage is very good so it has educated her in signs and symptoms.”*

One conversation noted that **information may not be equally available to all women:** *“The conversation was about cancer Breast, Bowel and Cervical. When we talked about signs and symptoms and screenings the Client said “Although I have good understanding and go to all of my cancer screenings not everyone does” and “I find that there is a lack of understanding (of signs and symptoms) and knowing where to go in ethnic minorities”.*

### Breast Cancer

**Breast cancer was the most frequently discussed type of cancer** with cervical and bowel cancer being mentioned fewer times.

- Where the **signs and symptoms of breast cancer** were noted people usually referred to the emergence of unusual lumps or breast pain: *“[she is] regularly palpating the breast and aware that any unusual pains needs to be checked with doctor”*.
- People were generally **more likely to be aware of the signs and symptoms of breast cancer than other cancers:** *“we discussed the all the cancers breast, bowl ,cervical the ladies said they knew more about breast and bowel symptoms but not cervical we went on the website and had a look at all the symptom's but they were all up to date on there cervical screening”*.
- In one case, greater knowledge about breast cancer in comparison to other cancers was directly attributed to **public health messaging:** *“I would say that I*

*am a lot more aware of the symptoms of Breast cancer as it is so well publicized, I am not as informed about the signs for the other two”. Other women described following medical advice: “checks boobs regularly as is advised”.*

- Examples of **the importance of awareness of signs and symptoms** were recorded: *“This was a conversation about cancer screening and how important it is, however, this lady had cancer which wasn’t picked up on the routine mammogram. She had gone for a mammogram and it came back clear. She had a spot on her breast at the time that was concerning her. After a few weeks of having the mammogram she decided to go back to the Doctors and they sent her to the breast clinic straight away where in fact she did have cancer and she had to have a mastectomy. Luckily she knew the signs and persevered with getting a second opinion”.*

### **Cervical cancer**

Although fewer conversations were recorded about cervical cancer compared to breast cancer, and signs and symptoms were noted less frequently, **a clear theme about take up and experiences of cervical screening emerged.**

Take up of cervical screening services could be limited by:

- **Terminology** – *“The person recognised the term smear test but not cervical cancer screening.” / “The conversation was about cervical cancer screening. The individual was unaware of the term cervix as English is not their first language, therefore they did not recognise the term cervical screening. We showed the individual a diagram of a uterus and identified the cervix, they were able to recognise the diagram. Once the procedure was explained, the person stated that they had had a cervical screening before.”*
- **Awareness of cervical screening** – *“Some students were unaware of cervical screening in their home country, as it is only available privately and not regularly offered”. / “The individual was apprehensive about their appointment as they had never been to a cervical screening appointment, though they were older than the threshold, due to the fact they had recently moved to the country.”*
- **Fear** – *“This person spoke mostly about having a cervical smear tests coming back needing to be retested and how much this scared them.”*
- **Availability of female health professionals** – *“The conversation was about cervical cancer screening and wanting to ensure the doctor that was conducting the appointment was a woman. The person would not be comfortable with the appointment being conducted by a male medical professional.”*

- **Needing support** – *“Explained Chaperone can present at smear test if you fell uncomfortable. Group didn't know that chaperone can accompany for the smear test.”*

**Embarrassment at the intimate nature of cervical screening was frequently mentioned:** it was often linked to previous poor experiences and feelings of vulnerability.

*“She didn't attend it [cervical screening] because the last one she had the nurse commented she wasn't very relaxed and it was difficult to get to the right place as she was so uptight and needs to relax, this panicked her more making her even more stressed and therefore even harder to get done. It hurt her in the end and she left useless and said she would never do that again. I asked if she told the nurse this when having the implant but she said she hadn't told anyone as she was so embarrassed. I explained that our local GP surgeries offer double appointments for smear tests and are very kind, we would get one of the smear test champions to talk to her first and she agreed. We talked through signs of cervical cancer and gave a leaflet.”*

## **Bowel Cancer**

Bowel cancer was discussed in fewer conversations than breast and cervical cancers. References to signs and symptoms were infrequent.

**Recurring themes about bowel cancer in conversations included family histories and take up of the NHS faecal immunochemical test (FIT).**

- **Family histories** - *“Our conversation was around bowel cancer, screening and lady's family history. She said that her father died having a bowel cancer, it was very traumatic for her and she is quite anxious within that subject. She was very concerned about her being diagnosed too.” / “Father diagnosed with bowel cancer last year so she and her siblings all got tested. Had nothing previously from nhs about getting tested in early 50s.”*
- **FIT kit** - *“Client is up to date with bowel screening as she has the kit every few years though the post.” / “Used the kit sent through the post and was diagnosed from that.” / “She said she has received the FIT kit but hasn't got round to completing it but is up to date on the other testing.”*

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## Other types of cancer

Other cancers discussed in the conversations included:

**Rectal cancer** – *“Client talked about rectal cancer. Had surgery 8 years ago and struggling because has to use stoma bags. Needs a lots of support from GP, but no problems as interpreter is always provided and she attending very often.”*

**Skin cancer** – *“Person has ongoing health input due to high risk of skin cancer and has regular apintments to check out freckles and moles. Her mother has the same condition and has had to have skin cancers treated.”*

### 1.3 Menstrual and sexual health

Conversations about **menstrual health** covered physical issues (heavy or abnormal bleeding, tiredness, mood changes) but more reference was made to difficulties in getting **appropriate support**.

- *“Hasn't felt listened to and felt that women are just meant to 'put up' [with] period problems.”*
- *“General feedback was that the majority of women felt dismissed by healthcare professionals about their menstrual health. While they could recognise heavy periods, 3 women reported that these were dismissed by their GPs as normal.”*

**Cultural attitudes towards menstrual health** were also noted;

- *“All 15 women agreed that menstrual health and the menopause are still taboo to talk about.”*
- *“She felt that employers and Men should be educated more about menstrual health as currently alot of them just say things as a joke around it.”*

Specific services were singled out for praise: *“Has mirena coil fitted. Has had sti testing kit through iCash and is really pleased with this service as can be done from home. Marked improvement from how it was years ago”.*

Conversations about **sexual health** mostly focused on different types of **contraception** and their **pros and cons**: *“The person knew of some contraception methods, such as condoms and the pill, but did not know them all, nor did they know the distinction between LARC and other forms of contraception.”*

**Practicing safe sex and the risks of sexually transmitted diseases** were also discussed: *“The conversation was about sexual health, specifically STIs and contraception in midlife. The person was not very aware of the risks of STIs at their age and had never really thought about getting tested or using protection in new relationships. She assumed that STIs were only a concern for younger people and was surprised to hear that infection rates are increasing among those over 40.”*

## 1.4 Prevention

**Preventative interventions** such as screening and routine check ups were frequently mentioned in the conversations.

- *“We talked through why smear tests are offered and why preventative health appointments are so important.”*
- *“Checks boobs regularly as is advised. Has always had smear tests. Not yet been called for breast screening nor received bowel cancer test.”*
- *“We talked about checking for breast lumps, which she does in the shower, and for blood in her poo, which she said she does when she wipes.”*

### **Q32. What was raised in your conversation which you consider to have an impact on the person’s health and wellbeing in its widest sense?**

There were **300** responses to this question. The main issues raised were:

- impact of the menopause
- impact of prevention on general health and wellbeing
- impact of other health conditions and illnesses
- impact of poor mental health
- financial and economic factors
- impact of positive health care experiences
- barriers and enablers to accessing support

Effects of the menopause were discussed more frequently in this question than the effects of cancer, menstrual, or sexual health, and in particular the **wider impact of the menopause on women’s wellbeing**. People described how going through the menopause had – in addition to physical effects – a much wider impact on their lives:

- *“In the area of menstrual health and menopause, the conversation revealed that many women experience ailments that are trivialized by both the healthcare system and society ... **a lack of empathy and appropriate support can lead to a deterioration in the quality of life.**”*
- *“The patient described the menopausal period as “the most difficult time of my life”, highlighting the profound effect it had on her mental health and sense of identity. She experienced social withdrawal, emotional instability, and psychological distress, which were compounded by physical symptoms such as hot flushes and weight gain. These experiences had **lasting effects on her confidence, relationships, and engagement with the world.**”*

- *“Her menopause is not just about hot flushes and mood swings. This is a feeling of genuine loss.”*

For some women, the impact is experienced particularly acutely: *“being neurodiverse and in menopause can increase mental health problems and become overwhelming”*.

The **impact of prevention on general health and wellbeing** was also noted:

- **Healthy lifestyle** - *“She leads a very health-conscious lifestyle—with no smoking, no alcohol use, a good diet, and regular physical activity—all of which significantly contribute to her long-term physical and mental wellbeing.”*
- **Taking up screening offers** – *“Recently received letter for bowel screening and agreed to have it and has sent sample in last few days. ... She feels the nhs have really been on it with regards to this and very important”*.
- **Consistency of preventative health messaging** was questioned by one participant: *“The person has noticed that there is awareness raising/health campaigns in other areas but not in Waveney, for example in spotting symptoms of Ovarian cancer - when to to contact your GP. They feel that prevention measures like this may not be considered enough”*.

The **impact of other health conditions and illnesses on general wellbeing** was discussed in many conversations and covered people’s experience of managing acute and chronic diseases: *“She said that she has had difficulties with pneumonia a couple of years ago and the biggest difficulty has been falls and mobility problems”*.

Examples of the **impact of poor mental health** were also discussed: *“She reported periods of low mood and thoughts of not wanting to live. A follow-up has been arranged to check referral and to ask about waiting list. Client previously completed cognitive behavioural therapy (CBT), which she found helpful. She is now on the waiting list for another round of therapy”*.

**Broader financial and economic factors were referenced** in the conversations: *“Lots of things are impacting on her. Her physical health, mental health, money and debt and housing. There is no financial support available for people with cancer. Bills and rent are not considered in the persons journey through their treatment and this can sometimes out way concerns with treatment”*.

Some examples of the **impact of positive health care experiences** on wider health and wellbeing were also recorded: *“Another attendee commented that they had a great experience, an early hysterectomy meant that they could move on with their life”*.

People’s experiences of barriers to health care were frequently raised in the conversation as having an impact on wider health and wellbeing (barriers are described in greater detail in Section Two). **The main barriers and their impact on people’s wider health and wellbeing were:**

- attitudinal barriers – feelings of embarrassment, concern about discussing 'personal' matters, not wanting to know bad news, fear or worry and lack of trust in services.
- negative experiences with health professionals – lack of professional care and empathy.
- capacity for self-care – lack of capacity for self-care linked to a physical or mental disability, neurodiversity, mental health issues, age, or lack of support such as family and friends.
- lack of information – not knowing where to get information or who to talk to.
- not feeling listened to, heard, or understood.
- inability to access services or access them at convenient times.

Conversations also described **solutions to barriers and the factors which enable people to find and access health services** (addressed in greater detail in Section Two). People described changes which would have a positive impact on their general health and wellbeing as:

- improved support from medical professionals (such as sufficient time with GP, access to other health professionals or specialists)
- accessible information in preferred format or help with IT
- more/better medical services, tests and routine checks

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## Part 2: Enablers and barriers (Q4, Q5 and Q6)

### Q4. What did you find to be the enablers for the person/s in accessing support for the women's health topic (cancers, menstrual health, menopause or LARC) that was discussed?

There were **270** responses to this question. The main enablers were described as:

- personal motivation and ability
- outreach and community-based services and support
- appropriate and accessible information (leaflets, online help)
- access to appropriate services
- being supported by family and friends
- support from medical practitioners

People described the factors which **enabled them to access support** as:

- **Personal motivation and ability** – having the motivation, time, or money to seek care:

*“Her strong intrinsic motivation to maintain good health is a major enabler”.*

*“Enablers were her very own motivation and not giving up to the point that she went privately. She was quite capable of talking to people, aware of her symptoms and being conscious about her body/health.”*

*“Extremely capable of accessing health services and is active and motivated in doing so.”*

*“The person was enthusiastic about women's health topics and menopause and motivated to learn.”*

- **Outreach and community-based services and support** such as Trusted Communicators, mobile breast screening unit, facilitated peer-to-peer groups and safe spaces:

*“Her key message to others in the room was: ‘Don't wait — if something feels wrong, act quickly. Time is important.’ This encouraged others present to reflect on their own health and highlighted the power of peer experience in improving community health awareness”.*

*“Enablers -access to support groups /services that are easy to use.”*

*“She found talking to other women very helpful, especially when talking about peeing herself and dribbling! She is not alone!”*

- **Appropriate/accessible information (leaflets, online help):** people’s perception of the best place to get health information varied. One respondent noted that spotting an advert in her GP’s surgery prompted her to seek advice from the practice nutritionist about weight loss, but for other people, social media was their preferred choice:

*“We talked about why she felt TikTok was the place to get information and why she liked that best. It was relatable, conversational, could find lots and lots of information quickly relating to all aspects of the menopause. It has peoples personal experiences of symptoms and solutions, both good and bad. NHS website just has a list of symptoms you may have but doesn’t tell you how those symptoms may affect you or the impact that will have on your life or your relationships”.*

*“TV advertisements, letters from GP surgery and the bowel screening coming directly to the door.”*

*“She talked about having access to information via books, passed down intergenerationally through her grandmother and mother. Having access to this information helped her to recognise the signs and symptoms of menstrual health, sexual health and menopause issues.”*

- **Access to appropriate medical services and tests** including those which act as a ‘gateway’ to more specialised services:

*“We talked about the woman’s experience of finding a breast lump and seeing her GP, the referral went through quickly and within 2 months she had had an operation. The whole process was ‘terribly efficient, you couldn’t fault it’. Treatment was provided at the James Paget Hospital and Norfolk and Norwich both very good - ‘very reassuring, no complaints at all -(the staff) were very dedicated’. The check ups were really prompt and there was a dedicated nurse available 24/7 afterwards and after 12 months another mammogram ‘You felt there was back up all the time’”.*

*“The enablers for her attendance at cervical screening appointments were the pre-scheduled appointments and reminders”*

- **Being supported by family and friends:** informal friends and family networks were described as important sources of support:

*“Good family and friends network around her with lots of females to support and discuss many issues. Her mother in particular has been very helpful and supported her with accessing GP and when she had a miscarriage.”*

- **Support from medical practitioners** - caring and accessible medical practitioners were noted as enabling factors:

*“She knew that she could contact her nurse and surgery for advice, she has a good relationship with these services.”*

- **Other enabling factors** included being able to time off work, availability of interpreters and, in one case, *“support from host on arrival to the UK”*.

#### **Q5. What did you find to be the barriers for the person/s in accessing support for the women's health topic that was discussed?**

There were **281** responses to this question. The main barriers were described as:

- feelings of embarrassment, shame or concern about discussing 'personal' matters or being worried about 'bad news' or a health check
- not being sure where to get information from or who to talk to, not enough information, too much information, or conflicting information
- not being able to get support or services in preferred language or issues with interpreters
- negative interaction with a medical professional or lack of support and knowledge from health professionals
- physical or mental disability, neurodiversity, mental health issues, age or lack of support from family or friends
- lack of 'voice'
- actual or perceived lack or shortage of healthcare services
- inability to access support in preferred format or digital barriers
- insufficient time to engage
- health service offer the at wrong time of the day/week for the person
- prohibitive cost of care/treatments or accessing care or treatments
- lack of integration or communication between services

People described the barriers which **prevented them accessing support** as:

- **Feelings of embarrassment, shame or concern** about discussing 'personal' matters, symptoms, or undergoing health checks, or being fearful or worried about 'bad news' or a health check. People attributed these feelings to previous trauma, negative experiences of medical interventions, or cultural barriers. In some cases, the embarrassment expressed was attributed to being a particular age or life-stage.

*"The person described feeling embarrassed about her menopause symptoms."*

*"Barrier included the triggers in talking about this subject, shame in discussing issues with breasts due to differing cultural beliefs."*

*"They do not conduct breast examinations on themselves largely out of fear for what they might find."*

*"Another major barrier was embarrassment and stigma. She felt that talking about sexual health at her age was awkward and uncomfortable, both with doctors and with friends. She worried that bringing it up with a GP would make her seem "irresponsible" or that she would be judged for dating and having sex in midlife."*

*"They talked about the barriers that affected the younger generations. They spoke about their daughters generation who shied away from screening because it was embarrassing, uncomfortable and inconvenient. They said the discomfort was momentary and "Its a bit like having your boob shut in a fridge door"."*

- Not being sure where to get **information** from or who to talk to, not enough information, too much information, or conflicting information.

*"Felt somewhat overwhelmed at how much information was out there."*

*"Lack of knowledge of where to go for support or support available to her."*

*"There is so much information available she doesn't know where to start looking. Everyone has a different opinion about HRT and whether she should remove her ovaries and be postmenopausal."*

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- Not being able to get support or services in **preferred language or issues with interpreters.**

*“Most significant is language barrier - client needs to access interpreter in GP and hospital and it's not always available.”*

*“First barrier is definitely that English is not her first language. If she contacts her surgery she does that online so she can translate all online.”*

*“Disappointment and discomfort due to the presence of a male interpreter despite requesting a female.”*

*“Language barrier - English is not the person's first language and they are not fluent. The terms 'cervical' 'cervix' and 'screening' are not terms they come across often, and therefore they did not understand what was being asked of them. If English is not their first language, the cervical screening appointment letters can be ignored, removing the opportunity to access the appointment.”*

*“In terms of capability, the language barrier was a huge issue. She felt unable to fully explain her symptoms and concerns to her doctor because of her limited English skills. This made it difficult for her to speak for herself effectively and to feel understood. Without the right words, she felt she couldn't articulate the specific side effects she was experiencing with HRT, which led to her feeling dismissed and frustrated.”*

- **Negative interaction with a medical professional or lack of support and knowledge from health professionals.**

*“Knowledge of the subject by the GP and the nurse at the surgery seemed less than what she already knew, and she found this concerning.”*

*“He (the GP) said that HRT was not good for me and could cause cancer, he was very angry when I said that he knew about these things.”*

*“She is put off ever going back through gynaecology, the way the Dr was unprepared with no computer or pen and the way he spoke to her and also the very long wait for the appointment.”*

*““Gaslit by GPs”.”*

- **Physical or mental disability, neurodiversity, mental health issues, age or lack of support from family or friends.**

*“Having memory problems, easily confused if given too much information. Hearing and sight deteriorating.”*

*“The need to attend a hospital appointment which would cause an enormous amount of anxiety related to various sensory overloads. The lights, other people, noise etc.”*

*“The main barrier is that she has autism which makes her anxious about making the appointment, attending the appointment and physical disabilities make it difficult for her to get there.”*

*“Memory issues, which may impact health management and appointment attendance.”*

*“Her mums attitude, that there was nothing wrong. Had never attended or made a drs appointment by herself before. This made it difficult for her to access support.”*

- **Lack of ‘voice’:** not feeling listened to, heard or understood.

*“She is fed up of not being heard, not being listened and ignored.”*

*“Person felt sometimes not taken seriously due to being overweight.”*

*“”Women are dismissed by the medical profession”.*

*“They stated “I dont really feel that supported by my own GP surgery and I dont feel that they listen to me”.*

- Actual or perceived **lack or shortage of healthcare services** such as appointments, screening or tests.

*“Her motivation is reduced by the perception that access to gynaecologists in the UK is limited and only through GPs.”*

*“Access to preventive screenings and medical consultations can be limited by long waiting times for specialists and an insufficient number of facilities offering screening services. In certain areas, particularly rural regions, the number of healthcare providers is limited, making it more difficult to access tests and consultations.”*

*“The client has said (there are not enough doctors in the village as and the village has doubled in housing).”*

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- **Inability to access support in preferred format or digital barriers.**

*“As she did not use the internet or social media and these seem to be the only way of accessing more information, she felt very isolated.”*

*“Some women may also lack the necessary skills to navigate the healthcare system, such as booking appointments or identifying trustworthy sources of health information.”*

*“The change to digital for many services or access to appointments etc has been a barrier for this person, they do not use a computer and do not wish to, use only a landline. This has meant they have felt digitally excluded.”*

- **Insufficient time to engage** because of caring/family/work responsibilities.

*“Person said that the opportunity was sometimes difficult for them as they struggled to get time off work to see their GP.”*

*“Time as she has a young family and works.”*

- **Health services at the wrong time of the day/week for the person.**

*“Shift work schedule limiting appointment availability.”*

*“Difficulty to scheduling appointment with GP due to agency work and inflexible scheduling.”*

- **Prohibitive cost of care/treatments or accessing care or treatments.**

*“The pharmacy told me then that I had to pay for two separate prescriptions for my HRT every month that’s a lot of money!”*

Issues around the financial implications of ill-health and potential longer-term consequences for health were also raised in a summary of the conversation (Q2):  
*“She has had a lumpectomy which is healing well and thinks that she will be able to return to work sooner than she thought as she needs the money. I expressed my concern that she may be doing too much too soon and that she still needs to have her radiotherapy before she can make any decisions around returning to work. She is getting into more debt and her expenses to travel for appointments are mounting. She said she is thinking of not having radiotherapy as she cannot afford the fares. I said that there is financial support for this and that she should*

*be able to claim her fares back. We looked for this information and was able to see how she gets these paid for and has agreed to continue her treatment. She had applied for pip and had an appointment around her debt who are going to support her”.*

- **Lack of integration or communication between services**

*“While the patient was able to access support, reliance on private care abroad could be a subtle barrier to fully integrating with local healthcare. This might mean missed opportunities for holistic care coordination or delayed responses if symptoms arise between visits abroad. Additionally, the fact that her cervical screening from Poland was not automatically recognised in the UK system could limit seamless data sharing and tracking over time.”*

*“Results taking too long to be returned from the hospital. Lack of communication between doctors.”*

**Q6. What came up in your conversation that reflects what would have made the person's experience different to the one they had? Prompts: Solutions, any community assets.**

There were **258** responses to this question. Solutions or ways of improving women's experiences were described as:

- accessible information in preferred format or help with IT
- professional, appropriate and empathetic support from medical practitioners
- improved opportunities for the patient voice to be heard (individually and collectively); feeling listened to by health professionals
- better availability of medical services such as tests and routine checks
- support including help with accessing, navigating or arranging health care by people such as trusted communicators, intermediaries, or peer support workers
- community based or outreach medical services and services in variety of places
- better availability of interpreters or leaflets in first or preferred language
- changes in individual attitudes towards health care
- faster services with fewer delays
- better integration and communication between different health services

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- **Easily accessible information in preferred format or help with IT to access information**

*“Given that she relied on medication from Poland and initially had a different understanding of HRT than what she later heard from her UK GP, access to bilingual or culturally tailored resources could have supported her in navigating differing medical opinions with more clarity and confidence.”*

*“Client mentioned that she doesn't like online resources. printed resources have been provided about the menopause.”*

*“She also felt that better access to clear, judgment-free information could have helped. She never saw posters or leaflets about STI risks for women her age in clinics, and she didn't recall ever seeing midlife sexual health discussed in the media. If there had been more public awareness campaigns, she might have realized earlier that she was still at risk and that contraception could still be necessary.”*

*“If there were more signposting on NHS website.”*

*“Suggested surgeries could send out informative texts especially as people over 50 more likely to respond to a text with information than seek it on the internet.”*

*“Her experience has shown her that ageism is the biggest barrier for older women and that nhs service providers still do not give enough allowance for those isolated and not technologically able. Although this is improving as people become more technically literate, it could make a massive difference to those who are not, even life changing.”*

*“If they had not worked in medicine then they were far less likely to have been aware of the options open to them for screening and fast access etc. They felt that there did need to be more eye catching information about.”*

- **Professional, appropriate and empathetic support from medical practitioners**

*“GPs having deeper understanding of female-specific conditions.”*

*“More patience and experience from the nurse practitioner who carried out this particular smear test which caused a huge amount of distress. Some etiquette as she told this lady she had either an STI or cancer when she didn't.”*

*“Collective feedback that the attendees to the webinar would have benefitted from more specialized health care professionals in GP settings. Language used by male professionals was said to be minimizing of women's health and the impact it has on them.”*

*“She felt that a women's only clinic would be great as the male Drs "dont get it".”*

*“The nurses at the smear test appointment taking the time to reassure her. Not asking probing questions while also having a speculum inside her vagina and prodding her. The second nurse who walked in while she was undressed introducing herself before looking at her private area. Taking the time after the procedure to explain next steps and ask her if she had any questions.”*

*“They felt that if health professionals particularly male GP’s were more educated in the menopause and not dismissing women’s health issues their experience would have been much better and they would have felt less disregarded.”*

- **Improved opportunities for the patient voice to be heard; feeling listened to**

*“When she told one particular nurse that she didn't like being touched and that this was probably because of her autism, the nurse patted her leg in a totally inappropriate and patronising way and totally ignored her request not to be touched!”*

*“More active listening by some services/practitioners to achieve person centred outcomes.”*

*“A more sympathetic GP who was prepared to listen to what she had to say instead of "fobbing her off". Someone with her to advocate for her so she didn't feel so vulnerable and undervalued.”*

*“Health professionals listening more to patients personal experience and needs, everyone is different. 'More listening and understanding is needed'.”*

- **More medical services, tests and routine checks**

*“Being able to book ahead for non-urgent GP appointments, although this is offered online there are never any appointments available.”*

*“home testing for cervical cancer.”*

*“If it were easier to get a GP appointment, does not use computer so could be digitally excluded. More understanding from some reception staff.”*

*“Her experience might have been different if ... hormone testing was a standard part of menopause diagnostics, which would help women better monitor their health”*

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- **Support including helping with accessing health care systems or arranging care by people such as trusted communicators, intermediaries, or peer support groups**

*“Support - offering a peer support worker and wrap around support from our centre, understanding, listening, time for her to talk through her feelings out loud. Trust.”*

*“A patient navigator or advocate role could support individuals during the waiting period, checking progress of referrals and offering reassurance. Emotional support services, even informal peer-based or community-led, could help women like her cope with the uncertainty of waiting.”*

*“assistance with booking appointments, reassurance that support is available if client doesn't feel comfortable attending alone.”*

*“Having Health/community Champions who truly understood and were able to offer genuine support and advice to women.”*

- **Community based or outreach medical services, services in variety of places and accessible**

*“When we talked about community assets they really felt that somewhere that women could self refer to such as a menopause clinic was much needed as well as places for women to meet and talk. They said “A cup of tea and a biscuit and everything is fine”.”*

*“More community events just for women like the IWD events which are full of all things for Ladies health and wellbeing or even more engagement from Drs with their patients. ie, a womens health day at the surgery out of hours just for women to ask the questions they might not otherwise get the opportunity to ask.”*

*“Appointments to go to have the smear test at evenings and weekends. More places to go to have the smear test, like they have breast screening in supermarket car parks etc why can't they do the same for smear tests and make it easier for people who work to get checked either during their lunch breaks or before or after work.”*

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- **Solutions involving language such as better availability of interpreters or leaflets in first or preferred language**

*“More translated materials available to the individual so that they are able to improve their understanding of English terms around sexual health, and therefore able to advocate for themselves and ask for the support they need. There is no current opportunity where the individual, out of education, would be taught these terms in English.”*

*“Another solution would be if she knew that there are language support services available within the healthcare system. If she had been informed that she could request an interpreter for her appointments, she might have felt more confident in speaking openly about her symptoms. This would have removed the language barrier and likely resulted in a more productive visit. Lastly, If she was informed that language helpline is widely available then she would definitely access it. Her English is not bad but talking about detailed health issues it is another level. She is not feel confident to speak herself.”*

*“Ongoing support from Hanseatic Union with language barrier.”*

*“Support from a Polish-speaking community worker or interpreter at GP practices could significantly reduce the language barrier. Providing translated NHS materials and help with online or in-person GP registration increases access.”*

- **Changes in individual attitudes towards health care**

*“The person accepted that their misgivings were probably a generational thing and that their daughter would have no such difficulties.”*

*“The woman expressed that although she is aware of the importance of screening and women’s health checks, her emotional state and lack of motivation have consistently prevented her from taking action. She said she knows she should go, but “just can’t get myself to do it”.”*

*“If she wasn't so worried about taking up a Dr apt when she knows they are in short supply and there are others who she feels are more deserving.”*

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- **Faster services with fewer delays**

*“Faster access to diagnostic services following a breast lump report, especially in cases with a strong family history, would reduce stress and support early intervention”.*

*“She felt that her experience could have been improved by faster access to gynaecological specialists.”*

- **Better integration and communication between different health services**

*“Too many different opinions from different professional. Dr changing her medication and the nurse advising Hysterectomy. Look at the person as a whole, yes this is a menopause problem but she has other medical issues that need to be considered also.”*

*“Someone taking accountability for the issue rather than each person involved in her medical treatment saying it's not their area and passing the buck. She understands everyone has their specialism and area but she is a whole person and sometimes it would be nice to been seen as that.”*

*“One of the key points that could have improved the patient’s experience is better recognition or integration of overseas health records, particularly private cervical screening results. If there were a system that allowed NHS services to acknowledge verified international screening, it might have reduced the need for explanation or revalidation and improved the patient's trust and continuity of care”.*

Other factors which could have made the person’s experience different included:

- a more welcoming and better designed GP surgery
- being made aware of the option of having a female practitioner and double appointment for cervical screening
- knowing it is possible to be accompanied at an appointment.
- having the concerns that come with being a carer recognised.
- more information about financial support for cancer treatment.

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## Part 3: Outcomes of conversations (Q3, Q33 and Q34)

**Q3. As a result of the conversation did you support the person with any of the following? (You can tick more than one)**

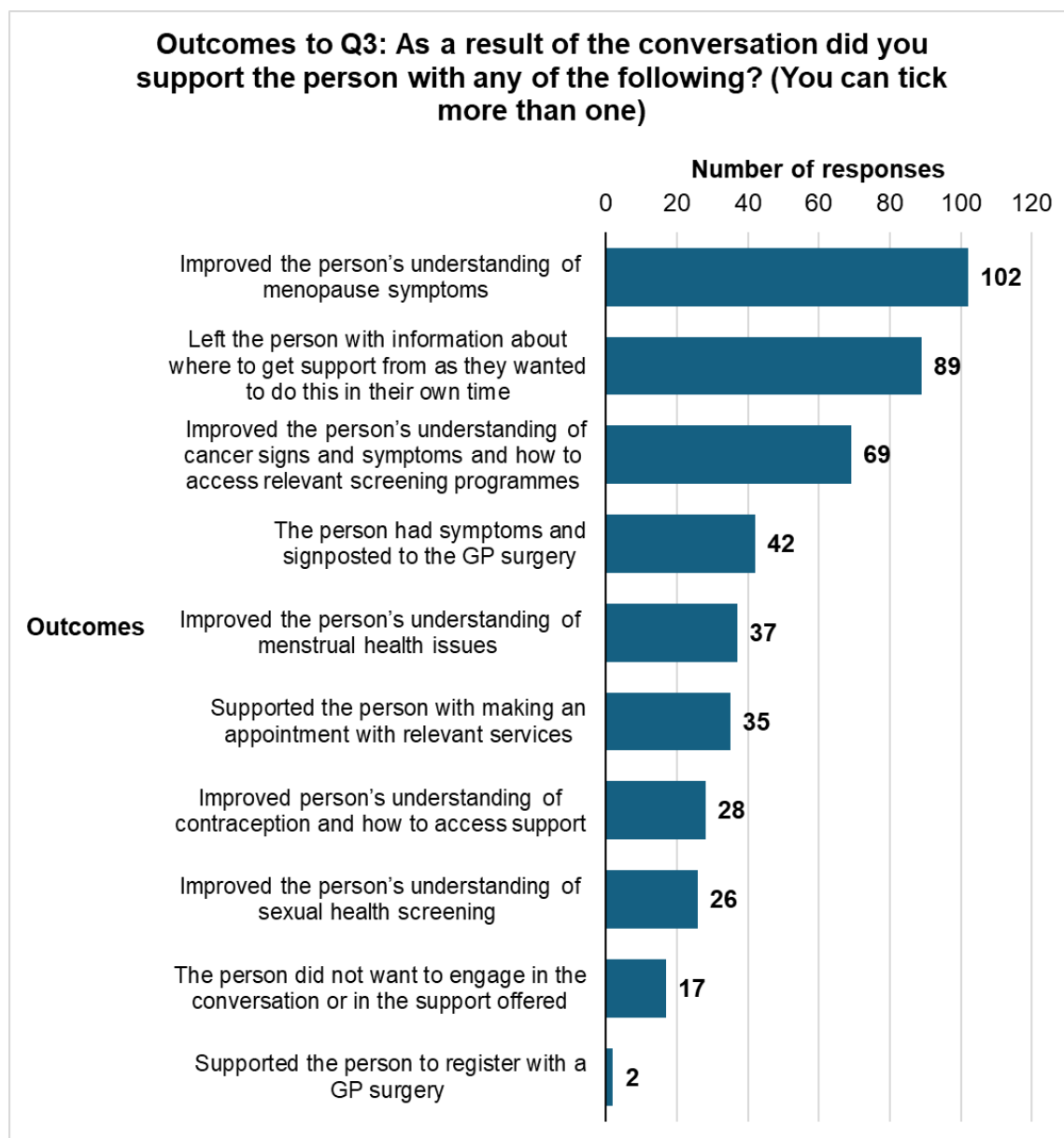
This question consisted of both quantitative and qualitative elements. Trusted Communicators were asked to tick types of support given as a result of their conversations from a list (quantitative) but were also given the opportunity to provide comment (qualitative).

There were **224** responses to the qualitative element of this question.

The main outcome reported was that the conversation helped to improve women's understanding of menopause symptoms. A summary of outcomes is provided in **Figure 1** below.

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**Figure 1: Summary of support given to the person as a result of the conversation**



A supplementary open question gave Trusted Communicators the opportunity to explain in further detail the outcome of their conversations. The main outcomes of the conversations were:

- the person or group's understanding of women's health issues was improved (through conversation, leaflets, signposting)
- people were supported to access treatment or seek further medical advice or care about women's health issues
- preventative interventions (check-ups and screening) were promoted

- the menopause was discussed in a supportive environment
- **The person or group’s understanding of women's health issues was improved (through conversation, leaflets, signposting)**

*“Supplied the group with leaflets and information to support the management of Menopause signs , and symptoms, and gave date for next Menopause support group session.”*

*“The conversation helped the woman better understand the potential signs of perimenopause, such as mood swings, hot flushes, and temperature fluctuations. We also discussed the importance of sexual health screening and contraception, which she had never previously considered.”*

*“Discussed the importance of breast screening, client wasn't aware about all symptoms, provided a leaflet and helped to arrange the appointment.”*

*“We had invited a Menopause nurse to speak to our group so this person was able to ask specific questions and receive expert advice there and then.”*

*“The person was given information about how to access sexual health screening support local to them. We talked about using contraceptives in later life and later life pregnancies, improving the persons knowledge of this.”*

- **People were supported to access treatment or seek further medical advice/care about women’s health issues**

*“Support was offered to book and to attend the appointment to help the client feel more confident. Despite requesting a female interpreter during the booking, a male interpreter was provided instead. The male interpreter provided essential information before the procedure but was asked to leave for the examination. Addressed the interpreter issue with the medical center.”*

*“We are going to book the lady on a one to one support with a menopause support worker.”*

*“Provided step-by-step guidance on navigating healthcare systems and booking procedures.”*

- **Preventative interventions (check-ups and screening) were promoted:**

*“Supported to make an appointment for cervical screening with their GP.”*

*“The lady has said she is behind on the breast screening we discussed her contacting the breast screening to get a new appointment.”*

*“X did not need much information as she was already aware of what is available for her at the age she is but she was interested to hear about bowel cancer screening.”*

- **The menopause was discussed in a supportive environment:**

*“This lady gained so much from hearing other ladies experiences of the Menopause.”*

*“We had a lengthy chat about just how many signs and symptoms there are of menopause and gave each other information which was great.”*

### **Q33. What action was taken at the time/as a result of your conversation?**

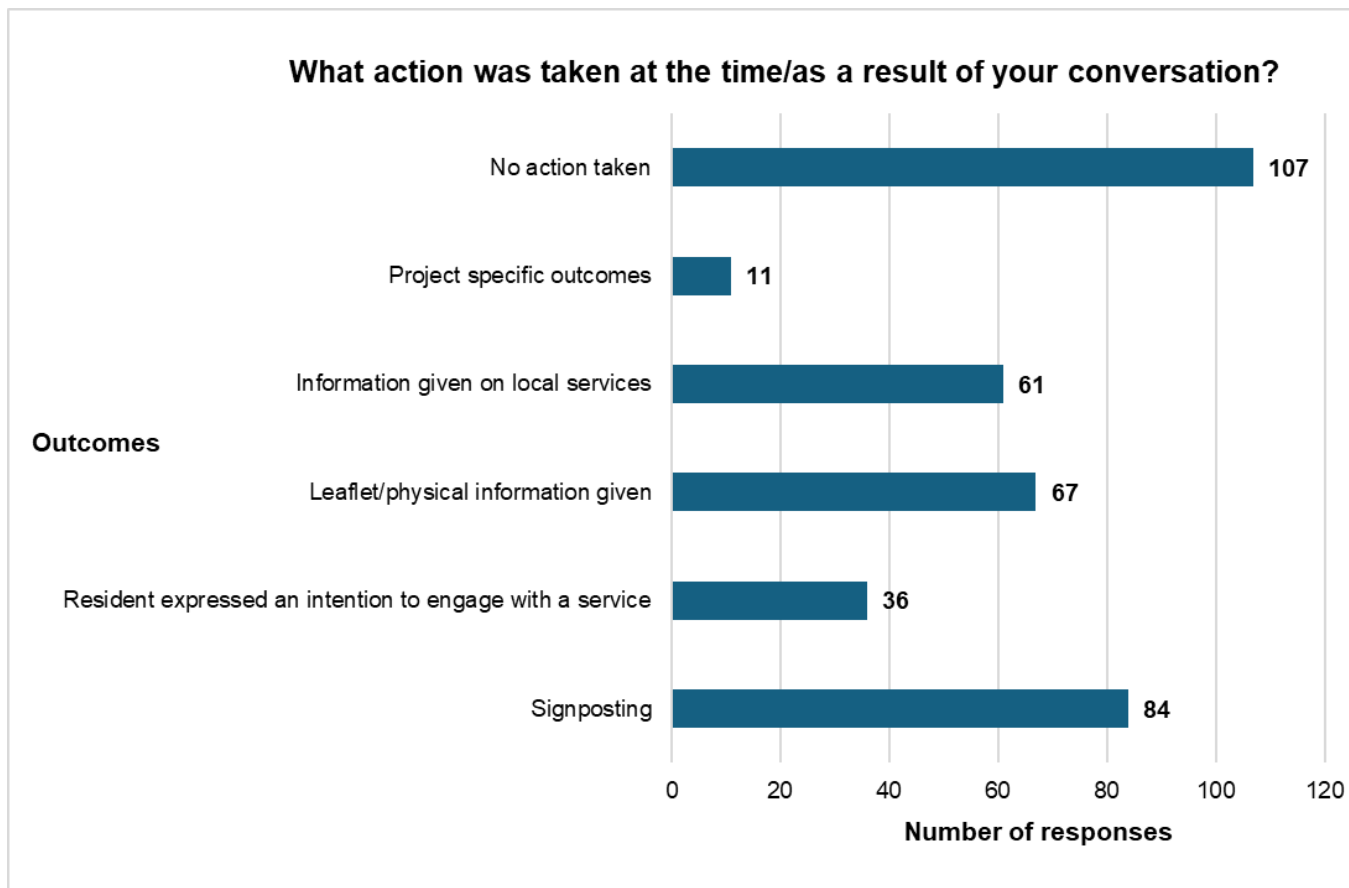
This question consisted of both quantitative and qualitative elements. Trusted Communicators were asked to tick relevant outcomes of their conversations from a list (quantitative) but were also given the opportunity to describe their actions (qualitative).

There were **43** responses to the open-text qualitative part of this question.

The most frequently mentioned outcome was supporting the person to access treatment or seek further medical advice about women’s health issues. A summary of these outcomes is provided in **Figure 2** below.

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**Figure 2: Summary of reported actions taken at the time/as a result of the conversation**



**Q34. If relevant, please give information about the actions taken, such as which organisations you signposted to.**

There were **127** responses to this question.

Trusted Communicators signposted people to their GP in many cases but also used their local and professional knowledge to direct people to charities, useful websites, and specialist medical teams. Women were signposted to:

- iCASH (noted ten times), Suffolk Sexual Health service, early pregnancy assessment unit
- Monthly menopause café, The Menopause Charity, Menopause Matters, menopause webinars being held by Daisy Programme during this project.
- Big C centre, James Paget Cancer support group, Keeping Abreast
- Norfolk and Waveney Mind, BEAT eating disorder support, mental health support services
- “Help to access Bupa which is an employ benefit,” Access to work
- Events at the local hospital and surgery, NHS website

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Report title: Community Voices Women's Health Report

Report Date: 19 May 2025

Report authors: Ellie Phillips, Sophie Bitten and Lizzie Benefer, NODA, Insight and Analytics, Norfolk County Council

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## **Community Voices and Women's Health: Turning Insight into Action**

### **October 2025**

#### **1. Introduction**

This report provides an overview of outcomes and system impacts arising from the Community Voices Women's Health Project, and how the insights have directly shaped commissioning, delivery, and workforce development within the Norfolk and Waveney Women's Health Hub (WHH) Programme. The project demonstrates how community-led insight can inform strategic commissioning and service transformation - turning listening into action. Community Voices has played a central role in the ICB's Women's Health Programmes strategy, ensuring that local services are co-designed with, and responsive to, the lived experiences of women across Norfolk and Waveney.

#### **2. Collaboration Between the Women's Health Programme and Community Voices**

The Women's Health Programme collaborated with the Community Voices Programme to help achieve one of its three core objectives: reducing health inequalities in women's health across Norfolk and Waveney.

The original aim of this partnership was to engage women aged 40 to 60, a key life stage characterised by significant health transitions such as menopause, menstrual changes, and contraceptive needs, alongside an increased emphasis on screening and early detection. Through meaningful engagement, the project sought to raise awareness, provide accessible information, and signpost women to appropriate support and healthcare services. This approach not only helped women to better understand and manage their own health but also enabled the Women's health Programme and its stakeholders to gather valuable insight into the barriers preventing many from seeking timely help or engaging confidently with primary care.

To achieve this, the Community Voices team commissioned nine VCSE partner organisations across Norfolk and Waveney to engage with women from a diverse range of communities; including ethnically diverse groups, rural populations, women experiencing deprivation, those with learning disabilities, and women affected by trauma or domestic abuse.

A Trusted Communicator model was adopted, recognising that women are more likely to share their experiences with individuals and organisations they already know and trust. This model created safe, supportive spaces for open and honest discussion about sensitive health topics. Each trusted communicator received introductory training on key women's health areas including menopause, menstrual health, contraception, and cancer screening, to equip them with the knowledge and confidence to manage queries sensitively, provide accurate information, and signpost women to the most appropriate local services.

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### **3. What We Heard: Key Insights**

Through this model, 766 in-depth conversations were held with women across the region. The outcomes of these conversations provided a rich qualitative evidence base that has since informed commissioning priorities, workforce training, and the design of the Women's Health Hub model across all Primary Care Networks.

Analysis of the conversations revealed five consistent themes:

1. Fragmented care and navigation difficulties - women struggled to access joined-up support for menopause, contraception, and gynaecological concerns.
2. Feeling dismissed or unheard - many women reported negative or invalidating experiences when seeking care.
3. Cultural and linguistic barriers - stigma, taboos, and language barriers limited access to preventive care and screening.
4. Low confidence and health literacy - many lacked the information or self-efficacy to advocate for their own health needs.
5. Trust and safety - women preferred to discuss sensitive issues with trusted local figures or within familiar settings.

### **4. The Why: Evidence and Insight**

The insights gathered through the Community Voices Women's Health Project provided a compelling rationale for system change. Women consistently expressed the need for local, trusted, and compassionate care delivered by professionals who listen, explain, and respond to their concerns without judgment. Many described fragmented care pathways, long waits, and experiences of being dismissed or overlooked when presenting with women's health symptoms.

These findings highlighted a clear need for services that are accessible, non-judgmental, and built on continuity of care. Women wanted to build relationships and trust, and to have access to joined-up support within their own communities. The insights also reinforced the importance of effective communication and health literacy, with many women reporting a lack of confidence to advocate for themselves in healthcare settings. This evidence base became the foundation for designing a new approach to women's health delivery across Norfolk and Waveney.

### **5. The How : The PCN-Based Women's Health Hub Model**

The findings directly informed the development of the PCN based Women's Health Hub model, a distributed model of care designed to bring specialist women's health services closer to home. Each hub provides access to contraception, menopause, menstrual, and pelvic health support locally, significantly reducing the need for hospital referrals, minimising stigma, and improving continuity of care.

Through this model, women can access timely, holistic support within their own communities, delivered by clinicians who understand local population needs. The programme has upskilled primary care teams through targeted training, enabling them to

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manage a broader range of women's health interventions safely and sustainably within general practice.

Crucially, the model promotes collaboration between GPs, the VCSE sector, and secondary care, fostering a community of practice that strengthens integration across the system. This joined-up approach encourages local partnerships and shared ownership of women's health improvement. For example, where a voluntary organisation runs a menopause café or community group, the hub actively promotes and connects this initiative within primary care, thereby ensuring women receive consistent, supportive, and joined-up care.

The PCN-based Women's Health Hub model therefore acts not only as a clinical delivery mechanism, but also as a catalyst for cultural change, embedding women's health as a shared system-wide responsibility and promoting collaboration at every level of care.

## **6. The Way We Deliver: Compassionate Care in Women's Health Training**

Informed by insights from the Community Voices Women's Health Project, the Community Voices and Women's Health Programmes are now co-developing "Compassionate Care in Women's Health". This training will be introduced as a mandatory requirement embedded within all Women's Health Hub contracts. The training is being co-designed collaboratively with VCSE partners, clinicians, and women with lived experience, ensuring that the *culture and quality of interactions* truly reflect what women told us matters most in women's health: kindness, empathy, and understanding - not only of their clinical conditions, but also of their cultural contexts and personal experiences.

This training focuses on trauma-informed and empathetic communication, supporting clinicians to approach sensitive discussions with confidence and care. It also helps staff to recognise the emotional, psychological, and cultural dimensions of women's health concerns and to respond appropriately. By embedding compassion as a core professional competency, the programme aims to move beyond procedural care towards relationship-based, emotionally intelligent practice.

Ultimately, the "Compassionate Care in Women's Health" Training seeks to establish a consistent standard of interaction across all hubs, ensuring that women in Norfolk and Waveney feel listened to, respected, and supported. In doing so, it reinforces the ICB's wider ambition to embed equity, dignity, and inclusion at the heart of system transformation.

## **7. Conclusion**

The Community Voices Women's Health Project demonstrates that listening differently leads to delivering differently. By grounding commissioning in lived experience, Norfolk and Waveney ICB has created a model that is inclusive, scalable, and sustainable. The Women's Health Hub model, informed by Community Voices, stands as a leading example of insight-led transformation within the NHS.

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# Community Voices QEH Project

## Introduction

The Quality Employment in Healthcare (QEH) project, supported by the Health Anchor Learning Network (HALN), is a collaborative initiative led by the Queen Elizabeth Hospital (QEH) to address employment inequalities in West Norfolk. As an anchor institution, QEH is uniquely positioned to influence local socioeconomic outcomes by improving access to secure, high-quality employment in healthcare particularly for individuals from deprived communities and underrepresented ethnic backgrounds.

Utilising the Community Voices Trusted Communicator model the aim of the project was to listen to and capture the experiences of the under-represented communities. This report presents findings from this engagement which captures the lived experiences of those who applied for roles at QEH but were unsuccessful or recruited into lower-grade positions.

Through 49 structured conversations facilitated by Trusted Communicators and analysed by the Norfolk Office of Data and Analytics (NODA), the project reveals critical enablers, barriers, and opportunities for reform in healthcare recruitment.

The insights gathered will inform a shared local plan for inclusive workforce development, contributing to the Norfolk & Waveney Integrated Care Board's (ICB) People Plan and supporting the West Norfolk Health and Wellbeing Partnership's (WNH&WP) goals.

## Key findings

### Prospective employees found out about job opportunities at QEH through:

- Online sources - QEH portal, websites such as Indeed, LinkedIn, and Trac job
- Family and friends, especially those currently employed at QEH
- A jobs fair at which QEH was represented

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The main **enablers to securing employment** at QEH are:

- A straightforward or fair process
- Easy to use online platforms for job applications
- Support from family members, friends, and/or community members
- A positive interview experience
- Access to / support for English language support services
- Assistance from a recruitment agency in the person's home country

The main **barriers to securing employment** at QEH are:

Language challenges – issues are around the individual's actual or perceived competency, and actual or perceived requirements of specific roles.

Additional barriers are:

- Attitudinal barriers such as lack of confidence or perceptions about QEH
- Confusion about the nature of the role and of requirements
- Barriers linked to processes including the interview
- Poor or slow communication between the recruiter and the applicant
- Employment opportunities do not fit with the individual's personal responsibilities
- Barriers with using IT to search and apply for jobs
- A perception that not being an English national puts applicants at a disadvantage

**Solutions to barriers** are:

- Improved language skills, more support for improving language, or a reconsideration of the language requirements for certain roles
- Better or more information about the opportunities available and necessary qualifications or requirements (including visa and sponsorship requirements)
- Better or more timely communication between recruiter and the applicant
- Better support to new employees
- Better support and guidance around the QEH application process
- Job opportunities available at a time convenient for the applicant

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## Recommendations

Based on the findings from the engagement here are five tangible and strategic recommendations and considerations:

1. **Develop a community-based recruitment support programme to build trust and access among underserved groups**
  - partner with local community organisations and existing Trusted Communicators to deliver regular, in-person and online “Employment Navigation Workshops” focused on job roles, application guidance, visa and sponsorship requirements, and interview preparation.
  
2. **Review and redesign recruitment communication process for transparency and timeliness to improve candidate experience and trust in QEH recruitment**
  - applicant communication protocol, including automatic status updates, personalised feedback, and realistic timelines for each stage of the recruitment journey.
  
3. **Introduce inclusive role design and flexible opportunities to align job structures with lived realities of underserved communities**
  - Co-produce part-time, flexible, and entry-level healthcare roles with input from residents, especially those with caregiving responsibilities or other structural constraints. Promote these roles prominently during recruitment drives.
  
4. **Launch a “Local Talent into Healthcare” Initiative to establish QEH as a leading anchor institution for inclusive employment**
  - Set internal targets for hiring from underrepresented communities and create entry-level apprenticeship or paid work experience pathways tied to progression opportunities. Track and report on progress through the WNH&WP and Norfolk & Waveney ICB structures.
  
5. **Create a multilingual recruitment pathway with language support tiers to reduce language as a barrier to employment whilst maintaining safety and role clarity**
  - Introduce role-specific language requirements aligned to actual need and to signposting to sources or offer of English support tiered English language support (pre-application, pre-interview, and post-hire phases), potentially in partnership with local ESOL providers or adult education services.

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## Background

This report provides analysis and a summary of conversations captured as part of the Community Voices QEH Project during April-July 2025. Grants were made through Norfolk Community Foundation to two organisations to carry out conversations with people who unsuccessfully applied for a role at QEH. Conversations also covered people's perceptions about job opportunities at QEH and the enablers and barriers to employment.

Conversations between Trusted Communicators and participants were recorded on the Community Voices Insight Bank. Analysis was undertaken by the Norfolk Office of Data and Analytics (NODA) in the Insight and Analytics Team at Norfolk County Council. Any quotes included in this report are given verbatim from the Insight Bank.

## Process

NODA was commissioned to analyse 49 conversations. A sample of comments was read, and a coding framework developed, tested, and refined. Each comment was coded, and codes were quality assured for consistency and accuracy. Analysis of quantitative elements of the project was out of scope although the quantitative elements of Q14 are included in this report.

The phrase 'Trusted Communicator' is used throughout as a way of describing people who lead the Community Voices conversations and is not intended to reflect a specific role within organisations.

Points are made in order of prevalence with the most frequently discussed topics appearing first.

## Analysis of questions

This report is structured into three sections which mirror the themes of the discussions:

Part 1 – General: recruitment and employment opportunities at QEH (Q12 and Q13)

Part 2 – Enablers and barriers to employment and possible solutions (Q15, Q16 and Q17)

Part 3 – Outcomes of the conversations (Q14)

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## Part 1: General: recruitment and employment opportunities at QEH (Q12 and Q13)

### Q12. Was the person sent a letter or email to participate in these Community Voices conversations? Were they successful or unsuccessful in the recruitment?

There were **41** responses to this question.

As two binary (yes/no) sub-questions were posed in Q14 (whether people received a letter or email to take part in the conversation and whether or not they were successfully recruited), it was not always possible to know which question the Trusted Communicator was referring to with a single response of 'no' (14 instances). Although it is unclear from the conversations how people were recruited, it is possible respondents were engaged informally, possibly through word of mouth, via existing networks and through key individuals.

*"This conversation is with a colleague who runs a church for nigerians/africans who came here on care visas. He asks for a catch up every now and then to tell me what is happening. ... so I used him as a focus group for those he represents."*

There were more examples of successful recruitment than unsuccessful applications although a few people did not hear anything from the QEH about their application.

### Q13. Please provide a summary of your conversation about employment opportunities within the Queen Elizabeth Hospital. Prompts: was the conversation about a recent experience that the person had? Were people aware of how to look for job opportunities at the QEH or health care generally? and/or experience of other NHS organisations.

There were **39** responses to this question.

**Identifying opportunities:** People use a range of online sources, such as the QEH portal for overseas recruitment, and websites including Indeed, LinkedIn, and Trac job to find jobs at QEH. Family and friends are also a source of information: knowing where to search for jobs appears well-understood. A jobs fair at which QEH was represented was also described. There were few references to other NHS organisations, or roles in health care more generally, except where the person described needing to work closer to home because it is difficult to reach QEH.

Responses to Q13 focus mainly on the barriers and enablers people face when seeking employment at QEH (these are discussed in greater detail in Q15 and Q16). In terms of barriers, language is the most frequently cited issue, followed by lack of clarity around requirements for the role, and issues with processes.

*“The person is aware about NHS job opportunities. He thought about applying online but was unsure because his English is not very well.”*

*“The computer literacy skills was my challenge, I never did computer in my country, and they never told us we have to be computer literacy, they should have told on the interview.”*

*“This person hadn’t applied for any jobs at QEH before, as she thought the process was too complicated. I showed her how to search for jobs at QEH and explained the application process.”*

Factors which enable people to secure employment are a positive interview experience, simple and fair processes, access to information about job opportunities and how to apply for them, and support from family or friends.

*“Nigerian nurse applied via UK website Trackjob. Easy application process, room interview with 2-3 people, all fair and easy to do. Received job offer within 3 days and was able to get vis within 2 months. She found the process easy and fair and felt the recruitment team were very helpful, sorting initial accommodation and refunding expenses. Very happy with recruitment process.”*

One respondent’s experience highlighted a potential issue with internal communication at QEH.

*“This lady is a Ukrainian refugee, trained Pharmacist who has tried applying at the recruitment day at the Job Centre, the hospital website and a health workers recruitments site. She has also sent in a resume for different positions including Catering and cleaner. Clearly desperate to work! She had an interview for Pharmacist but her documentation was not confirmed and verified for UK use. Her English is also not yet good enough - she got in touch about volunteering in the Pharmacy dept, but received no reply. The QEH Education and Training department sent an email to Pharmacy dept asking what could be done (which she showed me). She was copied in but no reply was given.”*

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## Part 2: Enablers and barriers to employment (Q15, Q16 and Q17)

**15. What did you find to be the enablers for the person/s in accessing job opportunities at the QEH? Prompts: did the person think the process was fair and easy to follow? Examples?**

There were **42** responses to this question.

People described the factors which enabled them to access employment at QEH as:

- **A straightforward or fair process:** *“Everyone thought the application process was easy and all 13 in the group had accessed the website, looked at the jobs - 9 had gone on to make applications.”*
- **Easy to use online platforms for job applications:** *“Easy done online, uploaded cv.”*
- **Support from family members, friends, and/or community members:** *“Enablers included access to English language support, help from community networks.”*
- **A positive interview experience:** *“Easy to use website, good interview process, fast decision and COS issue.”*

The following enablers were mentioned once:

- Access to / support for English language support services
- Access to information about job opportunities and how to apply for them
- Comments about assistance received from a recruitment agency in the person’s home country.

**16. What did you find to be the barriers for the person/s in accessing job opportunities at the QEH? Prompts: did the person think the process was fair and easy to follow? Please provide examples where possible**

There were **41** responses to this question.

### Language barriers

People told Trusted Communicators **the main barrier they experience in accessing employment at QEH concerns language issues**. People described feeling their language skills are insufficient or failing mandatory testing: sometimes the nature of the language barrier was undefined.

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- *“If you speak English yes, but if you lack a bit you might miss out on crucial answer. Most people don’t apply because they think they knowledge is nor enough.”*
- *“Failing OET [Occupational English Test] test three times.”*
- *“English language barrier.”*

Language challenges (people’s actual or perceived degree of linguistic competency and mandatory test requirements) were also mentioned as a potential barrier to employment in responses to other questions. Reliance on evidence of language proficiency can leave prospective or appointed employees vulnerable to fraudulent practices:

*“The clients come here on care visas as qualified medical staff and have followed processes. a particular issue is the need for an english certificate. Unfortunately many had been scammed and had paid for certificates from organisations that were fraudulent. Some did not find this out until they had been at work for 6 months - and were then asked to leave. They all had expresed they would have liked to have been told earlier or given a list of organisations that were trustworthy.”*

### **Additional barriers**

People described other factors which prevent them from working at QEH as:

- **Attitudinal barriers** such as lack of confidence or perceptions about working at QEH: *“One comment was these jobs are for “big people” not little people like us. They felt they wouldn’t have the english. They wouldn’t be wanted so didn’t apply.” / “... none wanted to work with patients although some said they would do other jobs.”*
- **Confusion about the nature of the role of requirements** (either because the role is poorly communicated or the prospective applicant lacks understanding): *“The client speaks English and the client thinks that if you work at the hospital you need to [k]no[w] all words related to medicine.”*
- **Barriers linked to processes:** *“The main barriers were a lack of understanding of the application process and the belief that it was too complicated.”*
- **Barriers in the interview process:** *“One lady had been called for an interview in domestic services as a cleaner. She said the interview lasted less than 5 minutes and they told her “face wouldn’t fit”.*
- **Poor or slow communication between the recruiter and the applicant:** *“Long time waiting for job offer.”*

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- **Employment opportunities did not fit with the individual's schedule or responsibilities:** *"...one said she was interested in working as a domestic service assistance because she had heard that they offered a shift between 9-3 - but had never seen the job advertised with school hours ..."*
- **Barriers with using IT:** *"Low IT skills in getting to the QEH jobs site - sat with him and googled it and looked for current vacancies"*
- **A perception that not being an English national puts applicants at a disadvantage:** *"Another lady who was a paediatric nurse in her country said she knew she wouldn't stand a chance because she wasn't English. However she is muslim and had her head covered and i could only think it was racism of some sort." / "He felt it was loaded for indigenous candidates, which he said would be the same back home in Nigeria."*

Seven people said there are no barriers.

Trusted Communicators also recorded barriers to employment in responses to other questions. As well as practical issues such as difficulties with transport to the hospital or the need to balance caring responsibilities with employment, some perceptions of QEH's institutional culture are negative:

*"The reason why the client did not try to get the job at the hospital is the language barrier. The client loves the atmosphere at the QEH and she wished to work in there in any department." / "Many talked about occasions where they had been treated rudely at the QEH which they felt was due to them not being english - they did not feel welcome at their medical appointments and did not feel they would be welcome working there - those they did know who worked there were in the lowest status jobs."*

**17. What came up in your conversation that reflects what would have made the person's experience different to the one they had? Prompts: where possible identify possible solutions to the barriers faced?**

There were **36** responses to this question. Solutions to barriers included:

- **Improving language skills, more support for improving language, or a reconsideration of the language requirements for certain roles:** *"Talked through ways to get help to pass OET." / "Reducing English language proficiency requirements for people whose first language is not English."*

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- **Better or more information about the opportunities available and necessary qualifications or requirements (including visa and sponsorship requirements):** *“The person’s experience could have been improved with clearer information about the variety of roles available at QEH, especially those that don’t require medical qualifications. If there had been more transparency in job listings or guidance on non-clinical roles, she might have felt more encouraged to apply for other positions.”*
- **Better or more timely communication between recruiter and the applicant:** *“one waited for 6 weeks to hear if they were going to be offered an interview which they felt was too long.”*
- **Better support to new employees:** *“We have previously suggested mentors to support staff at the QEH who are new to the country - they can then identify an issues at a very early stage when it is easy to put right.” / “Better onboarding and training on UK computer systems.”*
- **Better support and guidance around the QEH application process:** *“She said that a simple explanation or step-by-step guidance earlier would have made the process feel less intimidating and more accessible.”*
- **Job opportunities available at a time convenient for the applicant:** *“parent friendly shifts would make a difference.”*

### Part 3: Outcomes of conversations (Q14)

#### 14. As a result of the conversation, did you support the person with any of the following? (You can tick more than one)

This question consisted of both quantitative and qualitative elements. Trusted Communicators were asked to tick a box indicating the type of support they provided as a result of their conversations: they could choose from a list (quantitative) responses but were also given the opportunity to provide commentary (qualitative).

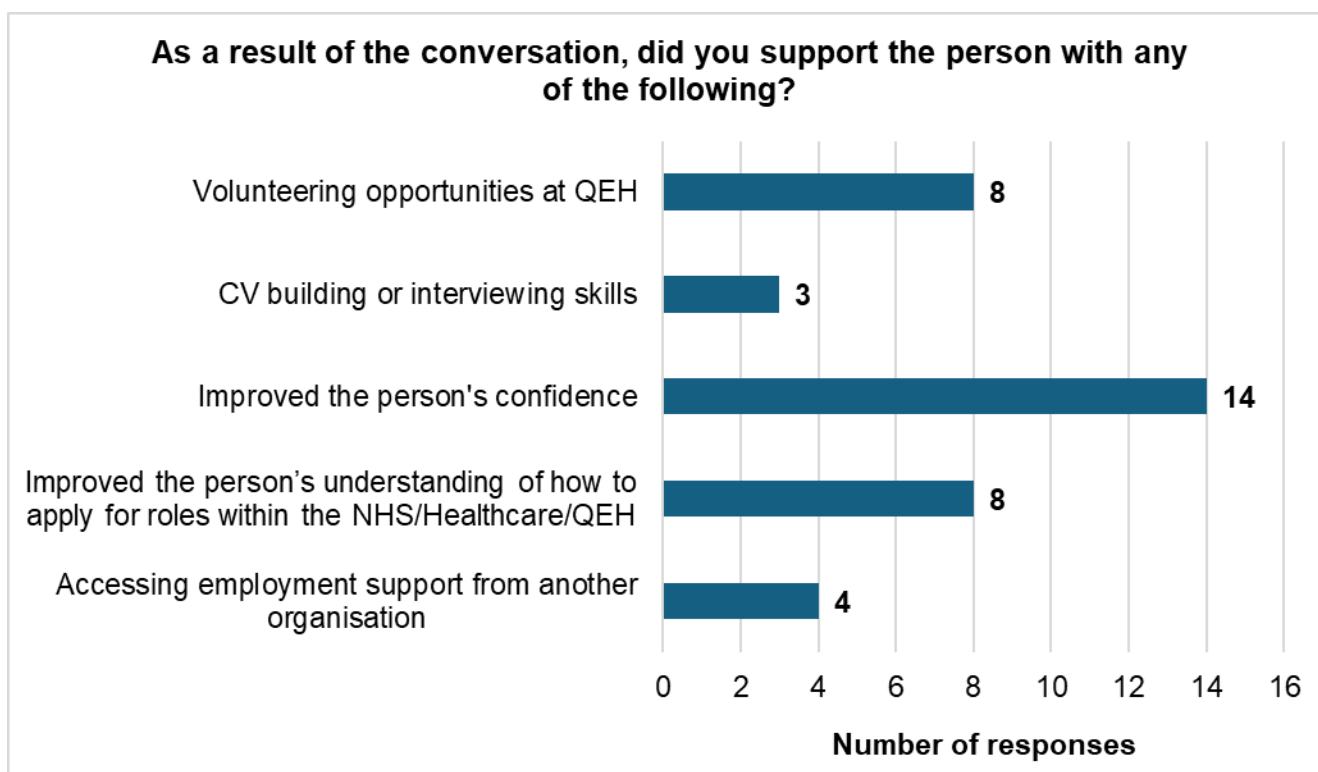
The main outcome reported from the options was improving the person’s confidence, although support with volunteering opportunities at QEH and helping the person understand how to apply for future roles at QEH were also selected multiple times. A summary of outcomes is provided in **Figure 1** below.

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There were **16** responses to the qualitative element of this question. Trusted Communicators supported prospective employees by:

- **Increasing people’s knowledge about roles and job-hunting:** *“Give some advice where the person can look for any work at the QEH.”*
- **Coaching or training individuals:** *“Computer basics course with our organisation.”*
- **Supporting language skills:** *“Information given about ESOL courses.” / “Referred to [name] for OET coaching.”*

**Figure 1: Summary of support given to the person as a result of the conversation**



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## Case studies

In some responses, Trusted Communicators described the person’s experience or used the individuals own words to explain the recruitment process or what it is like to work at QEH. The detail evidences many positive aspects of QEH’s employment offer and some areas for improvement, both by QEH and partners.

### Case study 1: Paediatric nurse

Satisfactory or good	Challenges
<p>Well managed interview Timely feedback from interview Alternative employment route suggested Positive recruitment process</p>	<p>Difficulty in locating application links Sponsorship regulations reducing potential jobs Incorrect advice provided suggesting lack of knowledge about UKNMC requirements</p>
<p><i>“A Ghanaian lady who had come to the UK via a recruitment agency that went bust and is kind of in limbo. English is 2nd language and I would judge easily B2 speaking/listening. Attended an open day and got interview for ED nursing job. Couldn’t find application links online, someone emailed her with it (as we chatted I googled them and found it easily though!). Good interview by two people, who got her relaxed and asked good questions, that she understood. 4 days later had successful letter and HR put on the tracking system. However she then failed the OET twice and ultimately the offer was withdrawn. Was told another route is band 3 care worker for a year and a line manager signing of English skills. No jobs with sponsorship as regs tightened. Found recruitment process was done really well. Issue for her was OET. She did mention that the guidance for coming to UK was put “adult general nurse” and then move to speciality (she is experienced Paediatric nurse) she has found that to be duff advice as she would need to redo UKNMC application and add qualifications to apply for a paediatric job.”</i></p>	

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### Case Study 2: Nurse

Satisfactory or good	Challenges
<p>Positive interview Simple visa application process</p>	<p>Delay in receiving interview decision Induction period did not allow recovery time from overseas travel Training team unaware of NMC training requirements: trained was rushed Issue with short notice for annual leave for people who need to book overseas flights</p>
<p><i>“Indian male nurse recruited in 2021. Partner already working at QEH. Applied via international recruitment page on QEH website. Online interview with 2 people - went well, had prepared well, so knew policies and procedures. 3 month wait for acceptance though. Visa application simple after receiving COS. Long journey and immediate induction - no time to get over jet lag. Training team weren't aware of NMC training changes, and was sent to Yeovil for OSCE training and exam in Oxford - difficult travel and all to rushed. Otherwise all okay. Issue with annual leave booking for internationals - only 3 weeks notice of leave allowed and so hard to book trips home, as prices very high with so little notice.”</i></p>	

### Case Study 3: Midwife

Satisfactory or good	Challenges
<p>Satisfactory interview as anticipated questions were asked</p>	<p>Unsatisfactory interview as requirements about computer literacy not established at outset Sense of unequal treatment compared to UK nationals in the same role</p>
<p><i>“This person applied from the Caribbean. She had to do an English exam first and then went through an Agency "Nuro". The recruiter did an initial interview but didn't know much about Qeh or the job. QEH panel interview went okay - expected questions about why wanting come to UK, tell about yourself, desire to be a midwife etc. No mention of computer literacy needed for the role. Successful Job given, visa success etc. She felt the was treated differently as non UK arrival - trainer didn't want to teach her, just the UK midwife. Different procedures than in Guyana. Was toyed out in front of doctors and other staff members. "The computer literacy skills was my challenge, I never did computer in my country, and they never told us we have to be computer literacy, they should have told on the interview".”</i></p>	

### Case Study 4: Women’s and Children’s Services

Satisfactory or good	Challenges
Timely decision following interview Good induction Good support from manager	Lengthy online application form: drop-down boxes or alternative paper format suggested Scope of role was extended when in post
<p><i>“The person had a 1yr contract that was extended for a while until funding ran out. Their partner worked as a nursing assistant so an email was sent for family members interested in a job to click a link to an online portal. She felt the online form was very long, perhaps some dropdown choices or even option for paper form would have made the process easier. The interview was with 2 people in Women and Children's services for 30mins. Most of the questions asked were already answered on the application form. She was told of appointment the same day. Good induction, straightforward and help from line manager to get used to the role. Got very busy and was asked to do things not on job description! Role ended after an extension when funding ran out.”</i></p>	

### Ethnicity

Disclosure of ethnic background was optional, therefore this information may not have been captured for all respondents – see **Table 1** below:

**Table 1: Summary of respondents' ethnic background**

Ethnicity	Total
Any other White background	10
African	7
English/Welsh/Scottish/Northern Irish/British	2
Any other Asian background	2
Caribbean	1
Indian	1
Any other ethnic group	1
Prefer not to say	2

**Twenty-three** respondents chose not to disclose their ethnic background. The most commonly reported ethnic background was any other White background (10), followed by African (7). **Two** respondents stated that they would prefer not to answer the question.

Report title: Community Voices QEH Employment Report

Report Date: 30 June 2025

Report authors: Ellie Phillips, Sophie Bitten and Lizzie Benefer, NODA, Insight and Analytics, Norfolk County Council

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**Community Voices** 

Using your feedback to improve care



The Queen Elizabeth  
Hospital King's Lynn  
NHS Foundation Trust

# Community Voices Briefing

1<sup>st</sup> August 2025

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# Community Voices QEH Project

## Addressing Employment Inequalities



The Quality Employment in Healthcare project, a collaborative initiative led by the Queen Elizabeth Hospital (QEH) and Community Voices. Supported by the Health Anchor Learning Network (HALN) with an aim to tackle employment inequalities in West Norfolk.

## Insights from Community Conversations



This presentation shares key findings derived from 49 structured conversations held with underrepresented communities, focusing on their experiences when applying for roles at QEH.

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# Project Background

The QEH project aims to listen to and capture the experiences of under-represented communities who applied for roles at QEH but were unsuccessful or recruited into lower-grade positions.

Through 49 structured conversations facilitated by Trusted Communicators and analysed by the Norfolk Office of Data and Analytics (NODA), the project reveals critical enablers, barriers, and opportunities for reform in healthcare recruitment.

The insights gathered will inform a shared local plan for inclusive workforce development, contributing to the Norfolk & Waveney Integrated Care Board's People Plan and supporting the West Norfolk Health and Wellbeing Partnership's goals.



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# How People Find Job Opportunities at QEH

## Online Sources

QEH portal, websites such as Indeed, LinkedIn, and Trac job

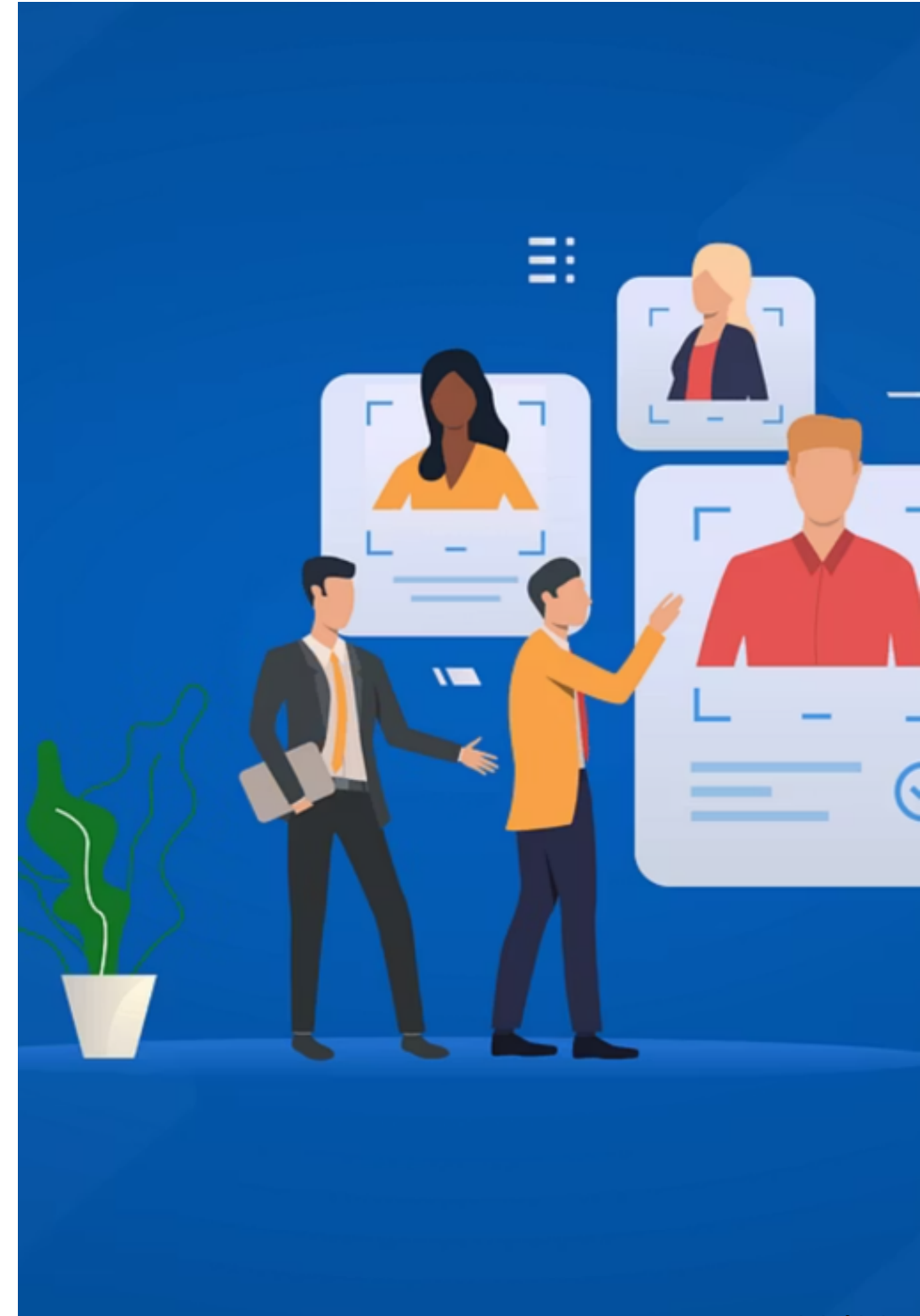
## Family and Friends

Especially those currently employed at QEH

## Jobs Fair

Events at which QEH was represented

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# Enablers to Securing Employment

## Straightforward Process

"Everyone thought the application process was easy and all 13 in the group had accessed the website, looked at the jobs - 9 had gone on to make applications."

## User-Friendly Online Platforms

"Easy done online, uploaded cv."

## Support Networks

"Enablers included access to English language support, help from community networks."

## Positive Interview Experience

"Easy to use website, good interview process, fast decision and COS issue"

Additional enablers included access to English language support services and assistance from recruitment agencies in applicants' home countries.



# Barriers to Securing Employment

## Primary Barrier: Language Challenges

"If you speak English yes, but if you lack a bit you might miss out on crucial answer. Most people don't apply because they think their knowledge is not enough."

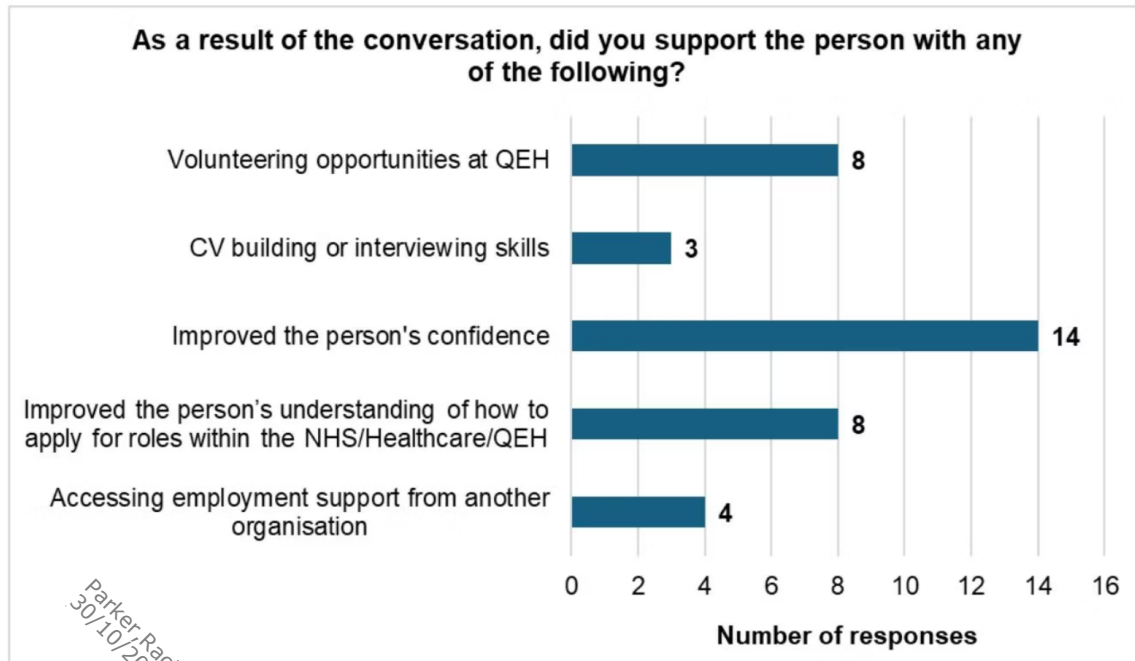
Issues revolve around the individual's actual or perceived competency, and actual or perceived requirements of specific roles.

## • Additional Barriers

- Barriers such as lack of confidence
- Confusion about role requirements
- Process-related barriers including interview issues
- Poor or slow communication
- Scheduling conflicts with personal responsibilities
- IT barriers when searching/applying for jobs
- Perceived disadvantage for non-English nationals

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# Outcomes of Conversations



## Support Provided by Trusted Communicators:

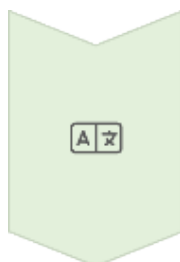
- Increasing people's knowledge about roles and job-hunting
- Coaching or training individuals
- Supporting language skills

"Give some advice where the person can look for any work at the QEH."

"Computer basics course with our organisation."

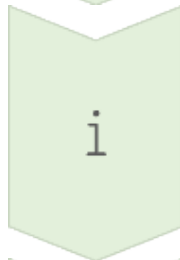
"Information given about ESOL courses."

# Solutions to Barriers



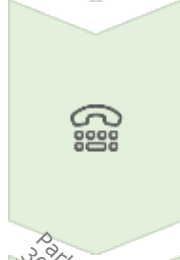
## Language Support

Improved language skills, more support for improving language, or reconsideration of language requirements for certain roles



## Better Information

Clearer information about opportunities and necessary qualifications (including visa and sponsorship requirements)



## Improved Communication

Better or more timely communication between recruiter and applicant



## Enhanced Support

Better support for new employees and improved guidance around the application process

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# Strategic Recommendations

1

## Community-Based Recruitment Support

Partner with local community organisations and Trusted Communicators to deliver "Employment Navigation Workshops" focused on job roles, application guidance, and interview preparation.

2

## Redesign Recruitment Communication

Develop applicant communication protocol, including automatic status updates, personalised feedback, and realistic timelines for each stage of the recruitment journey.

3

## Inclusive Role Design

Co-produce part-time, flexible, and entry-level healthcare roles with input from residents, especially those with caregiving responsibilities or other structural constraints.

4

## "Local Talent into Healthcare" Initiative

Set internal targets for hiring from underrepresented communities and create entry-level apprenticeship or paid work experience pathways tied to progression opportunities.

5

## Multilingual Recruitment Pathway

Introduce role-specific language requirements aligned to actual need and tiered English language support, potentially in partnership with local ESOL providers.

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# Initial Actions

The findings from the Community Voices pilot have been shared with the Strategy and Transformation Executive Group, who have expressed full support for progressing the first two recommendations outlined in the report. This endorsement reflects both recognition of the existing work in this space and confidence in the Trust's ability to further strengthen and embed this approach.



Building on existing work we are already doing with our employment organisation across the community, we are looking to enhance our employability sessions, offering more tailored support based on the recommendations from the report.



We already use a fantastic candidate portal on Trac, which allows applicants live updates on their recruitment episode. Further communication and expected timelines will be built into employment workshops, to give potential applicants more insight into expectations for commencing their new role.

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# Thank you

## Q&A

Contact:

Amrita Kulkarni, [nwicb.communityvoices@nhs.net](mailto:nwicb.communityvoices@nhs.net)

QEH: Keighley Evans/Carrieanne Davies,

[gehinsight.project@gehkl.nhs.uk](mailto:gehinsight.project@gehkl.nhs.uk)

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## The Community Voices Programme in Norfolk and Waveney Analysis of impacts 2021 - 2024

November 2024

Jack Hallworth and Rebecca Owens, Evidence and Evaluation Hub,  
Research and Evaluation Team, NHS Norfolk and Waveney Integrated Care Board

Please contact [NWICB.EEHub@nhs.net](mailto:NWICB.EEHub@nhs.net) for any further information.

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## 1. Key impacts

- The conversation between trusted communicators and community members enabled mutual learning and enhanced knowledge for both groups on topics such as health screening, smoking cessation, and research engagement.
- VCSE organisations benefitted from the programme by gaining valuable insights through training, networking, and conducting the conversations. This strengthened relationships with their communities and allowed them to view health and wellbeing more holistically.
- Building trust within communities was important for establishing meaningful engagement, allowing trusted communicators and community members to consider and initiate preventative health actions and empowering individuals to take responsibility for their own health.
- Feedback suggested that the programme facilitated stronger, more effective collaborations across the integrated care system, generating an appetite to be more 'joined up' and understanding organisational perspectives.
- Ongoing conversations after the conclusion of individual projects highlighted the need for more robust and continuous funding to sustain engagement on health issues, refine the trusted communicator model, and improve the ability of the Community Voices programme to support long-term health outcomes.

## 2. Introduction

This report describes an analysis of impacts of the Community Voices Programme in Norfolk and Waveney. Community Voices (CV) works with trusted communicators in Norfolk and Waveney to speak with communities that may not already engage with the NHS and other bodies to hear what is important to them. The programme was established in 2021 and aims to ensure that people who experience disadvantage because of where they live or who they are can be empowered to understand and act on their health, have a place to share their views, and can help shape how health services are designed and delivered.

This analysis was conducted by the Norfolk and Waveney Integrated Care Board (ICB) Evidence and Evaluation (EE) Hub, a quasi-independent team with a range of methodological expertise providing evaluation support across the Norfolk and Waveney Integrated Care System (NWICS).

### **3. Method**

We used two data collection approaches for this analysis: a review of Community Voices reports and an interactive Ripple Effects Mapping exercise.

#### **3.1 Review of reports**

We analysed previous reports of eight specific Community Voices projects (Appendix 1). This analysis was guided by the following three questions and conducted qualitatively:

- What learning was acquired from the insights?
- What was the impact of the projects?
- What were the implications and considerations of the projects' outputs for people and communities, for the VCSE sector, for Community Voices, the ICB and the ICS?

Text that was relevant to these questions was extracted from the reports and analysed thematically in Microsoft Word.

#### **3.2 Ripple Effects Mapping**

Ripple Effects Mapping (REM)<sup>1</sup> is a participatory method for evaluating both the intended and unintended outcomes of an intervention. It typically produces a visual map of these outcomes and the connections (ripples) between them, which can then be reviewed and updated over time.

We conducted two Ripple Effects Mapping sessions: one with the CV steering group and another with a group of VCSE representatives. We also gathered additional input from steering group members who could not attend the initial session. We provided all participants with preparatory material and prompts to guide pre-session thinking. During the REM sessions, participants developed initial impact maps using MIRO (Appendix 2).

Data from REM sessions were combined and analysed thematically, enabling us to produce a map of the impacts and pathways as identified by the participants.

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## 4. Findings

Analysis of both the evaluation reports and Ripple Effect Mapping sessions has identified the following four key areas of impact:

- Gaining insight and learning from the conversations
- Impacts for VCSE organisations
- Building relationships and facilitating actions
- Raising awareness and identifying further impacts

### 4.1 Gaining insight and learning from the conversations

A recurring theme across most of the reports was the facilitation of mutual learning through conversations between trusted communicators and community members. These discussions, while initially focused on specific health topics, often expanded into more meaningful and broader conversations. This occasionally revealed unanticipated themes such as grief and emotional wellbeing, which further deepened the trust between community members and trusted communicators. This trust not only made conversations more substantial but also enabled ongoing dialogues that continued after the programme had concluded. Sustained conversations such as these allowed individuals to continue sharing information and seeking support, extending the focus of discussions into areas beyond the original topics, including mental health and social isolation.

Participants, including people from various communities, learned a wide range of topics during the course of these conversations. For example, people and communities gained knowledge about bowel cancer screening, smoking cessation, and maintaining physical and mental health, while also learning about the importance of research opportunities and health and care systems.

VCSE organisations learned more about the communities they serve, gaining valuable insights into community needs, challenges, and potential areas for improvement. Similarly, the ICB/ICS developed a better understanding of the reasons behind community responses to health topics, identified barriers to engagement, and discovered practical ways to address these challenges. Most participants also highlighted the importance of trust and confidence in facilitating these conversations, noting how these factors fostered ongoing engagement and led to positive changes over time.

### 4.2 Impacts for VCSE organisations

The ripple effects of the programme were also evident in the impacts on VCSE organisations. Many organisations reported that their participation in the programme had

provided valuable insights into the activities of other organisations within the sector, particularly through training sessions and the CV networking opportunities. This broadened their understanding of the sector and created a more connected community of organisations, all working to address broader health and wellbeing issues.

VCSE organisations developed stronger relationships not only with the communities they serve but also with other key partners. This increased collaboration, particularly in addressing health inequalities, has laid a foundation for future work in these areas, allowing organisations to have a greater impact in their communities. Many organisations also noted an increase in workload as a direct result of their involvement in the programme, with additional projects and expanded areas of service delivery, ultimately leading to the generation of new clients and engagement opportunities.

### **4.3 Building relationships and facilitating actions**

Building strong, trust-based relationships with community members was key to the success of the programme, as it enabled a more holistic approach to care and improved collaboration between organisations. This process took time but was crucial for tailoring support and aligning services to meet the specific needs of the community. Connectors, or trusted communicators (the terms are used interchangeably), who played a pivotal role in strengthening relationships, found that their consistency in engaging with local residents facilitated more meaningful interactions, particularly with historically underserved communities.

The programme also encouraged peer support among service users, with individuals sharing experiences and offering advice to one another. This peer support model not only helped to build community resilience but also created opportunities for people to take ownership of their own health. The increased frequency of interactions between VCSE organisations also played a key role, allowing these organisations to exchange insights, share best practices, and enhance their collective ability to respond to community needs.

Through these strengthened relationships, actionable outcomes were achieved in areas like bowel cancer screening and smoking cessation. Connectors used the insights gained through their conversations with community members to promote preventative health measures, raising awareness and encouraging individuals to take action, such as following through on health checks or making lifestyle changes. The trust established between connectors and community members played a crucial role in motivating these positive outcomes.

#### 4.4 Raising awareness and identifying further impacts

Alongside the relational impacts, the projects also led to tangible changes in the communities served. One of the key outcomes was the establishment of new, productive conversations and the strengthening of relationships. These conversations, which were often linked to the trusted communicator model, allowed for the identification of solutions to local health issues and contributed to a raised profile of important health topics. For example, the programme successfully facilitated participation in research, increased uptake of bowel cancer screening, and improved access to services. Many participants also reported a positive impact on individual confidence in addressing health needs, recognising symptoms (such as bowel cancer and smoking cessation), and engaging with the healthcare system.

While these positive impacts were significant, some reports suggested that more tangible, action-oriented outcomes could still be achieved in certain areas. There were calls for continued efforts to address specific health issues such as smoking cessation and more widespread engagement in health research. These included further action around smoking cessation, support for asylum seekers, and more focused and widespread research engagement. Some evaluations also suggested a need for further work to include those that are more isolated. This additional work may require increased capacity among the team who manage the Community Voices model to coordinate and facilitate this increased scope.

### 5. Implications and considerations

The trusted communicator model has proven to be an effective approach for gathering insights, building relationships, and identifying priorities across the ICS, but several considerations must be addressed for its continued success.

**Building on the role of trusted communicators.** Ensuring the VCSE organisations and trusted communicators are provided with the support and resources necessary to continue building trust and driving change within the communities they serve.

**Taking actions to alleviate implementation challenges.** Addressing barriers like accessibility, funding, and isolation may allow future projects to achieve broader engagement and result in tangible health improvements.

**Mitigating risks to the operation of Community Voices.** To keep the Community Voices programme functioning as effectively as possible, continual resourcing of the programme team is required. Having individuals to coordinate the programme proved instrumental in increasing engagement with both VCSE organisations and the ICB/ ICS.

## 6. Conclusion

The Community Voices programme has been effective in using the trusted communicator model to build trust and confidence, enabling communities to engage meaningfully in conversations about their health and care. Through these conversations, Community Voices has facilitated mutual learning, from individuals and communities to VCSE organisations and the ICB/ ICS, contributing to increased awareness of health issues and greater understanding of community needs. This collaborative approach has led to significant impacts, including improved engagement with health topics, strengthened relationships, and increased confidence in addressing health needs.

[<sup>1</sup>Ripple effects mapping: capturing the wider impacts of systems change efforts in public health | BMC Medical Research Methodology | Full Text \(biomedcentral.com\)](#)

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## Appendix 1 - Reports included in the analysis

Topic	Type of report	Scope
Community Voices programme evaluation	Service evaluation  Community Voices Project Service Evaluation Report – Nikki Garner, Norwich Institute of Health Ageing (NIHA), University of East Anglia, March 2023	Outcome and process evaluation of the programme
Smoking cessation <sup>2</sup>	PowerPoint presentation of insights presented in COM-B framework  Community Voices qualitative presentation (smoking cessation), February 2024	Barriers and enablers to smoking cessation, complex beliefs around smoking cessation, role of personal circumstances important
Refugee and asylum seekers support	PowerPoint presentation of highlights  CV4- Refugee and Asylum Seekers Support – Highlight report	Barriers and enablers to keeping healthy, importance of motivation, understanding, access, opportunities
Three 'pillars': living and working, lifestyle, health and care services	Analysis summary and case studies (two reports)  ICB Pillars Summary (Round 1), NODA, January 2024 ICB Three Pillars Summary (Rounds 1 and 2), NODA, February 2024	Components of healthy lifestyles in Norfolk, barriers, what matters to people
Bowel cancer screening	Evaluation report  InHIP Community Voices Evaluation, Matthew Whelband, Evidence and Evaluation Hub, Norfolk and Waveney Integrated Care Board, February 2024	Barriers and facilitators to bowel cancer screening, knowledge, awareness of symptoms, engagement.
Research engagement	Evaluation reports (two reports)  Research Engagement Network Development Programme – Evaluation report, Rebecca Owens, Michael Twigg, Evidence and Evaluation Hub, Norfolk and Waveney Integrated Care Board, April 2023 Research Engagement Network (REN) Phase 2 Programme Evaluation Report, Jack Hallworth, Evidence and Evaluation Hub, Norfolk and Waveney Integrated Care Board, April 2024	Understanding of health and care research and its role in personal health, participation in research.

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# Appendix 2 – Ripple Effects Maps

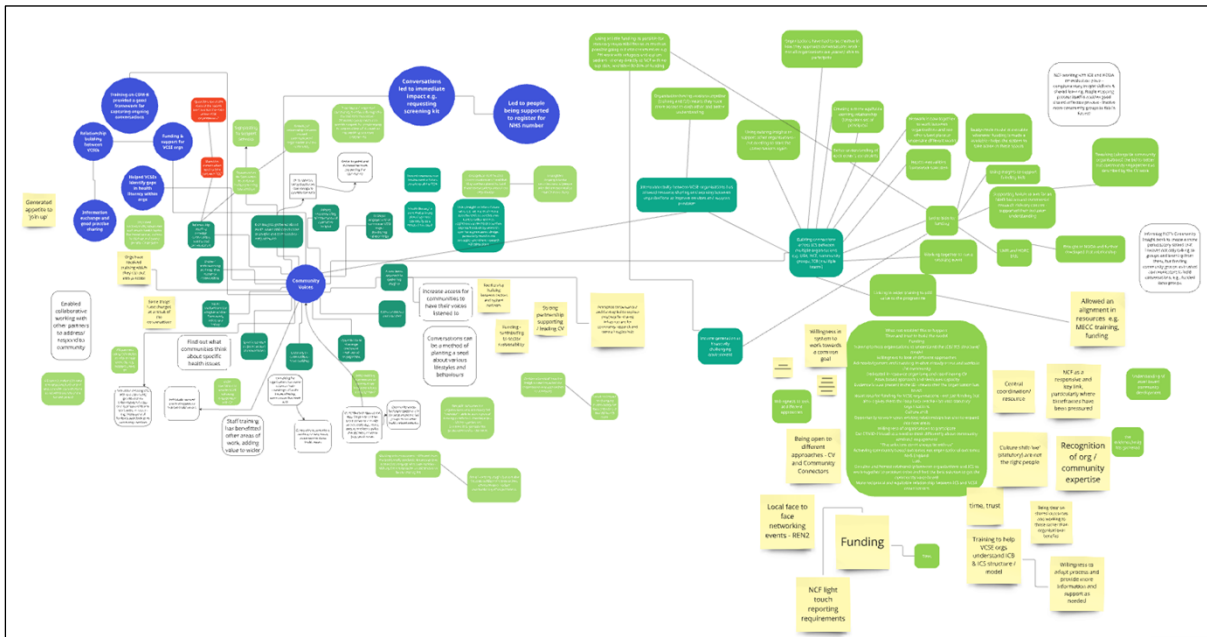


Figure 1: Initial REM worked up during first session with CV steering group.



Figure 2: First analysis of REM, grouping similar themes for presentation to steering group.

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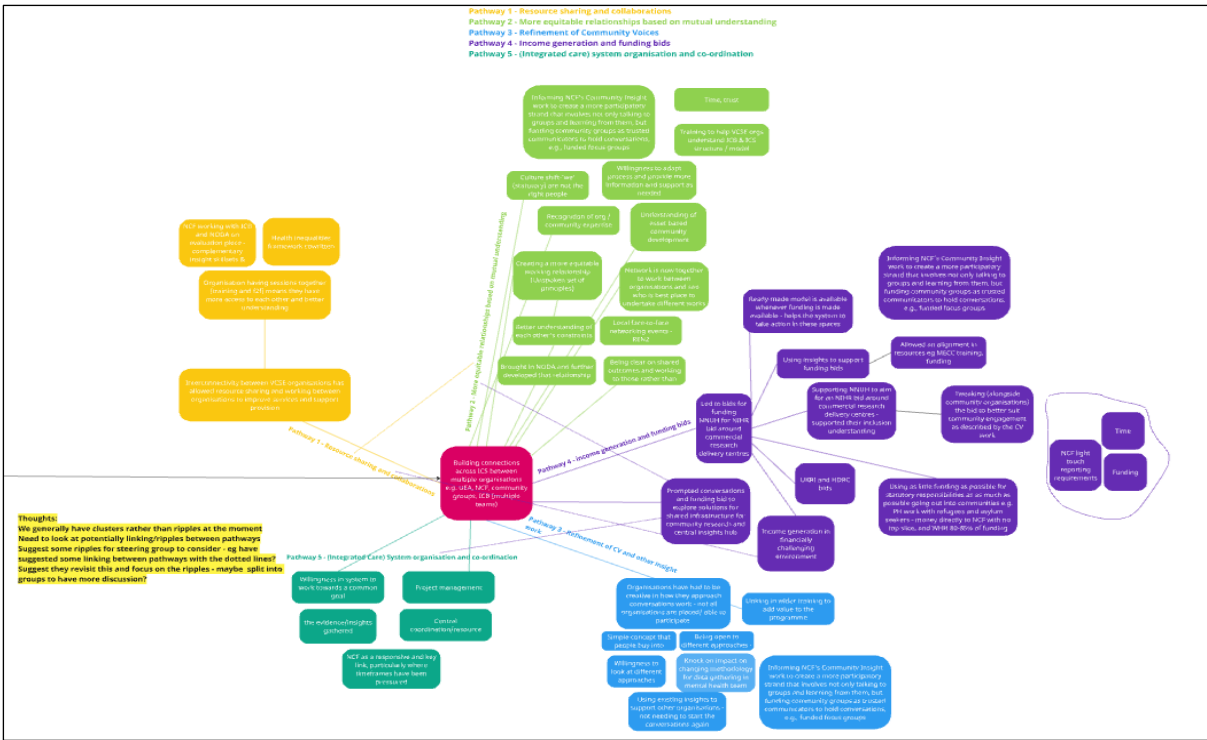


Figure 3: Adapted map to demonstrate potential ripples in a single impact grouping.

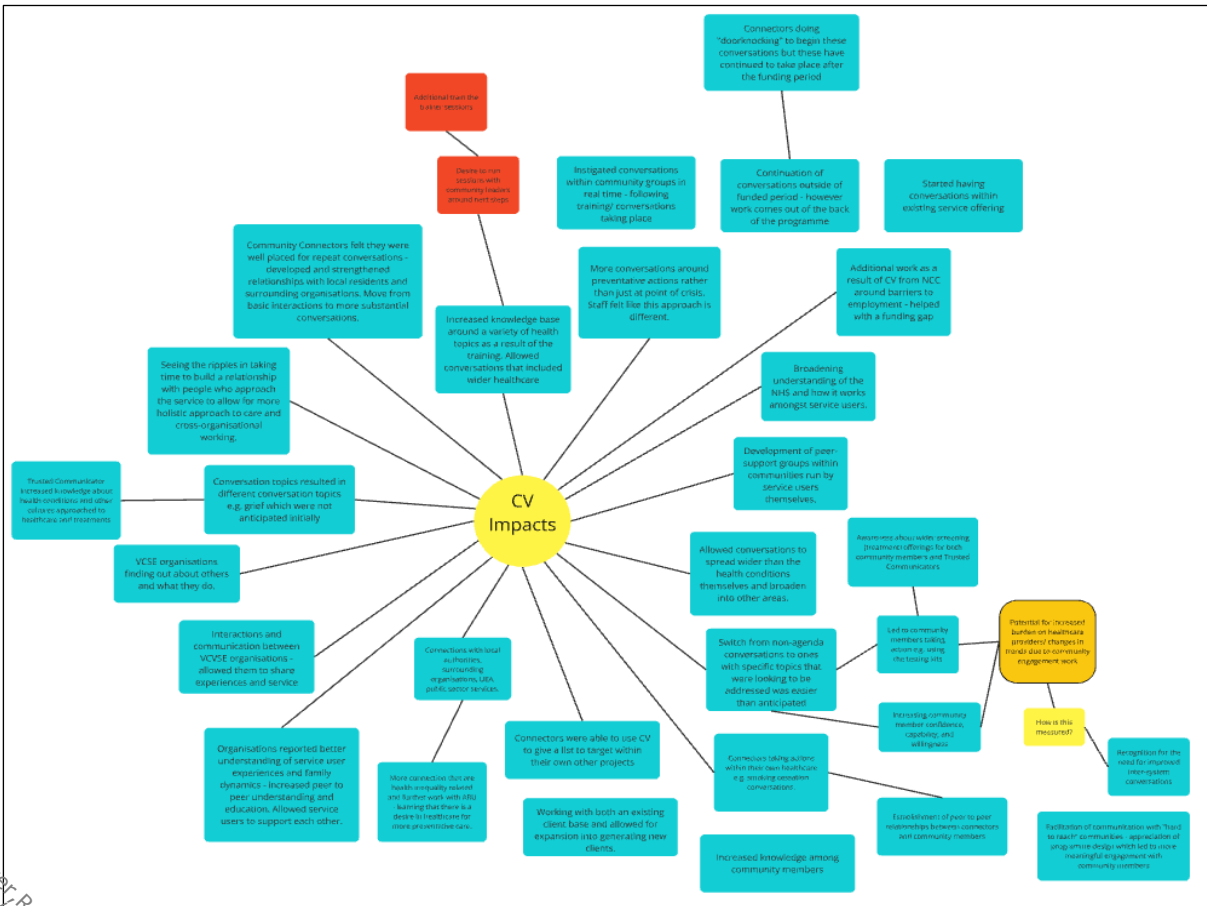


Figure 4: Map from additional REM session conducted with VCSE partners and trusted communicators.

Agenda item: 11

<b>Subject:</b>	Update on the work of the Norfolk and Waveney Ageing Well Programme
<b>Presented by:</b>	Dr Frankie Swords, Executive Medical Director
<b>Prepared by:</b>	William Lee, Clinical Programme Manager
<b>Submitted to:</b>	N&W ICB Patients and Communities Committee
<b>Date:</b>	3 November 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 an update on the significant progress of the Norfolk and Waveney Ageing Well Programme, demonstrating tangible benefits for our older population. The Dementia workstream is showing particularly strong results, having helped close the gap in our diagnosis rate from 8% to 3.6% below the national target, supported by initiatives like a planned pilot of a digital Dementia App and the development of a new Dementia Information Pack.

Across the other workstreams, the system-wide adoption of the Rockwood Clinical Frailty Scale is improving care, notably through its use by the East of England Ambulance Service to aid hospital handovers. We continue to see positive impacts from our Prevention workstream's Health Connect initiative and our collaborative efforts to reduce unnecessary conveyances from care homes has shown progress, with 58% non-conveyance being achieved, the highest recorded. The Committee is asked to note this progress as we continue to enhance support and outcomes.

**Report**

**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.”*

This workstream is critical for our population, which is older than the national average. With over 12,000 people living with dementia in Norfolk and Waveney, our

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coordinated efforts are focused on enhancing support and outcomes for individuals and their families.

**Progress Update:**

- Dementia Diagnosis Rates: Recent national data shows positive progress. Since the Ageing Well programme commenced, the gap in our dementia diagnosis rate has closed from 8% below the national target to 3.6% below target. While work remains, the coordinated projects underway are expected to close this gap further in 2026.

**National View**

	Apr-23	Apr-24	Apr-25	May-25	Jun-25	Jul-25	Aug-25
<b>National Average</b>	63.2%	64.6%	65.5%	65.6%	65.8%	66.1%	66.1%
<b>ICB Average</b>	59.0%	61.5%	62.2%	62.5%	62.6%	63.3%	63.4%
<b>National Target</b>	67.0%	67.0%	67.0%	67.0%	67.0%	67.0%	67.0%
<b>Var (CCG v National)</b>	-4.2%	-3.1%	-3.3%	-3.1%	-3.2%	-2.8%	-2.7%
<b>Var (CCG v 67% Target)</b>	-8.0%	-5.5%	-4.8%	-4.5%	-4.4%	-3.7%	-3.6%

- Dementia Charter: In 2024, the N&W ICS launched a Dementia Charter to establish shared commitments for high-quality, compassionate care. We are pleased to confirm that in 2025, all statutory providers across Norfolk and Waveney have now signed the charter, demonstrating a unified system-wide commitment.
- Dementia Self-Assessment: This mechanism drives year-on-year improvement against the Charter's commitments. The initial self-assessment in December 2024 established a baseline across four core domains. The identical assessment will be re-issued in December 2025 to directly measure progress and demonstrate our system's collective impact.
- NeuHealth Dementia App Pilot: Funding of £38,000 has been secured from the Community Transformation Fund to launch a 12-month pilot of the NeuHealth Dementia App in North Norfolk for up to 150 patients. This digital tool aims to support early identification, streamline clinical assessments, and provide continuous monitoring for patients with mild to moderate cognitive impairment. The pilot is planned for launch in early 2026.
- Dementia Information Pack: A comprehensive information pack for individuals and their carers, modelled on the 'Yellow Folder' used in palliative care, is in development. This project is a collaboration with Carers Voice, funded by a £30,000 grant. The first draft is expected for review in October/November 2025.

- Dementia & Delirium Training: We are aiming to deliver a series of high-impact, practical training events for health and social care staff in 2026,

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mirroring the successful "Frailty: Everyone's Business" model. The Alzheimer's Society are keen to be involved, and The Queen Elizabeth Hospital King's Lynn (QEH) has agreed to host the sessions.

### **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 standardized 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). A key development is the rollout of Rockwood to the East of England Ambulance Service (EEAST). Compliance is reported to be high, which is aiding handovers with ED departments and allowing acute trusts to recognise frail patients immediately on admission. Our goal is to continue this expansion into community & primary care.
- **Frailty Toolkit:** We are developing a Frailty Toolkit to work alongside the Rockwood scale, which will be distributed to providers. This toolkit is designed to offer practical guidance and support for the consistent application of frailty-attuned care. This is a joint piece of work, supported by the Suffolk and Norfolk East Education (SNEE) ICS, which has been assisting with its development.
- **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 via Ageing Well & Place monthly meetings.
- **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.

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### **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.

### **Progress Update:**

- **Healthy Ageing Campaign:** This is a new public health campaign that is launching to support adults in ageing as healthily as possible by focusing on three key pillars: Being Active, Feeling Connected, and Protecting Your Health. The campaign aims to educate residents, promote time spent in good health, and signpost to local support services.

The first phase, launching this autumn, will focus on the "Protect Your Health" pillar, aligning with the winter well campaign to promote vaccine uptake and screening programmes like NHS Health Checks. A comprehensive communications toolkit, including social media assets and printable materials, will be distributed to partners for promotion. The subsequent pillars for "Being Active" and "Feeling Connected" will be launched in the new year.

- **Warm and Well Campaign:** A collaborative effort with Public Health and Norfolk County Council to support residents during winter, including vaccination promotion will be published and promoted over winter 2025.
- **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.

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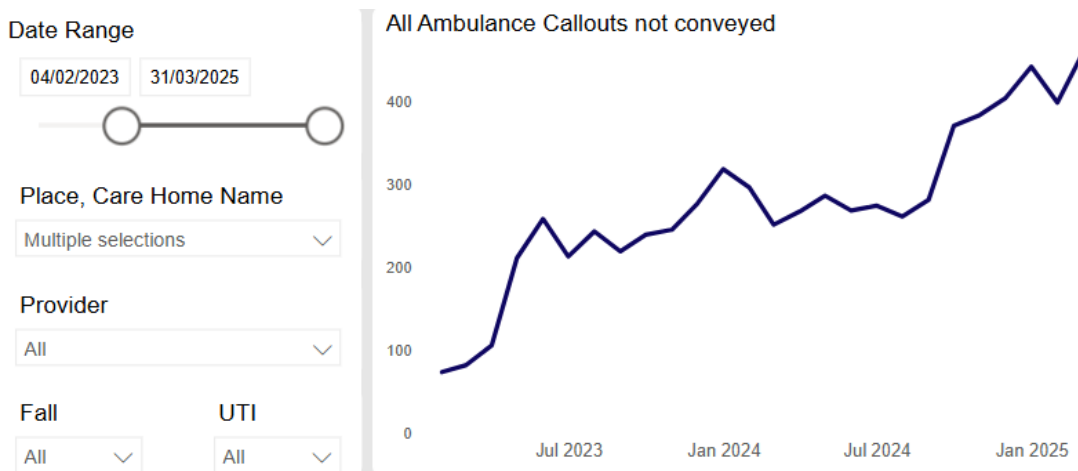
## Workstream Update - Care Homes & Housing with Care

*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 homes 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 redesigning 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.

### Conclusion

The Norfolk and Waveney Ageing Well Programme continues to deliver tangible, system-wide benefits. From innovating in dementia care and closing the diagnosis gap, to reducing falls and improving handovers through the system-wide adoption of

the Rockwood scale, the programme is making a significant positive impact on the health and wellbeing of our older population.

**Recommendation to the Committee:**

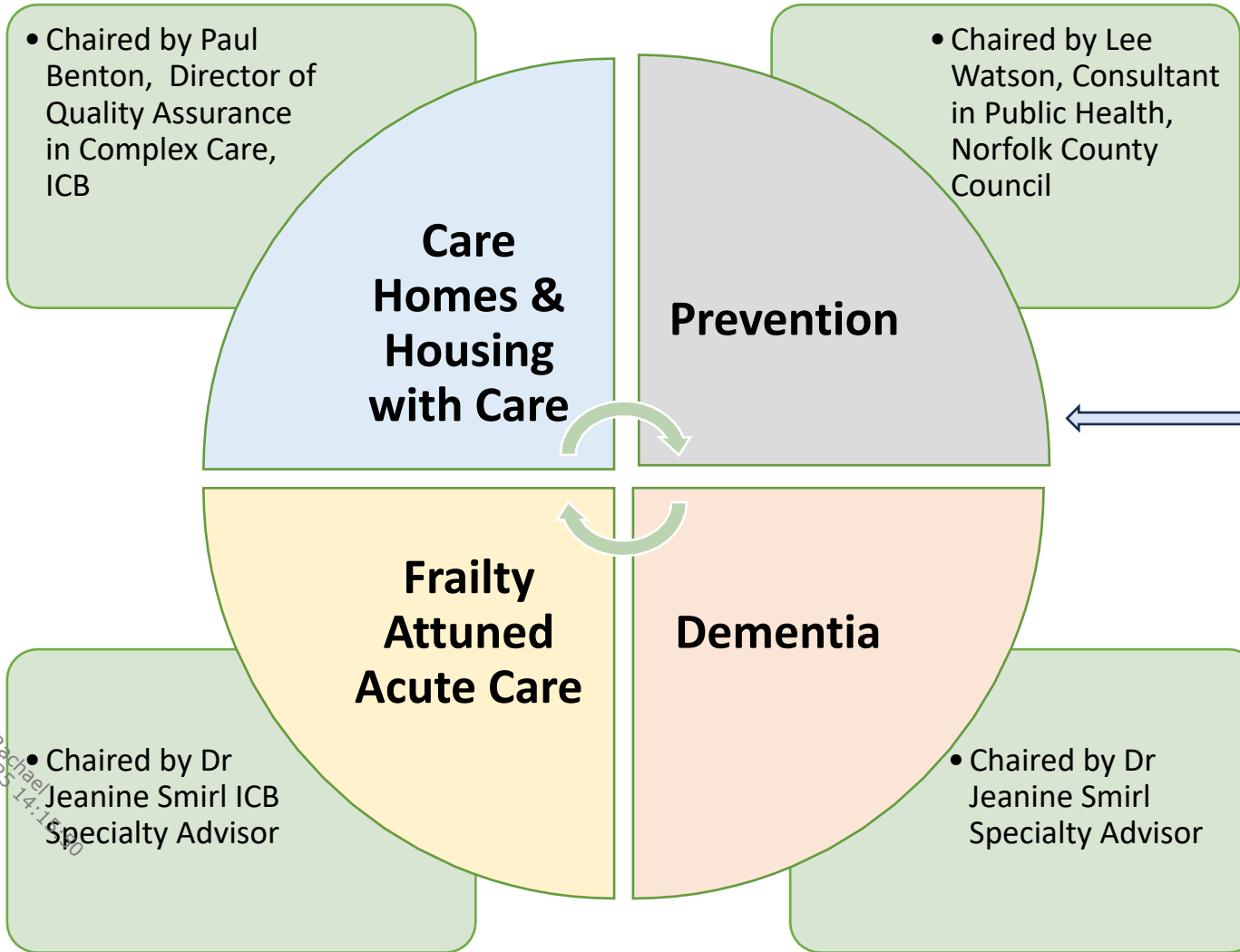
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**Governance:**

Key Risks	
<b>Clinical and Quality:</b>	<ul style="list-style-type: none"> <li>BAF05: There are increasing numbers of older people with complex health needs in Norfolk and Waveney</li> </ul>
<b>Finance and Performance:</b>	<ul style="list-style-type: none"> <li>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)</li> </ul>
<b>Impact Assessment (environmental and equalities):</b>	<ul style="list-style-type: none"> <li>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.</li> </ul>
<b>Reputation:</b>	<ul style="list-style-type: none"> <li>Risk of damage to reputation if service failure occurs.</li> <li>There will need to be an appetite for change as this is about professionals working differently together, and in partnership with families and carers</li> </ul>
<b>Legal:</b>	<ul style="list-style-type: none"> <li>No issues identified</li> </ul>
<b>Information Governance:</b>	<ul style="list-style-type: none"> <li>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.</li> </ul>
<b>Resource Required:</b>	<ul style="list-style-type: none"> <li>Input from the Integrated Care Board and system partners to the Integrated Care of Older People Programme Board</li> <li>Appropriate Programme and administrative support</li> </ul>
<b>Reference document(s):</b>	<ul style="list-style-type: none"> <li>Please see paper</li> </ul>
<b>NHS Constitution:</b>	<ul style="list-style-type: none"> <li>No issues identified</li> </ul>
<b>Conflicts of Interest:</b>	<ul style="list-style-type: none"> <li>No issues identified</li> </ul>
<b>Reference to relevant risk on the Board Assurance Framework</b>	<ul style="list-style-type: none"> <li>BAF05: There are increasing numbers of older people with complex health needs in Norfolk and Waveney</li> </ul>

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# Ageing Well - Overview: Programme Workstreams



**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

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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	11/09/2025	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 has been shared at Ageing Well programme board and a monthly touch base meeting with Place colleagues established.	To note	No	No	For assurance
2	Frailty Tactical Group Meeting	11/09/2025	ICB colleagues joined the SNEE frailty tactical group meeting which included members of their 'Age Well' programme. It was noted the similarities between their frailty programme and our Ageing Well. We have agreed next steps of unifying our projects to share best practice and begin co-operating where appropriate. This includes N&W presenting at their programme board in November.	Agreement to attend SNEE tactical groups & N&W ICB to present at their board in November.	No	No	For assurance and to note inclusion SNEE.
3	Ageing Well Programme Board	11/09/2025	Metrics for the dashboard have been sent to the BI team, due to capacity and merging with SNEE this will continue when their capacity allows. IPR report for some metrics produced for Care Homes and Paul Benton providing monthly commentary.	Will require support from the BI team once metrics confirmed	No	No	To note
4	Ageing Well Programme Board & Frailty SCN meeting	11/09/2025	<p>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. E-EAST have now adopted Rockwood and JPUH have fed back at recently frailty SCN meeting that their completion rate is near 100%.</p> <p>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.</p> <p>Frailty Toolkit in development to work alongside rockwood to aim providers in available services and next steps at each of the points of scale of rockwood.</p>	Workstream will now link with SNEE to share best practice.	No	No	For assurance
5	Ageing Well Programme Board	11/09/2025	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

Parker Rachael  
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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	11/09/2025	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	11/09/2025	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

Parker Rachael  
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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
8 - BAF05	Ageing Well Programme Board	11/09/24	<p><b>Risk:</b> Increasing numbers of older people with complex health needs in Norfolk and Waveney which could cause;</p> <ul style="list-style-type: none"> <li>• Growing ill health among older people and strain services and financial resources</li> <li>• Declining quality of care if demand exceeds capacity</li> </ul> <p><b>RAG Rating</b>  <b>Pre-Mitigation:</b> Critical (5 x 4 = 20)  <b>Post-Mitigation:</b> Critical (4 x 3 = 15)</p> <p><b>Progress and Actions</b>  <b>Mitigation</b></p> <ul style="list-style-type: none"> <li>• Increased focus on early intervention and upstream prevention via Ageing Well Board</li> <li>• Ageing Well Programme with substantive programme support and specialty advisors in post</li> <li>• Workstreams for Dementia, Frailty, Care Homes and Prevention established to facilitate change and improvement needed</li> </ul> <p><b>Update</b></p> <ul style="list-style-type: none"> <li>• Programme Blueprint developed and approved to support coordination of change and improvement work</li> <li>• Social Isolation and Loneliness needs assessment published to support understanding of vulnerable groups when implementing changes</li> <li>• Further prevention priorities identified for workstream to support healthy Ageing objectives</li> <li>• Letter sent to HWP requesting focus in 25/26 onwards to improve age friendly practices and increase age friendly status across N&amp;W</li> <li>• Overarching BAF risk discussion added to each Ageing Well Board agenda</li> <li>• Risks evaluated at each workstream; further risks considered</li> <li>• Reporting now integrated with InPhase risk system</li> <li>• Further investment in health improvement schemes has reduced mitigated scored to a 12.</li> </ul>	To Note	Yes	Yes	For assurance

Parker Rachael  
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Agenda item: 11b	
<b>Subject:</b>	<b>Dementia Workstream Update</b>
<b>Presented by:</b>	<b>Dr Jeanine Smirl (Clinical Steward Ageing Well and Compassionate Care)</b>
<b>Prepared by:</b>	<b>William Lee (Clinical Programme Manager)</b>
<b>Submitted to:</b>	<b>N&amp;W ICB Patients and Communities Committee</b>
<b>Date:</b>	<b>3 November 2025</b>

**Purpose of paper:**

To provide an update to the ICB Patients and Communities Committee on the work of the Norfolk and Waveney Ageing Well Programme, specifically relating to the Dementia workstream.

**Executive Summary:**

This paper provides an update on the Dementia workstream of the Norfolk and Waveney Ageing Well Programme. Our population is older than the national average, with significant health inequalities and a decreasing healthy life expectancy, underscoring the critical importance of this work for over 12,000 people living with dementia in our area.

The programme is delivering tangible projects aligned with its four key objectives. Progress includes the launch of a Dementia Charter, now signed by all statutory providers, and the initiation of a Dementia Self-Assessment process to drive year-on-year improvement. We are also developing a comprehensive Dementia Information Pack with carers and have secured funding to pilot an innovative Digital Dementia App in North Norfolk. Furthermore, plans are advanced for system-wide Dementia & Delirium Training.

These coordinated efforts are already showing impact, having helped to close the gap in our dementia diagnosis rate from 8% to 3.6% below the national target.

The committee is asked to note the progress made and the strategic direction as we continue to enhance support and outcomes for individuals and families living with dementia

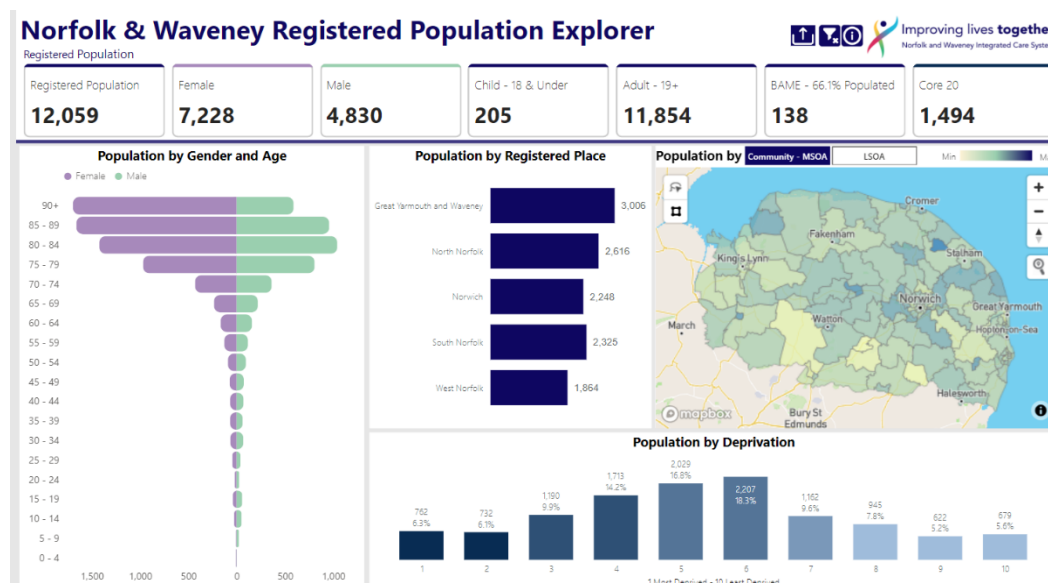
**Report**

**Background:**

Parker Rachford  
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Norfolk and Waveney have an older population compared to the rest of England. A quarter of the population is aged 65 and over and about 1 in 30 is aged 85 and over.

Across Norfolk and Waveney life expectancy is slightly longer than the average across England and is currently 80 years for males and 84 years for females. However, there are significant variations in life expectancy between the most deprived and least deprived areas of Norfolk and Waveney which is over 8 years for males and over 6 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. Available data indicates that there are over 12,000 patients with diagnosis of Dementia in Norfolk and Waveney.



**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.”

**Current Projects:**

NeuHealth Dementia App Pilot:

We are launching a 12-month pilot of the NeuHealth Dementia App, a digital tool designed to transform the pathway for patients with cognitive impairment. Building on their successful similar model for Parkinson's disease, NeuHealth has now released a dementia-focused application. This pilot aims to leverage digital technology to support early identification, streamline clinical assessments, and provide continuous monitoring for patients, both pre- and post-diagnosis.

Parkinson's Support  
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The pilot will enrol up to 150 patients in North Norfolk who are in the pre-diagnostic phase (under 65 years) and are experiencing mild to moderate cognitive impairment. The core concept is to use Social Prescribers within GP surgeries to onboard selected patients onto the app. This approach prevents additional administrative burden on primary care teams.

Instead of facing long waits for a traditional Memory Assessment Clinic appointment, patients in the pilot will use the app to complete digital cognitive assessments. This allows for early tracking of their health and can expedite treatment if the system flags a need for intervention.

The pilot is funded with £38,000 secured from the Community Transformation Fund. This proposal was approved by the North Place Board on 22nd July. The funding is allocated for the one-year trial period. NSFT will commission this on our behalf to speed up the IT integration and aid contractual hurdles to ensure we can launch in early 2026.

### Dementia Information Pack

We are developing a comprehensive information pack for individuals diagnosed with dementia and their carers, modelled on the concept of the 'Yellow Folder' used in palliative care.

This project is a collaboration with Carers Voice, who will deliver the first draft of the pack for review in October/November 2025. The initiative is funded by a £30,000 grant from the Community Transformation Fund.

Based on initial planning, the pack is designed to be a one-stop resource and will likely include:

- A simple Dementia Assessment Tool to help GPs gauge patient needs.
- Essential Service Leaflets with clear contact information.
- The "This Is Me" document to support person-centred care.
- Practical guidance on Advanced Care Planning, Power of Attorney, and Benefits.
- Information on Driving regulations, support networks, and assistive technology.
- An appointments log or checklist to help manage annual reviews and track the care journey.
- Details on local support groups and resources for living well.

The pack will be designed with a clear, non-overwhelming flow and will be available in both physical and digital formats for easy access and integration into hospital systems. The final naming of the pack will be informed by direct feedback from people living with dementia and their families.

### Dementia & Delirium Training

To design and deliver a series of high-impact, practical training events for health and social care staff, mirroring the successful "Frailty: Everyone's Business" model, but

Parker Michael  
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with a dedicated focus on dementia and delirium. The goal is to make foundational knowledge and best practice in these conditions a standard part of professional development across the system.

The training curriculum will be built upon nationally developed webinars and materials, created with the social care sector and supported by Norfolk and Suffolk Care Support Ltd. We are pleased to confirm that the Alzheimer's Society is keen to partner and support the delivery of these sessions. The Queen Elizabeth Hospital King's Lynn (QEH) has previously agreed to host the training events, with a planned launch in 2026.

### Dementia charter

In 2024, the Norfolk and Waveney (N&W) Integrated Care System (ICS) launched a Dementia Charter.

This charter establishes a set of shared commitments and standards to ensure that individuals living with dementia, along with their families and carers, receive consistently high-quality, compassionate, and effective care across all local health and social care services.

We are pleased to confirm that in 2025 all statutory providers across Norfolk and Waveney have now signed the charter, demonstrating a unified system-wide commitment to improving dementia care and support.

### Dementia Self-Assessment

The Dementia Self-Assessment is a mechanism for driving year-on-year improvement against the commitments of the Norfolk and Waveney Dementia Charter. It transforms the Charter's principles into actionable accountability by asking providers to complete a standardised self-assessment across four core domains: Diagnosis and Pathway, Local Population and Place, Training and Prevention, and Data Collection. The initial assessment in December 2024 established the starting point for each provider.

This project is designed as a continuous improvement cycle. Following the 2024 returns, providers will use their results to inform local improvements. By re-issuing the identical assessment in December 2025, we as a system will be able to directly measure progress, identify areas of change, and demonstrate the collective impact of provider efforts. This process ensures our shared commitments translate into tangible, measurable enhancements in dementia care for the people of Norfolk and Waveney.

### **Dementia Data**

We have recently been provided with national data regarding Dementia Diagnosis rates. You can see that when Ageing Well programme commenced, N&W were 8% off target and this improved to 3.6% off target. It still shows that work is needed but with our work ongoing regarding Dementia Charter, Training, Self-Assessment

Parker  
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forms, Dementia Information pack and Dementia App pilot, we hope to close this gap in 2026.

### National View

	Apr-23	Apr-24	Apr-25	May-25	Jun-25	Jul-25	Aug-25
<b>National Average</b>	63.2%	64.6%	65.5%	65.6%	65.8%	66.1%	66.1%
<b>ICB Average</b>	59.0%	61.5%	62.2%	62.5%	62.6%	63.3%	63.4%
<b>National Target</b>	67.0%	67.0%	67.0%	67.0%	67.0%	67.0%	67.0%
<b>Var (CCG v National)</b>	-4.2%	-3.1%	-3.3%	-3.1%	-3.2%	-2.8%	-2.7%
<b>Var (CCG v 67% Target)</b>	-8.0%	-5.5%	-4.8%	-4.5%	-4.4%	-3.7%	-3.6%

### Recommendation to the Committee:

To note the content of the report.

### Governance

<b>Key Risks</b>	
<b>Clinical and Quality:</b>	<ul style="list-style-type: none"> <li>BAF05: There are increasing numbers of older people with complex health needs in Norfolk and Waveney</li> </ul>
<b>Finance and Performance:</b>	<ul style="list-style-type: none"> <li>A consistent approach will ensure there is equitable investment of resources across the ICS (which in turn will lead to equitable demands on acute resources)</li> </ul>
<b>Reputation:</b>	<ul style="list-style-type: none"> <li>Risk of damage to reputation if improvement from providers doesn't occur.</li> </ul>
<b>Legal:</b>	<ul style="list-style-type: none"> <li>No issues identified</li> </ul>
<b>Information Governance:</b>	<ul style="list-style-type: none"> <li>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.</li> </ul>
<b>Resource Required:</b>	<ul style="list-style-type: none"> <li>Input from the Integrated Care Board and system partners to the Integrated Care of Older People Programme Board</li> <li>Appropriate Programme and administrative support</li> </ul>
<b>Reference document(s):</b>	<ul style="list-style-type: none"> <li>Norfolk and Waveney Integrated Care System Ageing Well Strategic Framework</li> <li><a href="#">Dementia Self-Assessment v1</a></li> <li><a href="#">Dementia Charter for signing v1</a></li> </ul>
<b>NHS Constitution:</b>	<ul style="list-style-type: none"> <li>No issues identified</li> </ul>
<b>Conflicts of Interest:</b>	<ul style="list-style-type: none"> <li>No issues identified</li> </ul>
<b>Reference to relevant risk on the Board Assurance Framework</b>	<ul style="list-style-type: none"> <li>BAF05: There are increasing numbers of older people with complex health needs in Norfolk and Waveney</li> </ul>

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Agenda item: 13

<b>Subject:</b>	<b>VCSE Assembly Update Report</b>
<b>Presented by:</b>	<b>Tim Gardiner, Chair VCSE Assembly</b>
<b>Prepared by:</b>	<b>Tim Gardiner, Chair VCSE Assembly</b>
<b>Submitted to:</b>	<b>N&amp;W ICB Patients and Communities Committee</b>
<b>Date:</b>	<b>3 November 2025</b>

**Purpose of paper:**

To provide updates and oversight of the work of the VCSE Assembly.

**Executive Summary:**

The VCSE Assembly has launched a refined governance structure featuring a collaborative VCSE Assembly Board and a VCSE-Led Strategy Group to provide clear direction, drive strategic integration, and ensure accountability within the ICS. This structure is underpinned by clear missions focused on enhanced Communication and Engagement, Influencing and Culture Change, and Policy and Practical Change. Recent achievements include establishing effective communication channels (newsletters and webinars) and proactive strategic advocacy by the Chair, including advising on commissioning for better health outcomes, co-facilitating the "Get Norfolk Working Plan," securing VCSE representation on key steering groups like Marmot Place, and initiating discussions on innovative VCSE support for community services, all of which strengthen the sector's foundational role in improving patient and community outcomes.

**Report**

This report outlines the progress made in structuring the Voluntary, Community, and Social Enterprise (VCSE) Assembly to enhance clarity, improve governance, and drive the strategic integration of the sector within the Norfolk and Waveney Integrated Care System (ICS).

Refined Governance Structure

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A new governance structure has been implemented to provide a clear and cohesive framework for the VCSE Assembly's future operations:

#### VCSE Assembly Board:

This collaborative board comprises ICB Partners, the VCSE Chair, and Vice-Chairs. Its primary function is to drive the action plan, mitigate risks, and develop tangible solutions to embed the VCSE sector into the ICS and strengthen key relationships. It has been recommended to Exec SROs that this is a combined Norfolk & Suffolk function, to enable future alignment.

#### VCSE-Led Strategy Group:

This group comprises of VCSE sector leaders and is tasked with defining the strategic direction and work plan of the Assembly. It serves as an innovation space for ICS colleagues to engage with sector leaders on how the VCSE can improve patient and community outcomes across Norfolk and Waveney. It also provides an essential mechanism for accountability for the Chair's work and VCSE Assembly Board. Efforts are underway to diversify the Strategy Group membership to enhance sector-wide representation and mitigate potential conflicts of interest.

### VCSE Assembly Mission and Objectives

The Assembly has established clear mission statements to define its purpose and objectives:

#### Communication & Engagement

- *To actively inform and engage the VCSE sector through regular channels (newsletters, webinars, events), sharing opportunities for collaboration and engagement, including through working groups.*

#### Influencing & Culture Change

- *To champion and advocate for the VCSE sector, highlighting its capacity to deliver health and wellbeing outcomes and driving a better understanding of its value within the ICS.*

#### Policy & Practical Change

- *To co-produce and deliver a joint Assembly Action Plan with ICS and VCSE colleagues, focused on mitigating sector risks, embedding the sector in ICS strategies, and providing expert advice for effective collaboration.*

#### VCSE Voice

- *To empower VCSE advocates, including the Strategy Group, ensuring the sector's perspective is central to driving the action plan, identifying key risks/barriers, and holding ongoing work accountable.*

### Recent Engagement and Communication Activities

Significant progress has been made in establishing effective communication channels and facilitating high-value engagement:

Parker Rachford  
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Regular Newsletters, distributed monthly to a direct list of approximately 80 individuals, with wider dissemination through networks like Empowering Communities Partnership (approx. 400 individuals) and the Mental Health Forum (over 100 organisations). This serves as the primary conduit for information from ICS partners, system updates, and engagement opportunities.

#### Engagement Events:

- Co-facilitated an event on the "Get Norfolk Working Plan," which was attended by 50 sector leaders face-to-face.
- Held the first sector-wide VCSE Assembly webinar with over 45 VCSE organisations participating. The session included interactive discussions with ICB and Adult Social Care colleagues on Neighbourhood Working and an item on the East of England Social Impact Procurement Framework.
- A future webinar in December will focus on engaging the sector regarding Adult Social Care's new priorities and supporting future community engagement aligned with strategic commissioning ambitions in the ICB

#### Chair's Advocacy and Strategic Contributions

The Chair has been actively engaged in advocating for the VCSE sector's role and capabilities within the system:

- Discussed approaches with Public Health Norfolk regarding commissioning health checks, specifically targeting high-need cohorts. This includes potential commissioning of community-led organisations with trusted relationships to improve uptake and facilitate holistic support, thereby positively impacting health outcomes.
- Advocated for a non-clinical, holistic community-support approach during a Public Health Suffolk workshop on Tuberculosis (TB) cases among vulnerable cohorts (e.g., homeless individuals with complex needs), highlighting the lack of understanding regarding appropriate solutions. Follow-up is anticipated to develop a VCSE-led community support workshop. I want to highlight this as a key aspect of the important work of the VCSE Assembly and lack of community led solutions on this topic. There was significant representation from Public Health, ICB and clinical staff, which dominated the approach and conversation, and lack of opportunity to discuss solutions as a group.
- Provided steering and drafting support for the "Get Norfolk Working Plan," including co-facilitating successful engagement sessions.
- Advised ICB colleagues on engaging with the prospective 'Norfolk Cancer Charity Collaborative' to map provision and enhance coordinated working relationships.
- Successfully advocated for a VCSE Advocate to be appointed to the Marmot Place Steering Group in West Norfolk. The appointee will be supported by infrastructure organisation Community Action Norfolk, which hosts a local VCSE network, to ensure a transparent feedback loop and legitimate sector representation. Learning from this initiative will be shared system-wide, via VCSE Assembly.
- Initiated conversations with NHS Community Trusts on how the VCSE could support unallocated patient visits, aiming to innovate around patient discharge

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and holistic community support to alleviate pressure on community nursing staff.

**Recommendation to the Committee:**

Formally endorse new governance structure of VCSE Assembly to enable work plan.

Formally endorse the VCSE Strategy Group as a place of innovation and co-production for use for early engagement with VCSE advocates to help drive better outcomes for patients and communities. Encouraging ICB and ICS staff to actively engage with this group.

Highlight the advocacy work and concerns regarding the approaches in the TB workshop, including the lack of understanding regarding asset based community work and holistic approaches to support patients and communities. Consider how we could do this differently and with better outcomes for future and ongoing workstreams across the system.

**Governance**

Parker Rachael  
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Agenda item: 14

<b>Subject:</b>	<b>Population Health &amp; Inequalities (PH&amp;I) Board 21/10/2025 – Assurance &amp; Escalation Report</b>
<b>Presented by:</b>	<b>Dr Frankie Swords, Executive Medical Director</b>
<b>Prepared by:</b>	<b>Dr Frankie Swords, Executive Medical Director</b>
<b>Submitted to:</b>	<b>N&amp;W ICB Patients and Communities Committee</b>
<b>Date:</b>	<b>3 November</b>

**Purpose of paper:**

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

**Executive Summary:**

The Population Health & Inequalities Board (PH&I) Board meets bi-monthly and was last held on Tuesday 21 October 2025. The report details points of assurance and escalation as well as a high-level risk overview summary

**Report**

Please find attached document.

**Recommendation to the Committee:**

To note the contents of the report.

**Key Risks**

**Clinical and Quality:**

Health inequalities are avoidable, unfair and systematic differences in health between different groups of people, which impact on longer term health outcomes and a person’s ability to access healthcare. Population Health Management is a systematic way of working to understand the health and care needs of our population and put in place new models of care to deliver improvements in health and well-being. This work is fundamental to the delivery of our ambitions in relation to Prevention and addressing Health Inequalities. There

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	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.
<b>Finance and Performance:</b>	None identified
<b>Impact Assessment (environmental and equalities):</b>	N/A
<b>Reputation:</b>	None identified
<b>Legal:</b>	None identified
<b>Information Governance:</b>	None identified
<b>Resource Required:</b>	N/A
<b>Reference document(s):</b>	N/A
<b>NHS Constitution:</b>	<ol style="list-style-type: none"> <li>1. The NHS provides a comprehensive service, available to all</li> <li>3. The NHS aspires to the highest standards of excellence and professionalism</li> <li>4. The patient will be at the heart of everything the NHS does</li> <li>5. The NHS works across organisational boundaries</li> <li>6. The NHS is committed to providing best value for taxpayers' money</li> <li>7. The NHS is accountable to the public, communities, and patients that it serves</li> </ol>
<b>Conflicts of Interest:</b>	N/A
<b>Reference to relevant risk on the Board Assurance Framework</b>	BAF 01 (Previously BAF 06)

## Governance

<b>Process/Committee approval with date(s) (as appropriate)</b>	
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Parker Rachael  
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# Population Health & Inequalities (PH&I) Board - Points of Assurance / Escalation [21/10/2025]

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
111.	PH&I Board	21/10/2025	NHS Digital Weight Management Programme (DWMP) – Phase 2	Norfolk & Waveney ICB are the top referring ICB Nationally and have achieved 86% of our NHSE eligible referral target (as of August 2025 data provided by NHSE).	N/A	N/A	For assurance	
112.	PH&I Board	21/10/2025	VST Call Handler – Fixed term vacancy (until 31/03/2026)	External interviews undertaken, due to no internal applicants, position offered subject to recruitment HR checks and processes.	N/A	N/A	For assurance	
113.	PH&I Board	21/10/2025	Wider Determinants of Health; Maternity Community project	Project under evaluation with positive early outcomes. Plans are being considered to embed this as business as usual, with further exploration involving ICB and other interested teams.	N/A	N/A	For assurance	
114.	PH&I Board	21/10/2025	PHM Annual Report – 2024-25	PH&I Board endorsed this report. This will be published on the ICS website to inform wider staff and partner organisations across the ICS.	N/A	N/A	For assurance	
115.	PH&I Board	21/10/2025	Capacity risks within PHM and HI teams	Senior leaders from both teams to meet to discuss capacity risks with increased demands and competing priorities currently.	N/A	BAF01	For assurance	
115.	PH&I Board	21/10/2025	TIAA – Internal HI Audit	Reasonable assurance received, follow- up actions identified, results will be shared at a future PH&I Board and Patient and Communities Committee.	N/A	N/A	For assurance	
116.	PH&I Board	21/10/2025	Inequalities, Prevention and Outreach Strategic Review	The project is on track, project parameters and outcomes agreed, the team is compiling both quantitative and qualitative data to inform future arrangements, with next steps planned through December.	N/A	N/A	For assurance	

PH&I Board  
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Rachael

# Population Health & Inequalities (PH&I) Board - Points of Assurance / Escalation [21/10/2025]

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
117.	PH&I Board	21/10/2025	Health Inequality Strategic Framework for Action - Year 2 actions	The PH&I Board received an update on the Health Inequality Strategic Framework for Action, highlighting progress on year one actions, and the establishment of year two priorities as approved by the ICP. A key focus is the development of a resource hub, hosted on Knowledge NoW, to provide accessible training, webinars, articles, and other materials to support the ICS workforce in addressing health inequalities.	N/A	N/A	For assurance	
118.	PH&I Board	21/10/2025	First VCSE Assembly engagement event	This session was well attended and covered neighbourhood health and procurement, with active discussions on how the voluntary sector can support community engagement and statutory procurement processes. These events will now run every two months, with open invitations for statutory colleagues to join.	N/A	N/A	For assurance	
119.	PH&I Board	21/10/2025	Upcoming VCSE partnering session at ICS Conference	The team will lead a session, focusing on innovative approaches to engaging people and communities, and showcasing voluntary sector work.	N/A	N/A	For assurance	
120.	PH&I Board	21/10/2025	Programme Risk Registers – Deep Dive	Risk registers are being actively monitored and wording reviewed. It was agreed that a deep dive would be useful, specifically in relation to equitable investment principles and commissioning strategy, which will be arranged for a future PH&I Board.	N/A	N/A	For assurance	
121.	PH&I Board	19/08/2025	BAF01 – Mitigated Risk Score Reduction	In August 2025, the BAF01 mitigated risk score was reduced from a 12 to 8. The PH&I Board are retrospectively requesting for the Patient & Communities Committee to ratify this risk score reduction.	N/A	BAF01	For approval	

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## Programme Risks as of 21/10/2025 – PH&I Board

### BAF01 Health Inequalities and Population Health Management Risk (October 2025)

Overarching BAF01 (previously BAF06), risk score remains at 8 (as previously reported). Risk summary wording amended.

### Population Health Management Risk Register (October 2025)

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

1 risk score remained the same:

- 'PHMI19 PHM team resources to respond to system demand' risk score 9.

### Health Inequalities Risk Register (October 2025)

The HI team reported 4 risks. No new risks were added, 1 risk score was increased, and 3 risk scores remained the same (as previously reported) and below 15. Risk summary wording amended.

1 risk score increased:

- 'HI04 Failure to address health inequalities through not meeting legal and policy requirements' risk score increased from 6 to 9.

3 risk scores remained the same:

- 'HI02 Failure to address health inequalities due to incomplete data picture for health inequalities' risk score 6.
- 'HI05 Failure to reduce health inequalities due to ICB financial position' risk score 12
- 'HI07 Failure to reduce health inequalities through insufficient Place resources and mandate' risk score 12.

### VCSE Assembly Operational Risk (October 2025)

The VCSE team reported 5 risks. No new risks were added, the risk scoring remained the same (as previously reported) and below 15. Risk summary wording amended.

5 risk scores remained the same:

- VA01 'Lack of system-wide understanding of VCSE Assembly role and function' risk score 8.
- VA02 'Lack of engagement across wider VCSE sector' risk score 8.
- VA03 'Representation gaps in VCSE engagement in ICB/ICS workstreams' risk score 9.
- VA04 'Conflicts of interest amongst VCSE Assembly Board members' risk score 6.
- VA05 'Ongoing resources to develop and embed VCSE Assembly model and deliver action plan' risk score 9.

# Population Health Management

Annual Report April 2024 - March 2025



Parker Rachael  
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**Protect-NoW**  
Proactive Population Health and Care for Norfolk and Waveney

Protect NoW is tackling inequalities and improving access to health and care services for Norfolk and Waveney.

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**Thank you to all the teams and individuals who have led and contributed to PHM projects to improve health outcomes and reduce health inequalities across Norfolk and Waveney in 2024-2025.**

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## Executive Summary

In 2024–2025, Norfolk and Waveney ICS embedded Population Health Management (PHM) more deeply into routine practice. Building on Protect NoW and place-based partnerships, we expanded the use of linked data, risk stratification and targeted outreach to support proactive, personalised care. The PHM Virtual Support Team engaged 60,000+ residents across 17 PHM projects, with several programmes achieving uptake above national benchmarks.

We strengthened core PHM infrastructure (renewed the Eclipse PHM platform), launched new intelligence assets (the Registered Population Explorer and the Strategic PHM & Inequalities Dashboard) and progressed data-sharing (Section 251 application) and service processes (enhanced call handling).

Looking ahead, our focus is to scale high-impact interventions, deepen data integration through the Data Hub, standardise evaluation, and enable Integrated Neighbourhood Teams with actionable insights. This report summarises progress, learning and next-year priorities to improve outcomes and reduce health inequalities across Norfolk and Waveney.

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## Introduction to PHM, our strategy and priorities

The Norfolk and Waveney Integrated Care System (ICS) is embedding Population Health Management (PHM) as a core way of working, supporting our ambition to move from reactive treatment models to proactive, preventative care.

Throughout 2024-25, we have accelerated the delivery of targeted interventions at scale, achieving national-leading outcomes in programmes such as the Digital Weight Management Programme (DWMP), National Diabetes Prevention Programme (NDPP), and Warm Homes initiatives. We have successfully engaged tens of thousands of patients through our Protect NoW Virtual Support Team.

Importantly, we are now transitioning from pilot initiatives to embedding PHM approaches as business-as-usual across the system. Our focus is on sustainability, scalability, and ensuring that proactive, preventative care becomes the norm.

This report outlines our progress, highlights key projects and outcomes, and sets out our aspirations for the coming year. It demonstrates how, by turning data into action, we are delivering tangible improvements in the health and wellbeing of the people we serve.

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## Defining Population Health Management

"Population Health Management (PHM) is an approach that uses data to help health and care systems understand their populations better, predict future health needs, and target interventions to improve health outcomes and reduce health inequalities."

(Source: *The King's Fund*, 2022)

This evidence-based approach enables us to link data and intelligence from across health and care services to better understand the needs of our communities, predict future risks, and design personalised, preventative interventions (*Figure 1*). By doing so, we can improve health outcomes, reduce health inequalities, and target resources more effectively across the system.

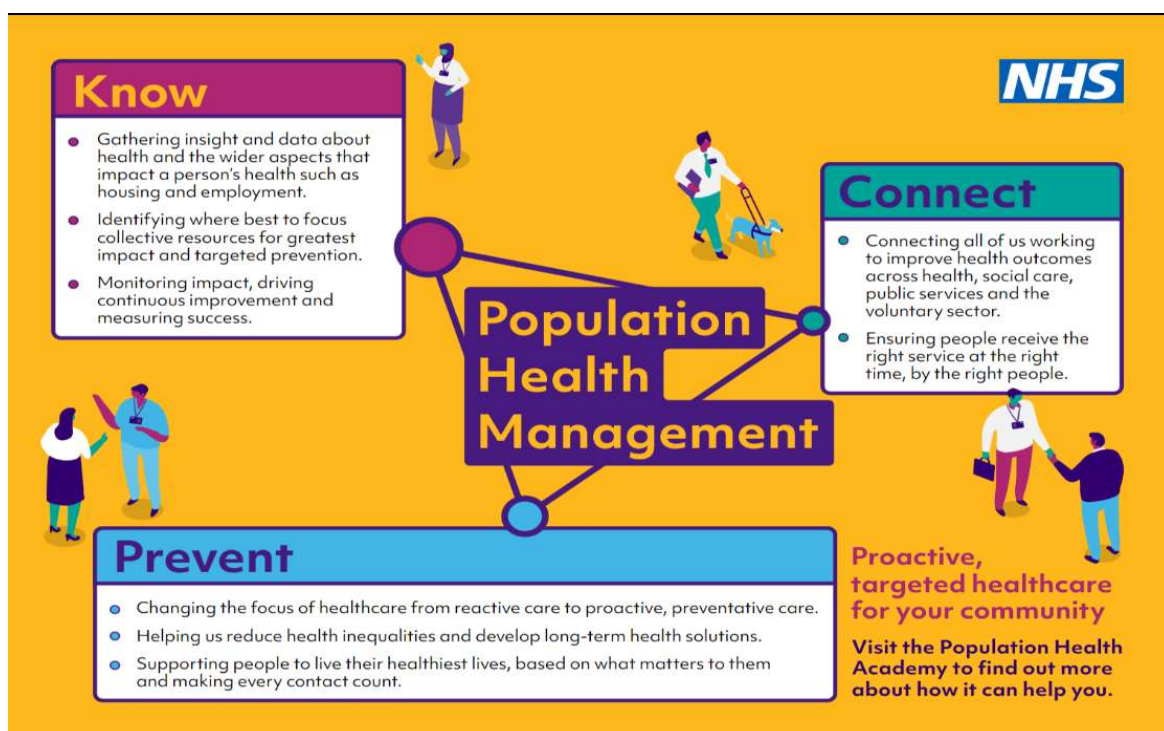


Figure 1 – Know Connect Prevent (NHS England)

## Norfolk and Waveney ICS PHM Strategy

The Norfolk and Waveney ICS PHM strategy can be found by clicking this link: [Population Health Management Strategy PDF](#)

Our vision is clear- we want to deliver proactive, personalised, and preventative care that helps people live healthier lives for longer. Building on our existing success with Protect NoW and place-based partnerships, we are expanding our use of linked data and cross-system collaboration to identify need earlier, intervene in a smarter way, and reduce unwarranted variation. Our approach also recognises that health is

shaped by more than clinical care and we are including the wider determinants of health in our work programme.

By embedding PHM into how we work, we aim to:

- Understand needs and risks through linked health, care, and wider datasets.
- Target support proactively to those most likely to benefit.
- Address health inequalities by focusing on people and places experiencing the greatest disadvantage.
- Empower teams at every level — from Primary Care Networks and Integrated Neighbourhood Teams to system level— with actionable data insights.
- Use intelligence to plan services strategically, responding to changing population needs over time.

### NWICB Priority Areas (2024-25)

Our PHM priorities in 2024-25 were based on analysis of the key drivers of health inequalities, where we knew there was scope for improvement and evidence-based interventions already identified (Figure 2).

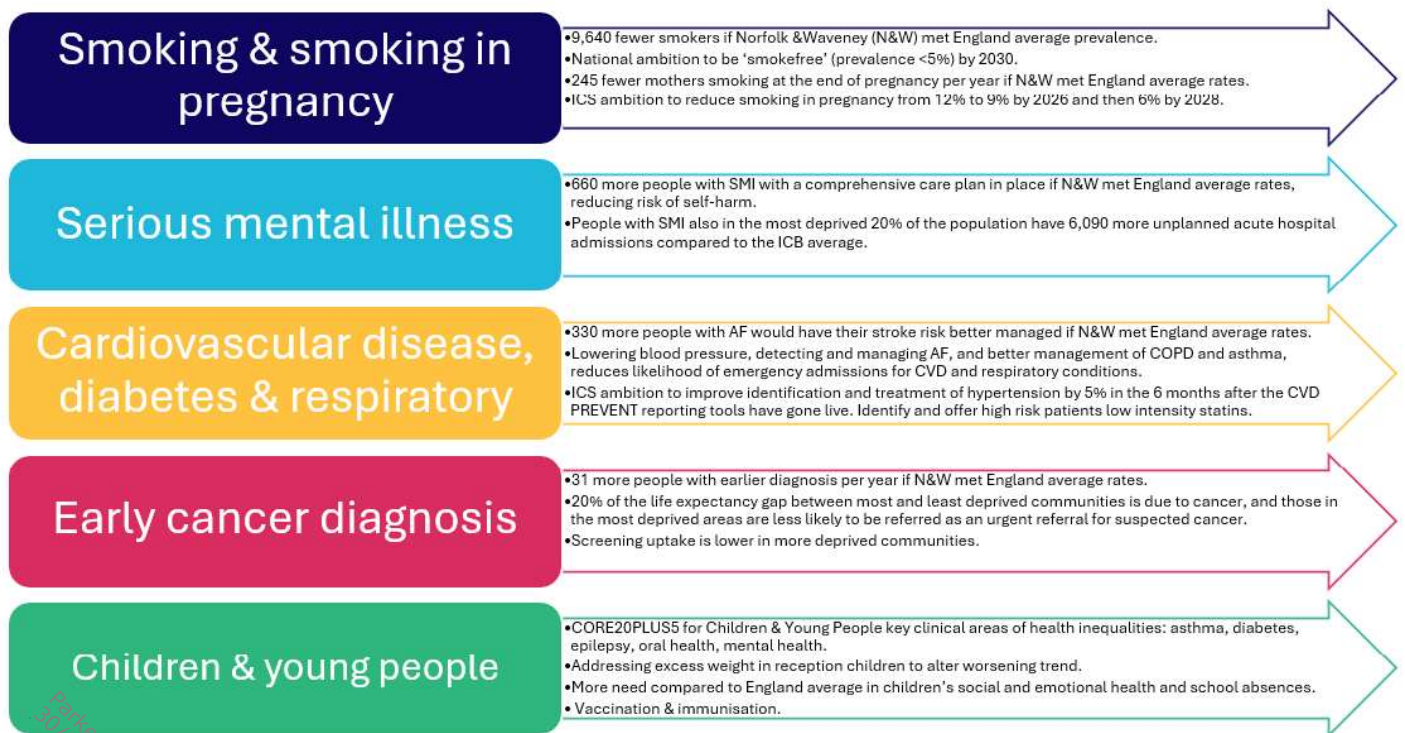
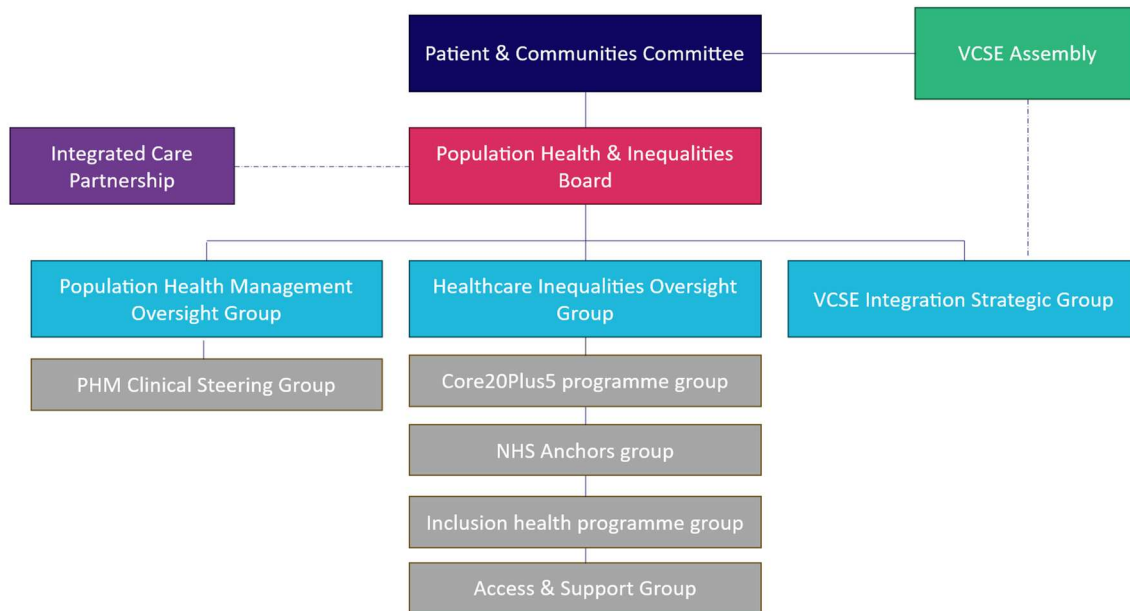


Figure 2 – PHM Strategic Priorities (N&W ICB)

## Our PHM Team and Governance arrangements

The PHM team operates across organisational boundaries, bringing together expertise in data analytics, project delivery, public health, and clinical engagement. The team's governance structure ensures strategic alignment and robust oversight (Figure 3):



*Figure 3: Norfolk & Waveney Population Health & Health Inequalities Governance arrangements for PHM and Health Inequalities (N&W ICB)*

- **PHM Clinical Steering Group**

The PHM Clinical Steering Group is led by PHM Clinical Stewards and is responsible for approving the support of projects and responding to clinical queries. The group brings together members of the PHM team, Clinical Stewards, Business Intelligence (BI) specialists, and wider system partners to ensure that clinical input supports the effective delivery of the Population Health Management programme across Norfolk and Waveney.

- **PHM Oversight Group (PHMOG)**

The Population Health Management Oversight Group (PHMOG) brings together system partners to drive the delivery of the Population Health management programme to improve health outcomes across Norfolk and Waveney.

- **Population Health and Inequalities (PH&I) Board**

The Population Health and Inequalities Board (the PH&I Board) brings together system partners to oversee the delivery of the Integrated Care System (ICS) Population Health Management (PHM) programme and to oversee system-wide action to reduce health and care inequalities across Norfolk and Waveney.

- **Collaborative BI and IG Support**

Our PHM team works in close collaboration with the Business Intelligence (BI) and Information Governance (IG) teams. The BI team supports the development of analytical tools and dashboards that drive insight and decision-making, while the IG team enables safe, lawful data use through robust governance processes — helping us to unlock the value of linked datasets across the ICS.

- **Protect NoW Virtual Support Team (VST)**

The VST is the operational delivery arm of the Protect NoW programme, responsible for patient engagement via tailored outreach — letters, SMS, and phone calls — targeting tens of thousands of residents identified through risk stratification and deprivation mapping. This translates strategic PHM interventions into real-world impact by connecting patients in high-risk or underserved groups with preventative services like diabetes prevention, mental health support, and cancer screening.

Our multidisciplinary team provides project leadership, strategic alignment, analysis, operational delivery, and evaluation support for PHM programmes.

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## Implementing our strategy - achievements in 2024-2025

Our approach is built around the three key pillars of PHM:

- **Infrastructure,**
- **Intelligence, and**
- **Interventions.**

### 1. Infrastructure: Building the Foundations

To enable PHM delivery, we have ensured we have the right tools, systems, and governance in place:

- We successfully completed a PHM software procurement exercise, selecting **Eclipse** (by Prescribing Services Limited) as our ICS-wide PHM platform. Eclipse supports strategic segmentation of our registered population, helping identify unmet needs and opportunities for intervention.
- We collaborated closely with the Business Intelligence (BI) team and wider ICB colleagues to develop the **Registered Population Explorer Tool** within the Data Hub. This tool enables our teams to explore and understand the composition and characteristics of our population and is now part of business-as-usual operations.
- Our Information Governance team has been actively developing our **Section 251 application** to support safe and lawful data sharing for risk stratification and PHM purposes.

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- Improvements to our **call handling systems** for our Virtual Support Team have enhanced customer contact, providing better governance and a more streamlined patient experience.

#### **Future action for PHM infrastructure:**

We are finalising information governance processes to fully integrate PHM with Data Hub activities. We are also increasing awareness and promotion of PHM tools and resources, ensuring that frontline teams across the ICS can make full use of Eclipse and other assets.

## **2. Intelligence: Driving Data-Driven Action**

Using high-quality intelligence is critical to targeting resources where they can have the most impact:

- Working across the ICS, the ICB **BI Team** launched the **Registered Population Explorer Tool**, giving partners better visibility of our population data. (see Appendix 1)
- **Norfolk County Council** created a strategic **Population Health and Inequalities Dashboard**, providing a framework of indicators to monitor and measure progress against PHM strategic priorities.

#### **Future action for PHM Intelligence:**

We are currently reviewing and refining our initial PHM system priorities, ensuring we focus on the areas with the greatest impact potential. A Norfolk & Waveney **High Impact Assessment** is underway, to highlight the proactive and preventative care opportunities to improve patient outcomes. Additionally, we are tracking the effectiveness of multiple PHM projects and, with BI support, undertaking **risk analysis** work to better predict and prevent avoidable hospital admissions.

We have also launched a **training and workforce development programme**, holding the first PHM webinar in February 2025. Training will continue to roll out, helping embed PHM approaches at every level. At a local level, we are working with Places to **develop Integrated Neighbourhood Teams** that bring together multidisciplinary professionals around local population needs.

## **3. Interventions: Making a Difference**

Working with teams across the ICB and the Norfolk and Waveney system, the **Protect NoW Virtual Support Team (VST)** has played a pivotal role in delivering personalised outreach and intervention for our major PHM programmes, supporting a range of targeted projects including support for cold homes, diabetes prevention, digital weight management, familial hypercholesterolaemia detection, and bowel cancer screening (see Figure 4). Further detail on these projects can be found below.

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The VST model is now embedded as a **core operational delivery mechanism** across the ICS. A detailed VST report is attached at Appendix 2.

### **Impact Highlights 2024–25**

PHM is moving from process to population-level impact.

- **60,000+ residents** were engaged through proactive outreach.
- **17 PHM projects** were delivered, spanning diabetes prevention, cancer screening, weight management, mental health and wider determinants such as Warm Homes and energy efficiency.
- **We are now the highest referring ICB nationally for the NHS Digital weight management programme**, and referrals to the National Diabetes Prevention Programme also exceeded national benchmarks, demonstrating how personalised, data-driven engagement can improve preventative care.
- Targeted projects have achieved tangible outcomes — including reducing elective backlogs (vasectomy waiting list project), supporting early cancer detection (lung cancer screening in Great Yarmouth & Waveney), and improving pregnancy outcomes through maternity social prescribing.
- A **programme of evaluation** has been designed, to ensure every PHM project is measured for effectiveness and impact. All projects now include built-in evaluation frameworks, ensuring that monitoring and assessment are integral from the outset. In addition, the Community Voices programme enhances qualitative insight by capturing the lived experiences and perspectives of those most impacted by our initiatives.

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# Projects Supported by PHM and the VST 24/25

Completed	Ongoing
 <p><b>DWMP (Digital Weight Management Programme):</b></p> <p>We identified 18,431 individuals with obesity, diabetes, or hypertension eligible for digital weight management digital programme. 4,627 referred in Phase 1.</p>	 <p><b>Health checks:</b></p> <p>2,517 people eligible for NHS health checks contacted and 556 went on to have checks which identify early warning signs of cardiovascular disease, stroke, kidney disease, and diabetes.</p>
 <p><b>Lowestoft Primary Care Network:</b></p> <p>We identified 240 high-risk patients with multiple long-term conditions and mental health conditions and linked them with Health and Wellbeing coaches for holistic support.</p>	 <p><b>Energy Efficiency (West Norfolk):</b></p> <p>1,092 vulnerable residents at risk of cold homes contacted, and linked 225 eligible people with Borough Council of King's Lynn and West Norfolk and offered energy efficiency home improvements.</p>
 <p><b>NDPP (National Diabetes Prevention Programme)</b></p> <p>We identified 1,081 patients at-risk of Type 2 Diabetes and referred to the NDPP to undergo early intervention and lifestyle changes.</p>	 <p><b>Maternity Wider Determinants of Health:</b></p> <p>We identified 818 pregnant people in Core20Plus areas and offered referral to 153 people to Family Hubs / Social prescribing support with social determinants of health early in pregnancy.</p>
 <p><b>Talking Therapies (IAPT):</b></p> <p>We identified 17,256 patients with mild-to-moderate mental health needs and referred 2,710 to talking therapies.</p>	 <p><b>Lung Cancer Screening Programme</b></p> <p>Protect NoW will support with implementation of lung cancer screening across Great Yarmouth and Waveney, targeting eligible populations through proactive outreach.</p>
 <p><b>Dementia (North Norfolk):</b></p> <p>We identified 1,097 people living with dementia and/or their carers and offered 426 people referral to council services for non-clinical interventions to enhance wellbeing and carer support.</p>	 <p><b>Bowel Cancer Screening:</b></p> <p>Using PHM data and risk stratification tools, we will target eligible individuals who may not routinely engage with bowel screening.</p>
<p>All these projects have been run in collaboration with teams across the <b>Integrated Care System</b>. We engaged with <b>31,928</b> people including:</p> <ul style="list-style-type: none"> <li><b>7844</b> from deprivation decile 1-4</li> <li><b>31</b> people living with severe mental illness</li> <li><b>288</b> people living with learning disability</li> <li><b>8757</b> people living with depression</li> <li><b>1097</b> people living with dementia</li> </ul>	
 <p><b>Improving lives together</b> Norfolk and Waveney Integrated Care System</p>	

Figure 4: Overview of interventions delivered by Protect NoW and PHM partners (N&W ICB)

## Projects supported by VST and Protect NoW in 2024–25

- **NDPP (National Diabetes Prevention Programme)**

The National Diabetes Prevention Programme (NDPP) is an evidence-based programme to support at-risk patients through early intervention and lifestyle changes, to prevent them going on to develop Type 2 diabetes. Protect NoW identified 1691 eligible patients at risk, then over a period of 3 months directly engaged patients via text, letters, and calls, particularly in rural and deprived areas to encourage them to join the programme. 378 patients said yes to the referral which led to an increase in our uptake of 22% among eligible people across Norfolk & Waveney ICS. This has been continued for the next financial year and is part of the 5-year plan to prevent diabetes in Norfolk & Waveney.

- **DWMP (Digital Weight Management Programme)**

The Digital Weight Management Programme (DWMP) supports individuals with obesity, diabetes, or hypertension using digital tools and apps. It is also evidence based, with 94% losing weight, and an average weight loss of 3.9kg for those completing the 12 week course. Protect NoW identifies eligible patients and contacts them through SMS, letters, and follow-up calls. The initial phase of the programme achieved increased uptake, particularly among patients from deprived communities, far exceeding national benchmarks: N&W ICB is now the highest referring system in the UK and phase 2 is currently underway. (see case study)

- **Maternity (Social Prescribing)**

This pilot, run in partnership with the Norfolk & Waveney Local Maternity and Neonatal System, and Family Hubs, connects pregnant women in deprived areas to community services and financial support after their first midwife appointment. The aim is to improve pregnancy outcomes by addressing social determinants of health early in pregnancy. (see case study below)

- **Lowestoft PCN (Patient Engagement with Health Coaches)**

Practices in Lowestoft PCN, supported by health and wellbeing coaches, engaged 240 high-risk patients identified through PHM data. The cohort, many with mental health issues and multiple long-term conditions, received social prescribing support and wellbeing interventions, leading to sustained patient engagement. (see case study below)

- **Mental Health Referrals (Talking Therapies/IAPT)**

Protect NoW led a campaign between April and September 2024 promoting the Norfolk & Waveney Wellbeing Service (IAPT) to patients with mild-to-moderate mental health needs. Letters, SMS, and phone calls encouraged self-referral, boosting access to mental health support while reducing strain on GP services. (see case study below)

# Case Study: Digital Weight Management Programme (DWMP) Phase 1 – Protect NoW

## Overview

Protect NoW supported referrals into the NHS Digital Weight Management Programme (DWMP) in Norfolk & Waveney, where uptake had historically been low. Using PHM tools, the programme aimed to identify eligible patients and increase equitable access, particularly in deprived communities.

## Aims

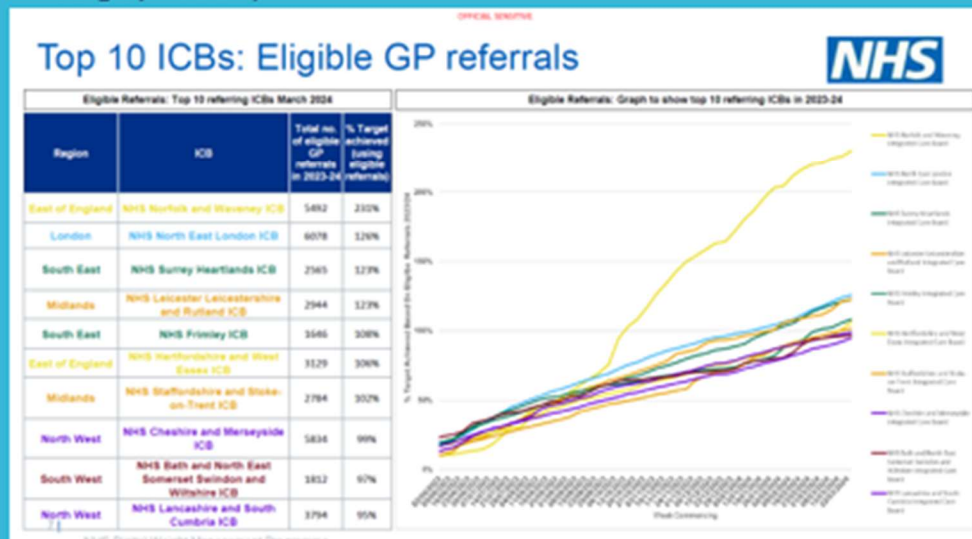
- Identify patients with obesity and diabetes and/or hypertension
- Increase equitable access, especially for deprived groups
- Improve referral numbers using a PHM approach

## Method

- 18,431 eligible patients identified across 32 GP practices
- Engagement via 18,196 letters, 14,521 SMS, and 40,157 calls
- Non-digital patients supported by call handlers, with accessible formats provided

## Outcomes

- 4,627 patients referred into NHS DWMP (25% of those contacted)
- 239 patients referred to local face-to-face services
- Higher engagement among older adults and men than through previous pathways
- Referrals from the most deprived communities increased by +8% compared with old models
- Referral numbers exceeded targets, outperforming similar ICBs nationally (see NHSE graph below)



## Learning

Multi-modal, proactive outreach can significantly increase access to preventative programmes like DWMP. Targeting deprived areas and providing non-digital options were critical in delivering more equitable referral outcomes.

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# Case Study: Maternity PHM Pilot – Social Prescribing & Family Hubs

## Overview

Launched in 2024, this pilot brought together the Norfolk & Waveney LMNS, Family Hubs, and the Protect NoW VST to support pregnant people in deprived areas. Using PHM data, the project identified those at greatest risk and linked them with non-clinical interventions through Family Hubs and community services.

## Aims

- Improve pregnancy and postnatal outcomes
- Engage pregnant people in IMD 1–2 areas
- Facilitate access to financial, housing, and mental health support
- Address inequalities in maternity outcomes

## Method

- Linked datasets (gestation at booking, IMD, smoking, SMI/LD) to identify patients
- Outreach via letters, calls, and questionnaires by VST
- Family Hubs offered three levels of support: advice, consultation, multi-agency planning
- Collaboration across housing, midwifery, early years, and welfare teams

## Outcomes (Feb 2025)

- **138 pregnant people supported**, 92% from IMD 1–2
- **67% sustained Family Hub engagement** (>24 hours)
- Referrals to Family Hubs rose from **13 to 93** during the pilot
- Improved early identification of needs such as homelessness, mental health, and financial insecurity
- Strengthened cross-sector collaboration and data sharing

## Patient Story – "Unborn E"

At 22 weeks, one patient was sofa-surfing after eviction with no income or baby equipment. Multi-agency support provided temporary housing, essentials, and antenatal care. The baby was delivered safely by C-section, with strong mother–baby attachment observed.

## Learning

- PHM tools and VST outreach uncovered hidden needs in deprived groups
- Early, coordinated non-clinical support improved maternal and infant wellbeing
- Better ethnicity data capture is needed
- Integration with Family Hubs shows potential as a scalable model for proactive maternity care

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# Case Study: Talking Therapies (IAPT) – Protect NoW

## Overview

The Protect NoW Virtual Support Team (VST) led a project to increase awareness of and access to the **Norfolk & Waveney Wellbeing Service (IAPT)** for individuals experiencing mild to moderate mental health difficulties, such as anxiety disorders and depression.

## Aims

- **Raise awareness** of available talking therapies and wellbeing workshops.
- **Improve access** to support services by removing barriers such as stigma, low awareness, and digital exclusion.
- **Increase self-referrals** into talking therapies, particularly among under-served groups.

## Method

- Letter sent to 17,256 patients inviting self-referral to the Wellbeing Service.
- SMS reminders followed one week later to reinforce the invitation.
- Telephone follow-up calls made by Protect NoW call handlers to encourage engagement, address queries, and offer direct support.

## Outcomes

- **2,710 patients** referred to talking therapies.
- **93.5% acceptance rate** into the service among referred patients.
- Increased engagement from patients with long-term conditions such as depression, learning disabilities (LD), and severe mental illness (SMI).
- Enhanced trust and patient experience through personalised outreach.

## Patient Feedback

*“I have already done six sessions of talking therapy over the phone with Wellbeing and I am very pleased with the service.”* — Patient voicemail

A paramedic patient expressed gratitude for the service, noting how information on workshops and social events would help her better support her patients and colleagues.

## Learning

Personalised, multi-channel outreach, combined with proactive follow-up, significantly improves access to mental health services, particularly for patients who may face digital barriers or stigma.

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- **NHS Health Checks**

Protect NoW delivered a campaign promoting NHS Health Checks through SMS, letters, and follow-up calls. NHS Health checks are offered to people aged 40-74, to identify people at risk of cardiovascular disease, stroke, kidney disease and diabetes, so they can benefit from support to prevent disease. This project targeted eligible patients across Norfolk & Waveney, especially those living with deprivation, who had been invited but not taken up the offer of a health check, leading to significantly increased patient uptake. N&W ICS now has the best performance for health check delivery in the East of England.

- **Energy Efficiency (West Norfolk)**

In collaboration with the Borough Council of King's Lynn and West Norfolk, the council provided data for residents living in deprived postcodes with the lowest energy efficiency ratings which Protect NoW matched with health data to identify at-risk residents. Eligible patients were contacted and offered grants for home energy improvements, aiming to reduce hospital admissions linked to cold-related illnesses. 229 patients were referred, and 49 people went on to receive additional benefits as a consequence of this project such as installation of solar panels, air source heat pumps, wall/loft insulation and such like.

- **Dementia (North Norfolk)**

Protect NoW conducted triage calls to patients living with dementia and/or their carers in North Norfolk. Following initial triage, patients were referred to council services for non-clinical interventions to enhance wellbeing and carer support, contributing to improved health and social care integration.

- **Diabetes Structured Education Promotion**

Protect NoW supported the promotion of structured diabetes education courses, including the X-PERT Diabetes Programme, across Norfolk & Waveney. Engagement campaigns helped patients with Type 2 diabetes access evidence-based education to improve clinical, lifestyle, and psychosocial outcomes.

- **Tier 3 Weight Management Programme (Patient Risk Stratification and Engagement)**

The project aimed to identify and engage patients with complex obesity requiring specialist Tier 3 services to ensure that the limited resources available were targeted at the people at the greatest clinical risk. Using PHM data, Protect NoW targeted high-risk patients to triage referral into intensive multidisciplinary weight management support, focusing on reducing obesity-related complications.

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- **Warm Homes (East Suffolk and Great Yarmouth)**

Protect NoW collaborated with local councils to support patients living with respiratory conditions (e.g., COPD, asthma) at risk of fuel poverty. Targeted patients were offered financial assistance to heat their homes, aiming to reduce winter-related hospital admissions and improve health outcomes in East Suffolk and Great Yarmouth (see case study below).

- **Lung Cancer Screening Programme**

Protect NoW supported the implementation of lung cancer screening across Great Yarmouth and Waveney, targeting eligible populations through proactive outreach. The aim was to boost early detection rates and address health inequalities in communities with historically lower cancer screening uptake.

- **Vasectomy Waiting List (Patient Engagement)**

Protect NoW supported the vasectomy waiting list reduction project by contacting patients and offering a choice of alternative providers. This successfully helped meet NHS England elective recovery targets, reducing overall waiting times for elective care.

- **Together Smoking Cessation (Patients with SMI)**

The project supported smoking cessation among patients with Severe Mental Illness (SMI) by encouraging referrals to specialist services. Together engaged patients through direct outreach, aiming to reduce smoking rates and improve long-term health outcomes.

- **Together Health Checks (Patients with SMI)**

Together supported health check delivery for patients with Severe Mental Illness (SMI) as part of a broader effort to reduce health inequalities. The project aimed to ensure comprehensive physical health assessments for patients who traditionally have lower access to preventive healthcare.

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# Case Study: Warm Homes (East Suffolk & Great Yarmouth)

## Overview

A place-led PHM project linking health and housing data to identify clinically vulnerable residents in cold, damp, energy-inefficient homes. Targeted households in Core20 communities to reduce fuel poverty, improve living conditions, and lower health risks.

## Aims

- Identify high-risk households using health + housing data.
- Focus on people with long-term conditions affected by cold homes.
- Connect residents to energy-efficiency and retrofit grants.
- Reduce preventable illness and hospital admissions.

## Method

- Health conditions (cardio, respiratory, mobility issues) matched with housing data (EPC ratings, deprivation).
- Data-sharing agreement enabled East Suffolk Council to contact residents.
- **437 residents in 307 households** identified.
- Outreach via letters, follow-up calls, and **50+ home visits**.
- Referrals into ECO4 and HUG2 national retrofit schemes.

## Outcomes (Dec 2024–Mar 2025)

- **78 households (25%) engaged** — higher than average.
- 50 home visits completed; 8 more booked for upgrades.
- Support delivered: heater loans, Winter Warmth Packs, fire safety checks, benefit referrals.
- Grants secured for insulation, heating, solar panels, and air-source heat pumps.
- Demonstrated the power of **clinically informed, place-based targeting** to improve health via non-clinical interventions.

## Patient Stories

Older adult with respiratory illness, received insulation, heater support, and welfare referrals.

*"It's made a real difference. I'm breathing better and not worried about the cold."*

Family in unsafe housing received emergency support and £30k ECO4 grant which provided full insulation, solar panels, and heating.

*"Great news – we have central heating! We couldn't have done this without your help."*

## Learning

- NICE-aligned criteria ensured those most at risk were prioritised.
- Cross-sector collaboration enabled smart, targeted outreach.
- A model of **proactive PHM**, tackling wider determinants of health.
- Next step: evaluate long-term clinical and financial impact.

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## **Future action for PHM Interventions:**

A number of new projects are currently under development:

- **Familial Hypercholesterolemia (FH)**

To identify people with possible undiagnosed FH, enable testing and treatment thereby saving lives through the prevention of seriously adverse Cardiac events.

- **CVD Prevention – Hypertension and Lipids**

To identify patients with untreated and or sub-optimally managed high blood pressure and high cholesterol to target appropriate interventions to improve the health outcomes of patients, see a reduction in the incidence rates of CVD, and the significant negative health outcomes associated with it. This project will be one of our largest prevention projects to date.

- **T2 Early on-set diabetes patients**

To improve engagement of patients with Early Onset Type 2 Diabetes (EOT2D) with Type 2 Diabetes in the Young (T2DaY) reviews provided by their GP Practice.

- **Identifying women with DM of child-bearing age pilot**

To increase the number of women with DM accessing pre-pregnancy care.

- **Community Voices - Lung Cancer Screening GYW – Phase 2**

To increase the uptake of the Lung Cancer Screening (LCS) programme particularly amongst communities who are disengaged and marginalised within the eligible population and maximise opportunities for smoking cessation via Swap to Stop scheme.

Further details of all completed PHM projects are available at:

[Population Health Management Projects - Norfolk & Waveney ICS \(improvinglivesnw.org.uk\)](https://www.improvinglivesnw.org.uk)

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## Conclusion and Next steps

In 2024–25 the PHM team has made significant progress with delivering on our strategy. We have strengthened our infrastructure and intelligence with the renewal of the Eclipse platform and the launch of the Registered Population Explorer and PHM Dashboard, and we have delivered positive interventions to over 60,000 residents across 17 projects, in line with our 5 priority areas to target and reduce health inequalities.

Looking ahead, our focus is on consolidating this progress by:

- **High-impact interventions** — Concentrating resources on programmes with the greatest potential to improve outcomes and reduce demand, including CVD prevention and increased cancer screening uptake.
- **Reversible risk framework** — Finalising and embedding a system-wide model for identifying “reversible risk” cohorts. This will allow earlier targeted interventions and enable INTs and PCNs to prioritise patients most likely to benefit from proactive support.
- **Standardised evaluation** — Applying a consistent assurance framework across all PHM projects, with agreed metrics for activity, uptake, equity, and outcomes. This will make it easier to measure impact, compare projects, and replicate successful pilots at scale.
- **Equipping Integrated Neighbourhood Teams** with localised insight to enable proactive, preventative care.

Together, these steps will ensure PHM continues to deliver measurable improvements in outcomes and equity for the population of Norfolk and Waveney.

**Thank you to all the teams and individuals who have led and contributed to PHM projects to improve health outcomes and reduce health inequalities across Norfolk and Waveney in 2024-2025.**

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## Appendices

### Appendix 1: Population Health Intelligence Tools

#### Summary

Tool/Development	Purpose	Benefits
Population Explorer	Access demographic and health need data at practice/PCN/place level	Supports planning, resource allocation, and understanding of population needs
PHM Dashboard	Track live progress against key strategic metrics	Enables timely action and continuous monitoring
Data Hub	Secure, linked datasets across health and care services	Supports richer analysis, modelling, and evaluation
Eclipse Analytical Tools	Advanced segmentation, risk modelling, place-level insights	Supports precise, localised project development and enables patient-level action

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#### Eclipse Analytical Tools: Supporting Place-Based Development

Eclipse continues to play a critical role in embedding PHM across Norfolk and Waveney, providing actionable intelligence that empowers teams at system, place, and neighbourhood levels to deliver more proactive, equitable care.

The Eclipse platform supports real-time analytics, advanced cohort segmentation, and risk stratification across the Norfolk and Waveney ICS.

Eclipse provides predictive modelling, and place-based intelligence to identify at-risk populations, target interventions, and measure outcomes at neighbourhood, PCN, and ICS levels.

We are working towards implementing '**launch in context**' features and **read-write capability** for patient records through Eclipse. These enhancements will allow clinicians and population health teams to move beyond insight generation to **direct patient-level action**, supporting proactive, personalised interventions in real time.

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## Registered Population Explorer Tool

The new **Population Explorer** provides dynamic access to registered population data across Norfolk & Waveney covering the demographics, health needs, and service usage at GP practice, PCN, place, and system levels.

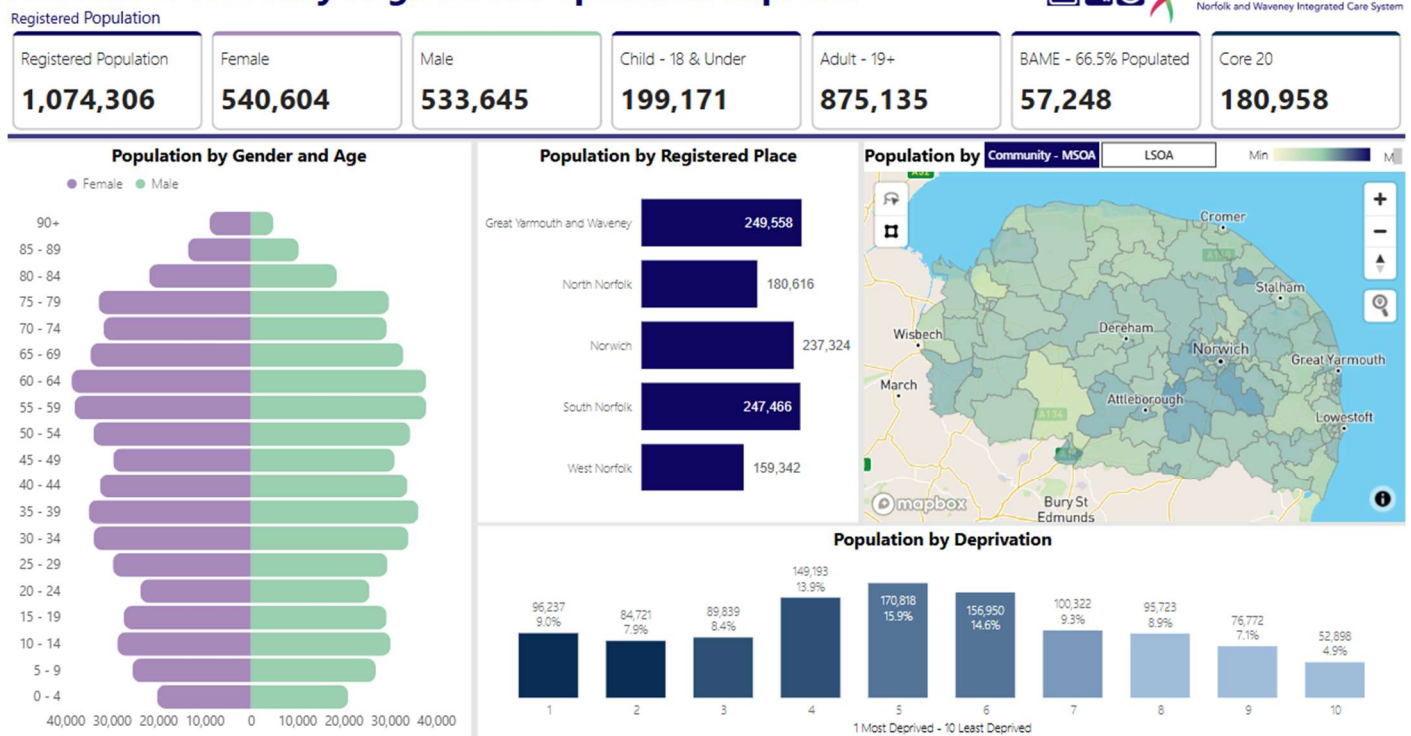
This tool enables users to better understand who their populations are, how they are changing over time, and where interventions can have the biggest impact.

### To access:

- Available via the secure internal BI Portal for NHS and Norfolk County Council users. To request access, please email: [i&a@norfolk.gov.uk](mailto:i&a@norfolk.gov.uk).

Link: [Norfolk & Waveney Registered Population Explorer - Power BI](#)

## Norfolk & Waveney Registered Population Explorer



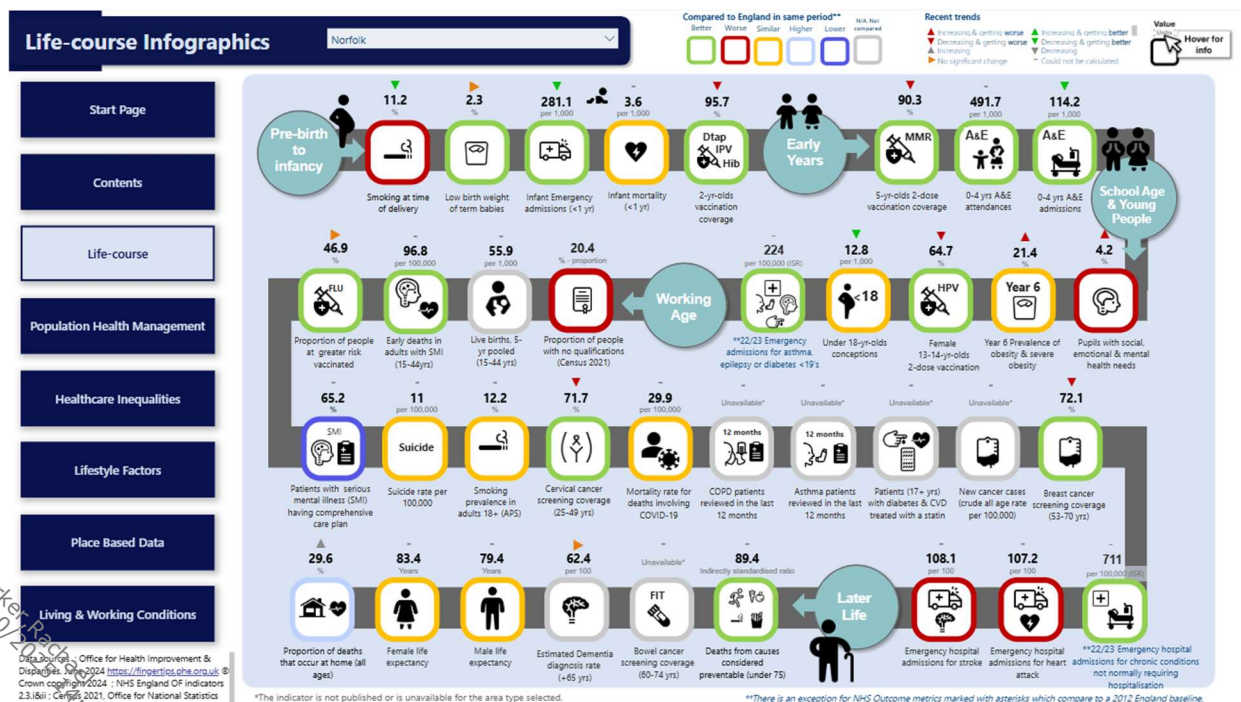
Population Explorer Dashboard (N&W ICB)- Example page

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# Population Health Management (PHM) Dashboard

The NCC Strategic **PHM & HI Dashboard** allows live tracking of key metrics aligned to our system’s strategic priorities and supports monitoring performance across major population health and inequalities focus areas.

- **Key focus areas:**
  - Smoking
  - Cardiovascular, respiratory diseases and diabetes
  - Cancer screening and outcomes
  - Severe Mental Illness (SMI)
  - Children and Young People
- **Broader coverage:** The dashboard also tracks lifestyle factors, healthcare inequalities (Core20PLUS5 indicators), and living and working condition measures.
- **How it helps:** By providing easy-to-digest visual data, the dashboard supports more timely, targeted action at both strategic and operational levels.
- **Access:**
  - Email: [i&a@norfolk.gov.uk](mailto:i&a@norfolk.gov.uk) for access assistance.
  - Link: [Norfolk & Waveney strategic population health & inequalities dashboard - WORKING DRAFT - Power BI](#)



**External Website Links**

Population Health Management Projects - Norfolk & Waveney ICS  
([improvinglivesnw.org.uk](http://improvinglivesnw.org.uk))

**Internal ICB Staff Intranet Link**

Population Health Management: Protect-NoW

**Norfolk and Waveney Integrated Care System Population Health Management Strategy 2024-2029**

Population Health Management Strategy - final designed version.pdf  
([improvinglivesnw.org.uk](http://improvinglivesnw.org.uk))

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## Appendix 2: VST Annual Report

A detailed report giving key data relating to the projects undertaken by the Virtual Support team is available at: [VST Report 2024-2025](#)

The slides are also copied below.

### PHM - Protect NoW VST annual report 24-25

The VST team has maintained its high standard in patient engagement through enrolment in additional training opportunities to enhance our knowledge and expertise in providing services and engaging with patients. Furthermore, all team members have received accreditation for motivational interviewing and National Council For Education Level 2 Certification in Customer Service for health and social settings.

We have encountered challenges with staffing attendance due to maternity leave and long-term sick leave. As a result, we have not been able to fully staff the year with 5 full-time equivalents (FTEs).

Throughout the year, we have supported and participated in various projects across the Norfolk & Waveney Integrated Care System (ICS) and Cambridge and Peterborough ICB. This effort has led to the dispatch of 16,856 letters and 13,214 SMS messages. We attempted to contact patients 60,739 times and successfully spoke with 20,970 patients over the phone, providing support and, where possible, alternative services. Out of the 31,928 patients invited to participate in various pathways, we successfully engaged with 20,970 patients and referred 9,795 to different NHS services based on project specifications and patient cohorts.

From the total of 31,928 patients in Norfolk and Waveney, we had successful engagement with:

- 7844 engagements with patients from deprivation decile 1 -4
- 31 engagements with patients living with SMI
- 288 engagements with patients living with LD
- 8757 engagements with patients living with Depression
- 1097 engagements with patients living with Dementia

Follow our work here:

<https://improvinglivesnw.org.uk/our-work/healthier-communities/population-health-management/phm-projects/>



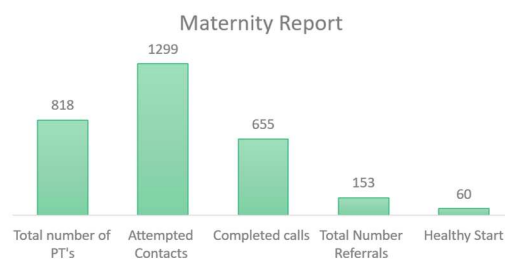
### PHM - Protect NoW VST annual report 24-25 – Ongoing to next financial year

#### Maternity Norfolk and Waveney

**Purpose:** This pilot uses a social prescribing model. This approach connects people to activities, support and guidance within their community with the aim of improving their health and wellbeing.

**Objective:** To support patients, living in the most deprived areas, in their early pregnancy with social and financial aid.

**Method:** The Protect Now team contacts pregnant women and birthing people after they have had their first midwife appointment. The Protect NoW Team raises awareness of the free services and support available to families during pregnancy and after their baby is born. This project is a collaboration between the Norfolk and Waveney Local Maternity and Neonatal System, Family Hubs and the Protect-Now team.



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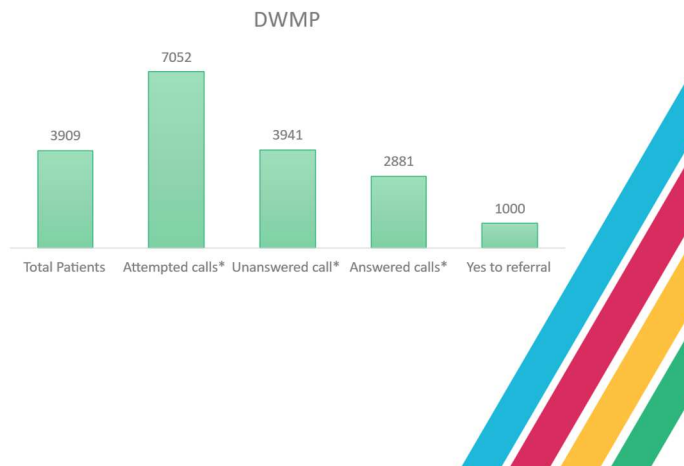
## PHM - Protect NoW VST annual report 24-25 – Ongoing to next financial year

### DWMP Phase 2 – Feb 2025

**Purpose:** Identifies adults living with obesity who also have a diagnosis of diabetes, hypertension or both. The project increases awareness and uptake of the Digital Weight Management Programme (DWMP) in Norfolk and Waveney to support local people to manage their weight and improve their health.

**Objective:** To reduce risks of other health conditions linked to high BMI including Type 2 diabetes, cardiovascular disease, joint problems, mental health problems and some cancers. To maximise the programme's potential for preventing premature death, disease, and disability. The programme is achieving its objective of tackling health inequalities with increased uptake from the most deprived populations and those least likely to access other formats of weight management support.

**Method:** Patients identified for this initiative will receive a text message inviting them to indicate their interest online or to decline the offer if they choose. For those without a mobile number, we will send a letter as an alternative. Additionally, any patient who has not provided a response will be contacted by the Protect NoW virtual support team via telephone to ensure they have all the necessary information.



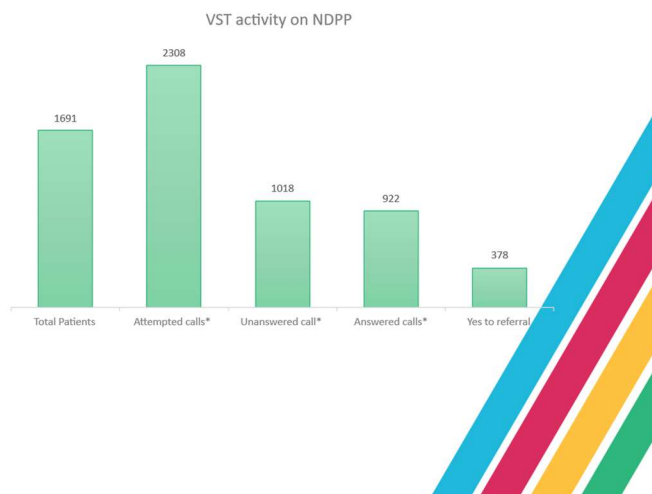
## PHM - Protect NoW VST annual report 24-25 – Ongoing to next financial year

### NDPP Phase 2 – Feb 2025

**Purpose:** Type 2 diabetes is largely preventable through lifestyle changes. It can lead to serious health issues like sight loss, kidney failure, heart attacks, and strokes. This project supports at-risk patients by referring them to the NHSE Diabetes Prevention Programme, particularly in rural and economically deprived areas with low referral rates despite many eligible patients.

**Objective:** The NHS Diabetes Prevention Programme aims to reduce the number of new diagnoses of type 2 diabetes, helping to save thousands of people from the potentially serious consequences of the condition. Completing the programme lowers the risk of developing type 2 diabetes by more than one-third.

**Method:** Patients eligible for this program will get a text message asking if they want to join. They can accept the offer by following the link or decline it. If a patient does not have a registered mobile number, they will receive a letter instead. If a patient doesn't reply, the Protect Now support team will call them to provide information about the NHS Diabetes Prevention Programme.



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## PHM - Protect NoW VST annual report 24-25 – Ongoing to next financial year

### Cambridge and Peterborough – PSL support

1. **Lipid Detection and Optimisation** – statin optimisation for at-risk patient groups (QRISK >20%, T1DM, CKD, established CVD)
2. **FH Detect** – case finding for patients at risk of familial hypercholesterolaemia, to establish risk score, lipid lowering therapy and consent for referral to service
3. **Hypertension Detect** – case finding for patients without coded hypertension but at increased clinical risk
4. **Hypertension Perfect** – support to patients with established hypertension, to ensure up-to-date monitoring, compliance and lifestyle.
5. **Health Record** – ensuring up-to-date clinical information is coded on the GP clinical system (weight, height, ethnicity, family history, smoking and alcohol)
6. **NHS Health Checks** – maximizing patient uptake onto the health check programme

PSL Projects



## PHM - Protect NoW VST annual report 24-25 Energy Efficiency East & West

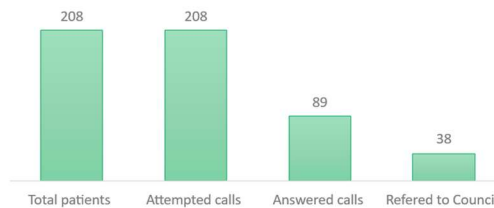
### Energy Efficiency - West Norfolk

**Purpose:** In this project, West Norfolk Council and the ICB are working together to support eligible individuals to access grants for home energy efficiency improvements.

**Objective:** The aim is to improve the health and wellbeing of Waveney residents and reduce the likelihood of hospital admissions or readmissions due to the direct or indirect impacts of living in an energy inefficient home.

**Method:** Data identifying West Norfolk homes with known low energy efficiency, will be matched with data on the occupants with existing health conditions, which are likely to be adversely affected by living in a cold home. The eligible health conditions are cardiovascular, respiratory, immunosuppressed, or due to limited mobility. Once matched, a list of households potentially eligible to participate in this home energy efficiency project are contacted by the Protect NoW via letter and or phone contact and offered referral to the Borough Council of King's Lynn and West Norfolk.

Energy Efficiency West



Note: Engagement started on the 13<sup>th</sup> of March 25, but calls for batch 1 were done on April 1<sup>st</sup>, will be part of 25-26 Financial year.

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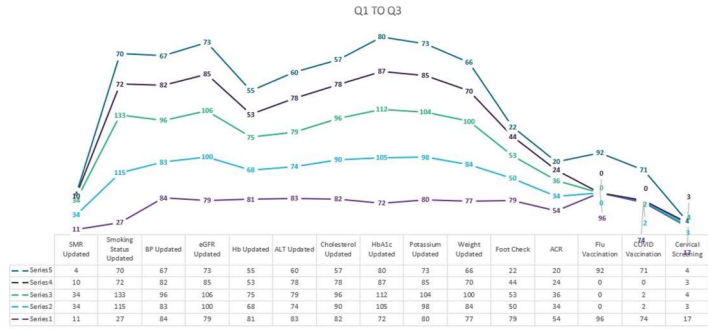
**PHM - Protect NoW VST annual report 24-25  
Lowestoft**

**Lowestoft**

**Purpose:** In this project Practices in Lowestoft are working together with health and wellbeing coaches to contact a small cohort of patients 240 who have been identified most at risk due their poor health and lack of engagement with the practices.

**Objective:** Engaged with a patient group with mental health and multiple co-morbidities and get and offer additional support available such's as social and care packs based on their needs.

**Method:** Increase patient engagement and ownership on their own health and wellbeing. All patients identified have been engaging through the year.



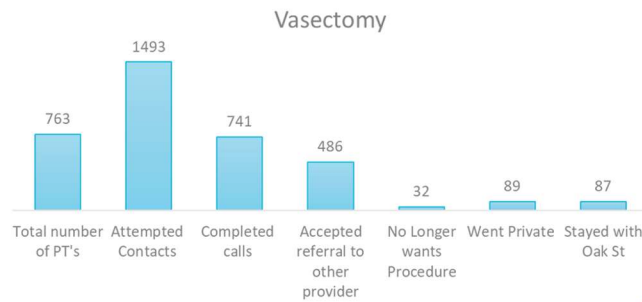
**PHM - Protect NoW VST Annual report 24-25 – Completed**

**Vasectomy Waiting lists – Oct' 24 to Nov' 24**

**Purpose:** To contact patients currently waiting for a vasectomy, to offer them choice to change to another provider.

**Objective:** To provide patients with a choice of providers and to reduce waiting list times for Elective Care to within acceptable limits. NHSE Planning Guidance 2024/25 recommends that waiting times are improved in the community and long waits are reduced.

**Method:** The Protect NoW VST Team contacts these patients to offer a choice of providers and then (if requested) arrange for onward referral to provider of their choice. This is also an opportunity to sanitise the waiting list as many patients may no longer wish to be on the list.



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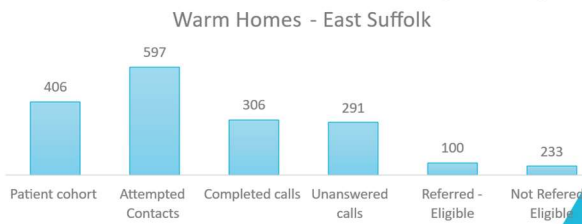
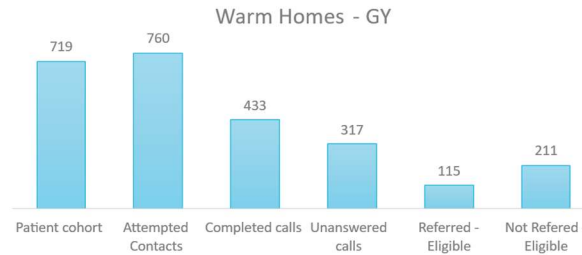
## PHM - Protect NoW VST Annual report 24-25 – Completed

### Warm Homes Great Yarmouth and East Suffolk: Completed in May 2024

**Purpose:** In an effort to reduce hospital admissions due to respiratory problems, patients with respiratory conditions who are at risk of living in fuel poverty, will be targeted for financial help in order to heat their home. The ICB will provide data about local people who live with Chronic Obstructive Pulmonary Disease (COPD) and Asthma to the local District Council, who then identify all the people who are eligible to participate in the Warm Homes project.

**Objective:** The aim is to improve the health and wellbeing of Waveney residents and reduce the likelihood of hospital admissions or readmissions due to the direct or indirect impacts of living in an energy inefficient home.

**Method:** Patient Identified data list was passed to Virtual Support Team (VST) who have contact these patients and offer financial assistance. This project is focussed on people living in Great Yarmouth and in the Waveney area of East Suffolk.



## PHM - Protect NoW VST Annual report 24-25 – Completed

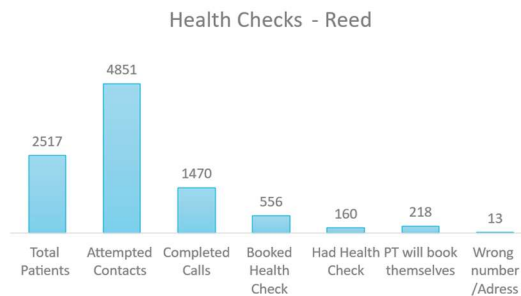
### Health Checks – Reed

**Purpose:** Regular health checks can help identify early signs of health issues. The NHS Health Check aims to reduce your risk of developing conditions that affect the heart and blood vessels, such as heart disease, stroke, and kidney disease. Many warning signs for these conditions, such as high blood pressure and high cholesterol, may not have noticeable symptoms

**Objective:** To increase the patient uptake of health checks and promote attendance.

**Method:** Identifying patients and sending SMS messages to eligible patients to promote the service so they can register and book health checks at the offered sites available by the providers.

Calls agents to attempt telephone contact with patients who have not self-serve to encourage participation.



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## PHM - Protect NoW VST Annual report 24-25 – Completed

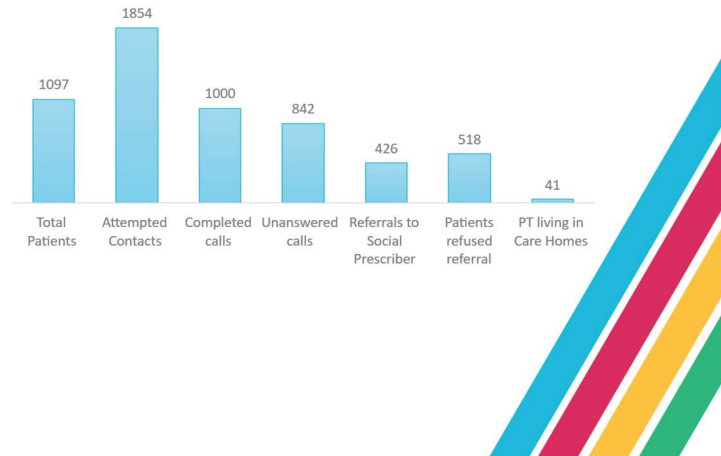
### Dementia – North Norfolk – Completed

**Purpose:** To contact patients of participating GP Practices coded as living with dementia.

**Objective:** To complete an initial triage call with the patient/and or identified carer/Power of Attorney to establish whether the patient living with dementia would like a telephone/face to face discussion with our District Council/ Norfolk County Council partners around non-clinical interventions to support their health and wellbeing and their careers.

**Method:** Protect Now Colleagues worked with a small project group to agree the list of triage questions and a script of the types of advice, information and practical interventions the patient or their carer will be able to receive should they wish to participate. Protect Now made the initial call and then passed the information back to the relevant Practice Manager. The Practice Manager shared under existing information sharing agreements/protocols with their Borough Council/Norfolk County Council.

Dementia Support - North Norfolk



## PHM - Protect NoW VST Annual report 24-25 – Completed

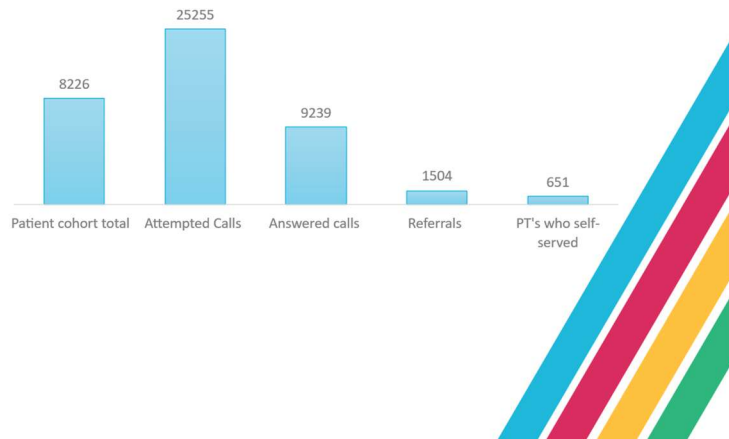
### Talking Therapies – April 24 to September 24

**Purpose:** To increase awareness of and access to the Norfolk & Waveney Wellbeing Service (IAPT) for people experiencing mild to moderate mental health problems such as anxiety disorders and depression. Appropriately use the capacity available within the Wellbeing service and meet the needs in our population.

**Objective:** Increased access to the Wellbeing Service resulting in benefits to the wider transformation including reducing the burden on primary care; improved employment outcomes; reduction in antidepressant prescribing; improved management of LTC; reduced need for secondary care services.

**Method:** Protect NoW sent out letters, followed up with SMS, to incentivise self-referrals to talking therapies. Follow up calls were made to all those who hadn't responded to the offer to encourage patients to engage with the service.

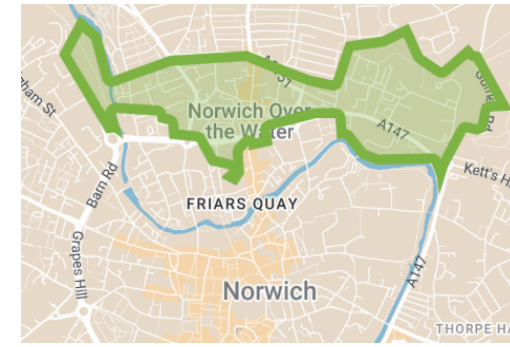
IAPT Phase 2



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# Central Norfolk Place: October 2025 Update

## In focus: North City Centre Integrated Neighbourhood Team



### An ICS wide piece of work:

**ICB – Place team;** Convening and providing an integrator function & strategic dental commissioning  
**NCC;** Adult social Care & Older Persons Mental Health. ICC roles providing coordination of care  
**NSFT;** CMHT teams & Mental Health Assessment in the community  
**Norwich City Council;** Housing Teams & Support Now  
**NCHC;** Community Matron, HIU & Physio teams  
**GP Practice;** referring complex cases, MDTs  
**CGL;** delivering drug and alcohol services in the community  
**MIND;** supporting complex cases  
**VCSFE;** providing preventative support services  
**Local Police;** Supporting victims of crime

### 1. Integration & Coordination

**Partners working together in a new way:** Co-ordinating a system response to complex cases, Reducing DNA's, Co-locating staff, Sharing risks and information, Reducing ineffective re-referrals, Increasing warm handovers, Exploring and sharing under-utilised ICS partner estates, Acknowledging that a population needs us to work differently and addressing a shared challenge together.

### 2. Accessibility & Delivery

**A community-based estate:** Using MECC approaches to maximise impact, Community facing visible support and locally accessible appointments, Bookable spaces for ICS partners to work in the area, Clinic days & opportunities for left shift – liver scans, physio clinics, pulmonary rehab clinics, Working with VCSFE partners to engage hard to reach people for preventative support, Strategic commission of a dental project, Reducing inequalities.

### 3. Digital, Data & Evaluation

**Understanding enablers and barriers:** Identifying digital barriers & working with ICB digital colleagues to create a toolkit for integrated projects, Using a needs-designated footprint, In-depth population demographic & activity analysis, Exploring new ways of using Eclipse within INT work - sharing access with partners, Risk stratification, Future proofing scalability, Realist evaluation techniques.

# Central Norfolk Place: October 2025 Update

## In focus: Wellness on Wheels (WOW) Bus

**Where we went in Summer 2025:**  
**FarmCamp (Place UK)** A Full-time workforce of 120 employees and seasonally up to 550. The majority of seasonal workers are economic migrants from overseas.

**St Martins** - Support for vulnerable adults who are homeless or at risk of homelessness by offering opportunities to develop the skills that will help them to live independently within the community

The *Wellness on Wheels (WOW)* Bus is a mobile healthcare unit designed to deliver quality health services where people live, work, and learn. It bridges gaps in access by bringing medical care, preventive screenings, and health education directly to communities. To identify locations for the WOW Bus, we combined community data, partnerships, and accessibility considerations. We focused on underserved neighbourhoods and areas with higher rates of health concerns, such as diabetes, smoking, or low vaccination coverage as examples. We then collaborated with local health departments, Primary care providers and underserved communities to determine where services were most needed. Accessibility was a key factor, ensuring the bus could park safely and residents could easily reach it, often near schools, community centres, or public transport stops. Additionally, visits were aligned with community events and gatherings to maximise outreach, and we collected feedback from patients/attendees and monitored attendance at previous stops to continually refine future location choices. This approach ensured the WOW Bus served the areas with the greatest need and

### 1. Treatment to Prevention:

- Provide accessible, equitable Healthcare for underserved populations
- Transition focus from treatment to prevention and wellness promotion
- Educate communities on healthy lifestyles, early detection and self-care
- Reduce hospital admissions and healthcare costs through preventative intervention's

### 2. Hospital to Community:

- Access & Equity – Bring essential health services to communities with limited access to care
- Prevention & Education – Focus shift from treatment to prevention
- Community Empowerment – Build Partnerships that strengthen local capacity and awareness

### 3. Analogue to Digital:

- Streamline care from hospital to community ensuring that treatment, follow-ups, and preventive services are coordinated and data-driven
- Identify community health trends to guide targeted interventions
- Track patient health efficiently
- Improved communication between practices, hospitals and communities



### Who we reached:

23 – Health checks  
20 – Women's Health Consultations  
30 – Signposts to other services

# Frailty & NHS Healthchecks

✓ Aligning with 10-year health plan & 25/26 Winter prep

**Summary:** We have added the Clinical Rockwood frailty score (CFS) & fracture risk assessment score (FRAX) onto the NHS Healthcheck template under the 'Additional Advice' section on the Ardens template. We are aiming to provide a more personalised and holistic approach to an NHS Healthcheck, piloting this within Central Norfolk to understand the learning and outcomes that may follow with a more personalised approach.

## Treatment to Prevention

- Normalising discussions around healthy ageing and bone health
- Early identification within a routine NHS healthcheck – identifying those at risk that may need further conversations with a more specialist professional around bone health
- More personalised and prioritised discussions around physical activity and nutrition – eg. importance of weight bearing and strength training especially for post-menopausal women

## Hospital to Community

- Proactive approach to frailty and fragility by intervening early to reduce, prevent and delay frailty and fragility fractures
- Reducing the need for hospital services in future – reducing the impact of major osteoporotic fractures within hospitals and GP

## Analogue to Digital

- Using globally known clinical frailty scores and risk assessment tools for identification

# NN4 Proactive Specialist Frailty Multidisciplinary Team (MDT) Meeting

✓ Aligning with 10 year health plan & 25/26 Winter prep

**Summary: A 2 hour monthly proactive virtual MDT– aimed for those at rising risk of admission for those with a Clinical Rockwood frailty score (CFS) of 5+ with 'what matters to the person' at the heart of the discussion – taking learning from a Surrey Downs Frailty model**

- Went 'live' on the 13<sup>th</sup> of October
- Inclusion criteria – CFS >5+ & 'what matters most to the person', age >65, registered to any NN4 GP practice
- Exclusion criteria – registered Care Home patients (for now)
- Any health and social care worker can request review if concerned



- Membership includes:
- NNUH – Geriatrician
  - NCH&C – Community Matron, Occupational Therapist, Physiotherapist
  - GP Practice/PCN – NN4 GP, Mental Health Practitioner, Clinical Pharmacist
  - NCC – Social Worker, Occupational Therapist, Norfolk First Support
  - NSFT – Older Persons Mental Health
  - Rapid Response team

## Treatment to Prevention

- Providing a proactive full comprehensive geriatric assessment (CGA) as per guidance from the BGS - led mainly by Community Matrons
- Supporting Personalised Care & Support Plan (PCSP) in a wide MDT model with 'what matters most to the person' at the heart of the discussion & therefore improving health & wellbeing outcomes
- Increased amounts of Advanced Care Planning
- Huge amounts of de-prescribing leading to cost-savings and the person is taking only those medications absolutely needed



## Hospital to Community

- A targeted, personalised & proactive approach within people's own homes for those that need it most & are at rising risk in the community
- Aiming to prevent hospital admissions by providing a holistic assessment and review of a person's health & wellbeing
- Aiming to avoid referral barriers through MDT working & in turn building better relationships with hospital & community colleagues
- Aiming to reduce unplanned GP home visits
- Supporting carer identification & increased signposting to support services for carers to maintain & improve carer health and wellbeing



## Analogue to Digital

- Using data either from: Eclipse to identify those at rising risk with a moderate-severe Electronic Frailty Index (eFI), a CFS of 5+ or known knowledge and concern in the community
- Collecting measurable outcomes pre/post MDT such as GP home visits, unplanned hospital admissions, de-prescribing cost-saving



# Central Norfolk Place: October 2025 Update

The following urgent and emergency care transformation schemes are being progressed by Central Norfolk partners which will support winter resilience.

## Winter Resilience: Community, Acute and Social Care

Development of the Frailty Hub at NNUH comprising Frailty Same Day Emergency Care (SDEC) and a Frailty Unit. Ward moves have enabled co-location of OPED (Older People's Emergency Department) and OPAC (Older People's Ambulatory Care) to deliver the Frailty SDEC which is adjacent to the OPM (Older People's Medicine) short stay ward, now to be the Frailty Unit. The Frailty Hub is supported by a multi-disciplinary approach, which brings together the Acute Hospital OPM Team, Acute Front Door Therapy team and NCHC Early Intervention Team, with the focus to avoid unnecessary admission and enable a timely, safe discharge home. The model will interface with Virtual Ward, NEAT/Rapid Response teams and Reablement services to promote recovery and optimisation of independence at home, promoting improved health and care outcomes as well as avoidance of readmission.

Development of "call before convey" via UCCH (in hours) and IC24 (out of hours) for ambulance crews attending care home residents to avoid unnecessary conveyance to hospital. This includes case holding via IC24 overnight with the development of next day Frailty Hot Clinic appointments at NNUH, linking to the Frailty Hub.

Last year's pilot of CfBO (Caring for Better Outcomes) to provide additional reablement services for hospital discharge alongside NFS has increased capacity for reablement services at home. CfBO is a collection of NCC Framework Domiciliary Care Providers with agreed competencies to enable reablement at home. A shift in activity profile for NFS has been noted from historically, predominantly supporting hospital discharge activity (70:30 ratio discharge to admission avoidance) to a broadly equal split of admission avoidance and discharge activity. This is enabling admission avoidance activity and capability to support developments such as Virtual Ward and Frailty SDEC. Investment in CfBO has continued this year.

# Central Norfolk Place: October 2025 Update

The following urgent and emergency care transformation schemes are being progressed by Central Norfolk partners which will support winter resilience.

## Winter Resilience: Community, Acute and Social Care

Working with partners NFS has introduced regular MDT meetings with health, social care and VCSE team members to discuss reablement and transition planning from the pathway to community services to maximise independence for individuals being supported by NFS and sustainability of outcomes to avoid readmission and/or re-referral to NFS. This has started in North Norfolk and Norwich and is intended to role out across Central Norfolk.

NFS have reviewed their processes to improve efficiencies and release additional service capacity. This together with the introduction of CfBO and NFS MDTs has contributed to the shift in NFS activity profile to more equally supporting admission avoidance and discharge activity.

The Norfolk and Waveney Community Support Service (NWCSS) has been reviewed, revised and extended for a year to enable the re-procurement of a new service, in response to reduced investment. This was a collaborative endeavour between place transformation and commissioning teams across Norfolk and Waveney. NWCSS provides a single point of access to rapid response, short term, informal support at home. The revised extended service launched on 1.10.25, has a focus on admission avoidance activity through front door hospital teams and services such as SDEC, Rapid Response teams, NFS, Virtual Ward as well as hospital discharge.

The co-designed and agreed Central Norfolk bed based intermediate care model for step up (admission avoidance) and step down (hospital discharge) has now been commissioned and mobilised including the new Therapy Led Willow Unit and the Reablement Recovery Pathway in Care Homes for individuals with moderate cognitive decline.

Focus continues on initiatives that support a reduction in length of stay at NNUH and bed based intermediate care pathways including improved board and ward round processes, MDT meetings, enhanced focus on Long Length of Stay Reviews, oversight of NCTR delays and optimizing weekend discharges including increasing criteria led discharge activity.

# Central Norfolk Place: October 2025 Update

## In focus: Care Homes – Winter Preparedness

**Summary:** We have looked at what preventative measures can be taken to aid care home residents in being ready for winter and how the Central Team can proactively support this. This includes but is not limited to: ensuring routine checks for long term conditions; annual structured medication reviews are in place in plenty of time and using a make every contact count approach with weekly rounds and seasonal vaccination programmes.

### 1. Supporting winter resilience

- As a high priority the initial focus is on patients with respiratory conditions for who winter can have a big impact.

### 2. Identify

- Utilising ICB Business Intelligence and Eclipse data, bespoke data packs have been compiled for each practice to highlight potential outstanding asthma and COPD reviews, pneumococcal, RSV and shingles vaccinations, annual structured medication reviews and if no resus status is recorded.

### 3. Mobilise

- Engagement with the Central Practice Manager's at the beginning of the month to promote the purpose of sharing the data packs with practices, with an offer to have a discussion to explore how to use the data if practices would find that beneficial.



Parker Rachel  
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# Central Norfolk Place: October 2025 Update

## In focus: Kneu Health Digital Assessment Pilot Project – North Norfolk

### Key patient concerns identified by the Central Team Working Group included:

- Undermanagement of conditions, resulting in preventable hospital admissions & prolonged stays which can have a detrimental effect on a patient's health
- Poor patient experiences due to delays in memory assessments & annual reviews
- Lack of integrated clinical data sharing among primary, VCSE, community, and secondary care, leading to inconsistent care and difficult transitions.
- No standardised approach to assessment, monitoring, or diagnosis, creating variation and a "postcode lottery" in care quality.

**Summary:** Kneu Health “Digital Cognitive Assessment Pilot Project” initiative provides a virtual monitoring pathway for individuals with dementia. The pilot is intended to support dementia assessments and treatment pathways for patients & carers on the NFST Memory Assessment Service (MAS) waiting list in NN1, NN2, NN3, and NN4 (North Norfolk). The Ageing Well Programme Blueprint for Norfolk and Waveney is based on six objectives from the N&W Clinical Strategy and aligns with nine regional strategic goals. This pilot programme supports the Dementia Attuned Care Pillar and links to project **DEM-003**, which aims to integrate digital identification and safety netting solutions—including AI—into existing or new NHS care systems and Electronic Patient Records (EPR).

This pilot involves the onboarding of 150 participants over a 12month period. Patients will complete digital cognitive assessments, thereby reducing the demands of traditional assessments. An independent evaluation will assess the clinical impact, user experience, sustainability, and cost-effectiveness of the pilot. This pilot is a fantastic example of an ICS system including primary & secondary healthcare, local authority partners, VSCE and private sector innovation.

### 1. Treatment to Prevention:

- Improve access to early and accurate dementia diagnosis via timely assessments and referral pathways.
- Neu Health provides continuous symptom monitoring and digital biomarkers that support earlier recognition of cognitive changes, aiding in faster diagnosis.
- Neu Health collects and translates patient-specific data to support the creation of dynamic, personalised care plans.
- The platform offers caregivers insight into symptom trends and condition changes, supporting informed decision-making and reducing stress.

### 2. :Hospital to Community:

- Improve access to mental health support for dementia patients, particularly around depression and anxiety.
- Neu Health tracks mental health indicators such as mood and behavioural changes, allowing early detection and intervention.
- Promote joined-up health and social care through shared care records and coordinated services.
- Real-time, objective data from Neu Health helps clinicians track patient progress and align care delivery with our communities.

### 3. :Analogue to Digital:

- Deploy digital tools and remote monitoring to enhance care and self management.
- As a smartphone-based remote monitoring tool, Neu Health directly supports digital-first care models and patient empowerment.
- Implement feedback loops, data use, and regular reviews to refine dementia services
- Real-time, objective data from Neu Health helps clinicians track patient progress and align care delivery with quality standards.
- Neu Health collects and translates patient-specific data to support the creation of dynamic, personalised care plans.



OXFORD UNIVERSITY  
INNOVATION

# Central Norfolk Place: October 2025 Update

## In focus: My Story, My Words, My Voice



Summary: To enable cultural inclusion of people who have experienced homelessness and those with complex needs through a co-designed digital concept to communicate individuals' stories to health and care professionals.

### 1. Aim

- To reduce delays accessing health and care services for seldom heard service users.
- To request volunteer service users to co-design a digital solution that prevents them from having to repeatedly relate the soundtrack of their lives to health care professionals.
- The participants have co-dependencies and are predominantly homeless people, or those with complex needs and severe and multiple disadvantages, who can often have chaotic lifestyles which require sustained psychological safety.
- By working in partnership with the patient cohort at St Martin's and NSFT, this initiative will enable opportunities for individuals to have an audible voice and to support the development of trusting relationships with primary care and wider health teams, to return for health interventions and monitoring and promoting wellbeing.

### 2. Approach

- Working in partnership with patients who are CORE20/Inclusion Health Communities, a local housing and a Mental Health trust, this project is to enable patients to develop trusting relationships with Primary Care and wider health teams through sharing their story digitally. Specialist leads and matrix working has enabled collective leadership to deliver the project.

### 3. Summary

- Our role has been to support our group of participants to assist our digital solution provider with implementation. We will continue working with co-production groups who are helping us with the chosen method of the digital solution.
- We are working with both Primary and Secondary Care to enable a creation of a pathway into practices/services where the patients are registered to implement the chosen solution and working closely with Digital Partners to identify options for recording and implementing.
- We are also focusing on accessibility, solutions to problems, further costings scrutiny, and promoting our project within the Primary/Secondary Care Network of Norwich, aligning with Integrated Neighbourhood Teams (INT'S)



Health and Social Care – RIX Software

# Central Norfolk Place: October 2025 Update

## In focus: Central Norfolk District Direct

**Summary:** District Direct operates as a critical partner to the Central Norfolk HomeFirst Hub, providing a single point of access and co-ordination of rapid support where housing related issues may lead to an unnecessary admission or delayed discharge from hospital or bed based intermediate care. Through transformation work and utilisation of non-recurrent funding opportunities, the Central Norfolk District Direct Service has expanded beyond the core Norfolk and Waveney model to support admission avoidance activity including onsite officers at NNUH, attending ED rounds working collaboratively with EEAST, NCHC EIT, NEAT and discharge teams to promote a prompt and safe return home. Funding for the expanded model has now been jointly agreed by Health and Social Care through the BCF, providing improved sustainability. Commissioners are completing work with the Provider to finalise contract arrangements. Focus remains on continuous improvement working with the Provider and system partners to adapt and further develop the service informed by activity and outcome data.

### 1. Treatment to Prevention

- Rapid practical action is undertaken e.g. repair to a door damaged for emergency access to prevent unnecessary admissions, access to temporary housing/services to reduce the risk of homelessness and promote improved health outcomes, home adaptations and/or decluttering of homes to enable improved access, mobility and function to promote independence.
- Onward referrals made as appropriate eg for financial advice, access to DFS Grants, to Social Prescribers to remove, reduce or delay longer term care needs and the requirement for unplanned care services.

### 2. Hospital to Community

- Individuals are supported to remain or return home promptly and safely to continue recovery in the community rather than remaining in a hospital bed due to housing related issues.

### 3. Analogue to Digital

- New contract arrangements will enable a greater breadth and depth of data reporting to support future service modelling and inform the improvements necessary to support system working, pathway developments and outcomes for individuals.

# Central Norfolk Place: October 2025 Update

## In focus: Primary Clinical Engagement Group (PCEG) meeting

**Summary:** The Primary Clinical Engagement Group (PCEG) meeting seeks to foster closer working relationships between GP's and other healthcare professionals within the Central Norfolk system. Enabling a forum where knowledge can be shared and clinical questions or scenarios can be collectively explored. Creating a better understanding of some of the clinical cases in Central Norfolk

### 1. Treatment to Prevention

The group enables engagement of various organisations to come together across Central Norfolk. Increasing knowledge amongst professionals and bridging the gap between treatment to prevention. By sharing patient knowledge, we can ensure that patients are managed proactively creating a stronger focus on prevention rather than treatment.

### 2. Hospital to Community

Both Hospital and Community professionals attend the PCEG meeting which assists in knowledge sharing and reviewing patient pathways. Gaining a better understanding of patient experience and how patients may receive care closer to home in the community. The previous PCEG highlighted how aspects of Respiratory care could be better managed within Primary Care.

### 3. Analogue to Digital

The PCEG meetings are held both in person and digitally to improve access for all professionals. However, what has been highlighted in the last meeting is the constrictions different organisations may have when using different software. This brought the professionals together to better understand how we can digitally innovate and provide the best care for our patients.

Parker Raeburn  
30/10/2025 14:10:00

# Central Norfolk Place: October 2025 Update

## In focus: Old Catton Integrated Working Group & Community Event

In January 2024, an Integrated Working Development Group was born around the Old Catton population, including the GP Practice, community health, social care, district council partners, as well as Citizens Advice. Data indicated that; local families were struggling with debt, getting a meal on the table, and obesity was rising in teenagers. The surgery did not have a PPG. There had been efforts to provide finance focused clinics in the practice through previous social prescribing resource but this was not attended as hoped.

More info available here:



Old Catton Event  
- The Story



This group has strengthened relationships and built trust and are now supporting and solving problems collaboratively. This environment enables psychological safe conversations and challenge for colleagues.

### Patient Engagement

Sept 2024, the group agreed to setup up a community engagement event. At the same time, the practice ran a coffee morning for patients. Attendance was much greater than anticipated and has led to the establishment of a strong Patient Participation Group (PPG). To inform what the event might look like the group drew together a survey that was shared with the Old Catton patients. The PPG reviewed the survey before sending. 268 people responded and the most common themes/areas of interest where people would like more info and support around were: LTCs, Mental health, Finance/benefits, Menopause, Physical Activity

### Delivery

Through the vast connections made, a broad range of opportunities emerged and the scale of the community event ballooned in terms of size and scale. Using a scout hut, across the road from the GP practice, 20 different providers and services supporting across all ages, attended the afternoon. This saw representation across health, housing, mental health and a wide range of VCSE partners. Coordination of all attendees (public and services) on the day was supported by practice and ICB staff, along with PPG members

### Learning

Around 50 local people attended the event. 50% of those were registered with Old Catton GP Practice, with others being registered a more than 12 other local GP Practices. The majority of people who attended reside in the NR6 or NR7 area but a small number were from North and South Norfolk. This offered a great opportunity for services and professionals to network and learn about each other. Reflections have helped to refine future planning and the practice is now looking to host more tailored events, with the next looking to focus on Dementia. This will enable more targeted communication and will consider whether to use booking slots so that people can benefit fully from the range of services on offer.

# Central Norfolk Place: October 2025 Update

In focus: North Norfolk Health and Wellbeing Partnership's Healthy Towns and Villages model and focus on Health Inequalities in our communities

**Summary:** The North Norfolk Health and Wellbeing Partnership agreed that the theme for the new Strategy and Action Plan would be **Healthier Towns and Villages**. Working Groups were formed to progress actions. Health Inequalities data and intelligence has been used to identify key areas of focus across the district, as well as localised data for towns and villages. The Health Inequalities Toolkit has identified key themes for the district: **MSK** (musculoskeletal conditions), **Digital Exclusion**, and **Healthy Living**. **Mental health** and **health literacy** are 'golden threads' which are woven into the action plan. Population Intervention Triangles (PITs) have identified gaps in provision for these themes across the district.

## Hospital to community

- The Partnership is focused on creating the environment where local community health and wellbeing infrastructure can flourish and be sustainable.
- Partners from across the statutory sector, anchor institutions, voluntary sector, and private sector come together under the umbrella of the partnership and its Working Groups to collaborate and identify where health and wellbeing services are most needed.
- Community development is being built on previous work around **Age Friendly Communities**, **PositiviTea events**, and **Mindful Towns**.
- Asset-based community development is the method being used to build up the Healthier Towns and Villages models in each community.

## Analogue to Digital

- A key priority of the partnership is **digital exclusion**, and partners (such as local libraries, mobile libraries, GP practices, and other community groups) are collaborating to tackle this.
- Alternative methods for sharing health and wellbeing support (such as through parish and town councils, parish leaflets and magazines, through community groups and networks/word of mouth, and social prescribers) have been identified so that residents and patients that are digitally excluded can still get the care they need.

## Treatment to Prevention

- The work of the partnership is focussed on prevention at the earliest stage, particularly by focusing on the wider determinants of health and making every contact count.
- Linking together partners on a system and district level, as well as a town and village level, increases awareness of the opportunities available which promote prevention within our place.

## Progressing Central Norfolk Place Board Developments

### Progress Update:

Engagement with General Practice via PCN CDs and LMC regarding GP representation in Place discussions and planning

Engagement with VCSE regarding VCSE representation in Place discussions and wider

### Next steps:

- Further engagement with general practice stakeholders, incl. LMC etc and VCSE
- Engagement with District Councils (5 in all)
- Work with Organisational Development colleagues regarding cultural and support needs for partnership development
- Review accountability materials from 2022, including Partnership agreement
- Formalise interface with Neighbourhood Steering Group, or other relevant bodies to support development and governance arrangements.
- Set up development phase – timeline and aims etc

Stakeholders (confirmed members)	Role and Org
Tracey Bleakley	SRO – Central Norfolk Place Development (local system)
Patrick Peal	Patient voice
TBC – Alex Berry leaving w/c 22 Oct 2025 David Roberts	NNUH – system focus Clinical Strategy
TBC	West Suffolk Hospital
Sonia Kerrison	NCHC – system focus
Dr Dan Dalton	NSFT – system focus
TBC – In discussion with LMC and practices	PCN – system focus
TBC – In discussion with LMC and PCN CDs	General Practice – System focus
Dr Demola Onakoya Tracy Williams	Place steward
In discussions with VCSE Assembly Steering Group	VCSE
Mark Burgis Emma Bugg Commissioning Finance BI PHM etc	ICB
Nick Clinch Ed Fraser	Norfolk County Council
Rachel Omori (Norwich) Jamie Sutterby (South Norfolk & Broadland)	District Council
Suzanna Meredith	Public Health

## Place partner commitment to Winter Resilience 2025-26

Great Yarmouth and Waveney Place will support the delivery of the Norfolk and Waveney Seasonal Plan, and will continue to work in collaboration to support resilience across health and social care services, and in our communities this winter.

Vaccination for flu, Covid, RSV and pneumococcal viruses will be delivered to all eligible populations, supported by the weekly vaccine programme board and briefings between all providers, mutual aid across the local system and outreach into communities via the Wellness on Wheels (WOW) bus.

The ask of GY&W Place Board members is for their organisations full backing for the winter vaccination campaign evidenced by promotion of the programme's local and national comms to staff and where suitable, to residents.

A Norfolk and Suffolk ICB campaign will shortly be available for Winter, focused on vaccination and prevention, and prioritises increasing the number of patients accessing urgent care in primary, community, and mental health settings, encouraging self care and choosing the right service, and raising awareness of hardship

1/6 support and warm home initiatives.

**VISIT THE** **NHS**  
**WELLNESS ON WHEELS BUS**

**Where will the bus be visiting?**

Lowestoft - 61 London Road, Lowestoft, NR32 1LT

**18th November**  
**10am - 3pm**

**What will be on the bus to help me?**

**Vaccinations: (All dates)**

- Covid & Flu (Eligible Adults)
- Flu (Children)
- MMR
- RSV
- Whooping cough for Pregnant women
- Teenage vaccines
- Immunisation records review and missed vaccines guidance

Lowestoft PCN Team - NHS Healthchecks / Cancer Screening Awareness

## Great Yarmouth and Waveney Place Board



**Jonathan Barber, Director of Strategy & Transformation, James Paget University Hospitals NHS Foundation Trust**

*Chair – Great Yarmouth and Waveney Place Board*

**Sheila Oxtoby, Chief Executive Officer, Great Yarmouth Borough Council**

*Vice Chair - Great Yarmouth and Waveney Place Board*

## Winter Resilience: Community, Acute and Social Care

The following schemes are being developed by GYW partners with the aim of schemes being in place to support winter pressures.

- Development of front door discharge model which is a proactive, multidisciplinary approach designed to support patients in the Acute Medical Unit (AMU) and Emergency Department (ED) to safely return home, avoiding unnecessary hospital admissions. The model will include therapy, social care, community and virtual ward.
- Opening of the new Same Day Emergency Care Unit with space for 20 patients in October 2025 to ensure patients are seen by an acute medicine senior decision maker at the earlier opportunity with the aim of avoiding admission where necessary
- A range of initiatives to support a reduction in length of stay including improved board and ward round processes, utilisation of Optica to support improved communication between teams, and increased criteria led discharges
- Continued development of intermediate care capacity including processes and pathways for pathway 1, and the intermediate care beds at Carlton Court and Beccles

# GYW Place: October 2025 Update

## Case Study: Home Energy Efficiency Scheme

Working with East Suffolk Council, GYW Place has pioneered a scheme which identifies patients with chronic respiratory illness and who are living in poor quality housing through Population Health data. The scheme targets households at risk of respiratory exacerbation and increased likelihood of hospital admittance, to support access to Home energy efficiency grants. This aligns to the 3 Strategic Shifts for healthcare:

### 1. 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.

### 2. Hospital to Community:

- By working with Local Authorities and energy suppliers, we have leveraged **existing** community-based resources to shift support where it can have the greatest impact

### 3. Analogue to Digital:

- The project involves sharing Population Health Management data and data sharing techniques at scale, enabling many more households to benefit compared to conventional service delivery methods



Watch a short film on the Suffolk Healthy Homes initiative by clicking on the image above [or this link.](#)

# GYW Place: October 2025 Update

## Health Connect – Respiratory Lens

The Health Connect Service has a core team of Connectors and two further dedicated Respiratory Connectors, who together will support seasonal resilience through promoting awareness of vaccinations as part of engagement with patients. The Respiratory Connectors aim to improve quality of life and reducing readmission rates for residents with respiratory conditions. The following describes how the respiratory lens is enabled:

### 1. Identification:

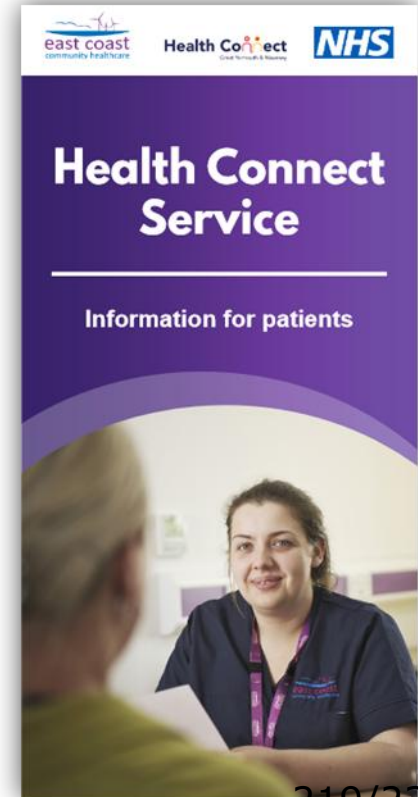
- Residents with respiratory comorbidities discharged from JPUH on pathway0 identified and referred to Health Connect. Patients may have additional complex needs and/or other long term health conditions
- Direct referrals also to Respiratory Connector if specific needs identified – direct from the ward, department or community

### 2. Engagement:

- Welfare calls to residents in the 'respiratory' cohort are more likely to result in ongoing casework and support to resident's post discharge.
- Engagement rates for respiratory cohort following a welfare call is 1 in 2, whereas core Health Connect service transition from welfare call into receiving service support is 1 in 5, on average.

### 3. Direct and Aligned delivery:

- More patients in the respiratory cohort required onward referrals to health partners inc. GP, Pharmacy, community health teams, pulmonary rehabilitation.
- Length of stay in 'Health Connect' service is longer with a higher level of f2f interactions. Service delivery aligns with partners and plays to individual strengths e.g. referrals to Warm Homes.



# GYW Place: October 2025 Update

## Focus on Vaccination

Vaccines are vital for eligible cohorts to help protect against seasonal viruses, and we are emphasising to frontline workers that vaccination reduces the risk of transmission to vulnerable patients, and helps maintain services during winter pressures.

Access to the National toolkit for the winter campaign materials is available [here](#), and Place partners are actively encouraged to make use of these resources.

Anyone can [book, change or cancel a free NHS flu vaccination at a pharmacy](#), or access vaccinations on the Wellness on Wheels Bus at the following locations (posters for each location are [available at this link](#)):

- Saturday 25th October, 9am – 2pm, Co-op, Hillside Road East, Bungay
- Tuesday 18th November, 10am – 3pm, 61 London Road, Lowestoft
- Wednesday 19th November, 10am – 3pm, Great Yarmouth Market Place
- Tuesday 25th November, 10am – 3pm, Shurblands, Gorleston



**Who is eligible for the flu vaccine this year?**

From 1 September 2025:	From 1 October 2025 :
<ul style="list-style-type: none"><li>• pregnant women</li><li>• all children aged 2 or 3 years on 31 August 2025</li><li>• Children with certain long-term health conditions (aged 6 months to less than 18 years)</li><li>• primary school aged children (from reception to Year 6)</li><li>• secondary school aged children (from Year 7 to Year 11)</li><li>• all children in clinical risk groups aged from 6 months to under 18 years</li></ul>	<ul style="list-style-type: none"><li>• everyone aged 65 years and over</li><li>• individuals aged 18 to under 65 with certain long-term health conditions</li><li>• care home residents</li><li>• carers in receipt of carer's allowance, or those who are the main carer of an elderly or disabled person</li><li>• those living with people who are immunocompromised</li><li>• frontline health and social care workers</li></ul>

# Great Yarmouth and Waveney Place Board



## Our original GY&W shared vision

*GY&W Place connects partners to enable collaborative planning, design and delivery of seamless services, to support residents to take control and live healthy, independent and dignified lives. Through integrated working, partners have a positive impact on population health by shifting to preventative services that address people's needs promptly and effectively.*

*"We want to progress our Place collaboration to enable people-centred care through services that are joined up, consistent and make sense to those who use them".*

N&W ICP Strategy commitment

Our Place Prospectus describes more of the work being delivered in our GY&W Place and future opportunities

## GY&W – Place Board membership (as of July 25)

NHS Acute Trust - James Paget Hospital Trust	Jon Barber ( <b>Chair</b> ) - Deputy Chief Executive <a href="mailto:Jonathan.barber@jpaget.nhs.uk">Jonathan.barber@jpaget.nhs.uk</a>
Gt Yarmouth Borough Council	Sheila Oxtoby ( <b>Vice Chair</b> ) - Chief Executive <a href="mailto:sheila.oxtooby@great-yarmouth.gov.uk">sheila.oxtooby@great-yarmouth.gov.uk</a>
ICB - GY&W Locality Team	Associate Director of East Place - <i>TBC</i> Rachel Hunt - Head of Place Development, Partnerships & Planning <a href="mailto:rachel.hunt6@nhs.net">rachel.hunt6@nhs.net</a> Emma Bray - Head of Place Transformation & Delivery <a href="mailto:emma.bray@nhs.net">emma.bray@nhs.net</a>
Providers of NHS Community services	Adele Madin - Executive Operational Director, ECCH <a href="mailto:adele.madin@ecchcic.nhs.uk">adele.madin@ecchcic.nhs.uk</a>
NSFT	Saru Mutema, Director of Operations <a href="mailto:saru.mutema@nsft.nhs.uk">saru.mutema@nsft.nhs.uk</a> Sarah Maxwell, Medical Director <a href="mailto:sarah.maxwell1@nsft.nhs.uk">sarah.maxwell1@nsft.nhs.uk</a> Tracey Holland, Director of Nursing <a href="mailto:tracey.holland@nsft.nhs.uk">tracey.holland@nsft.nhs.uk</a>
General Practice	Dr Sarah-Jane Lang - Clinical Advisor in GY&W - <a href="mailto:sarah-jane.lang@nhs.net">sarah-jane.lang@nhs.net</a>
Norfolk County Council (Adult Social Care)	Alison Gurney - Assistant Director, Partnerships and communities <a href="mailto:alison.gurney@norfolk.gov.uk">alison.gurney@norfolk.gov.uk</a> Michaela Hewitt - Assistant Director, East <a href="mailto:michaela.hewitt@norfolk.gov.uk">michaela.hewitt@norfolk.gov.uk</a>
Suffolk County Council (Adult Social Care)	Nick Pryke - ASC Assistant Director <a href="mailto:Nick.Pryke@suffolk.gov.uk">Nick.Pryke@suffolk.gov.uk</a> Jenny Blades - Head of Operations & Partnership (Waveney) <a href="mailto:Jenny.Blades@suffolk.gov.uk">Jenny.Blades@suffolk.gov.uk</a>
GY&W VCSE Lead Hospices	Ashley Bunn - N&W VCSE Assembly Place lead (GYW & West Norfolk) & CEO MIND, Cambridge, Peterborough and South Lincolnshire <a href="mailto:ashley.bunn@cpslmind.org.uk">ashley.bunn@cpslmind.org.uk</a> Judi Newman - Chief Executive, St Elizabeth Hospice <a href="mailto:Judi.Newman@stelizabethhospice.org.uk">Judi.Newman@stelizabethhospice.org.uk</a>
Norfolk Public Health	Dr Abhijit Bagade - Public Health Consultant <a href="mailto:abhijit.bagade@norfolk.gov.uk">abhijit.bagade@norfolk.gov.uk</a>
Suffolk Public Health	Dr Jeptepkeny Ronoh - Public Health Consultant <a href="mailto:Jeptepkeny.Ronoh@suffolk.gov.uk">Jeptepkeny.Ronoh@suffolk.gov.uk</a>
Nominated Rep from the HWPS for GY&W	Paula Boyce - Executive Director - People, GYBC <a href="mailto:paula.boyce@great-yarmouth.gov.uk">paula.boyce@great-yarmouth.gov.uk</a> Nicole Rickard - Head of Communities, ESC - <a href="mailto:Nicole.Rickard@eastsoffolk.gov.uk">Nicole.Rickard@eastsoffolk.gov.uk</a>
East Suffolk Council	Chris Bally - Chief Executive, ESDC <a href="mailto:chris.bally@eastsoffolk.gov.uk">chris.bally@eastsoffolk.gov.uk</a>
East of England Ambulance Service Trust	Peter Bumphrey - Business & Partnership Lead <a href="mailto:Peter.Bumphrey@eastamb.nhs.uk">Peter.Bumphrey@eastamb.nhs.uk</a> Jenny Stocking - Locality Area Manager <a href="mailto:Jenny.Stocking@eastamb.nhs.uk">Jenny.Stocking@eastamb.nhs.uk</a>
Additional Support	Oliver Cruickshank - Head of Communications & Engagement, JPUH <a href="mailto:oliver.cruickshank@jpaget.nhs.uk">oliver.cruickshank@jpaget.nhs.uk</a> Toni Penson - ICB East Place Administrator, N&W ICB <a href="mailto:toni.penson@nhs.net">toni.penson@nhs.net</a>