

Patients and Communities Committee

Mon 20 May 2024, 15:00 - 17:00

Virtual via Microsoft Teams

Agenda

15:00 - 15:00 **Meeting Agenda**

0 min

 00. Patients and Communities Committee - May - Final.pdf (2 pages)

15:00 - 15:00 **1. Chair's Welcome and apologies for absence**

0 min

Aliona Derrett

15:00 - 15:00 **2. Declarations of Interest**

0 min

For noting *Aliona Derrett*

To declare any interests specific to agenda items

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

15:00 - 15:00 **3. Minutes from previous meeting and matters arising**

0 min

Approval *Aliona Derrett*

To approve the minutes of the previous meeting (25.2.24)

 03 NW ICB PC Committee Minutes 25.03.24 DRAFT.pdf (12 pages)

15:00 - 15:00 **4. Action log**

0 min

Review, update, and approval *Aliona Derrett*

To note any outstanding actions from the previous meeting not yet completed

 04 Action log.pdf (1 pages)

15:00 - 15:00 **5. Lived Experience Representation**

0 min

Discussion *Karen Barker and Mark Burgis*

15:00 - 15:00 **6. ICB Long Term Dental Plan 2024-2029**

0 min

Information *Fiona Theadom*

 06a 20052024 Dental Plan P&C.pdf (7 pages)

 06b Long-Term Dental Plan - Summary slides.pdf (14 pages)

 06c Summary report Dental Long-Term Plan engagement.pdf (15 pages)

15:00 - 15:00 **7. VCSE Integration Programme and Assembly Update**

Parker Rachael
16/05/2024 16:35:18

0 min

Endorsement

Emma Ratzer and Mark Burgis

-  07a VCSE Integration Programme & VCSE Assembly_PCC_20.05.24.pdf (4 pages)
-  07b VCSE Assembly Development Proposal_Apr24_V4.0.pdf (25 pages)
-  07c VCSE Assembly Development Proposal_ Slides for P&CC.pdf (13 pages)

15:00 - 15:00

0 min

8. People and Communities Approach Refresh

Endorsement

Emily Arbon

-  08a 2024.05.24 Cover sheet P&C Approach_Co-Pro FINAL.pdf (3 pages)
-  08b 2024.04.02 NWICS People Communities Approach WORKING DRAFTv11.pdf (30 pages)

15:00 - 15:00

0 min

9. North Norfolk Place Board Update

Information

Dr James Gair and Heather Farley

-  09a North Norfolk Presentation - PCC - 20 May 24.pdf (12 pages)
-  09b NN Presentation - PCC - 20 May 24.pdf (13 pages)

15:00 - 15:00

0 min

10. Population Health and Inequalities Board Update

Noting

Dr Frankie Swords

-  10a 2024.04.16_PHI Board Report Cover Sheet.pdf (2 pages)
-  10b 2024.04.16_PHI Board Assurance-Escalations- v3 FS.pdf (2 pages)
-  10c PHMI Programme RR - April 2024.pdf (21 pages)

15:00 - 15:00

0 min

11. Ageing Well Programme Board Update

Noting

Dr Frankie Swords

-  11a Ageing Well Programme Report to PC Committee - 20.05.2024 v0.3.pdf (6 pages)
-  11b Escalation Report to P&C Committee 20.05.2024.pdf (1 pages)

15:00 - 15:00

0 min

12. Healthwatch Updates

Noting

Andy Yacoub and Alex Stewart

-  12a Healthwatch Suffolk Update 1.pdf (3 pages)

15:00 - 15:00

0 min

13. Any Other Business

Aliona Derrett

13.1. Norfolk and Waveney Health Inequalities Strategic Framework for Action

Approval

Tracy Williams

-  13a HI Framework_20.5.24.pdf (4 pages)
-  13b N&W Health Inequalities Strategic Framework for Action.pdf (22 pages)

Parker Rachael
16/05/2024 16:35:18

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

Monday 20 May 2024, 1500-1700hrs

Meeting to be held via MS Teams

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	Lead
1	15:00-15:15	Chair's welcome and apologies for absence	Chair
2		Declarations of Interest To declare any interests specific to agenda items <i>For noting</i>	Chair
3		Minutes from previous meeting and matters arising To approve the minutes of the previous meeting (25.3.24) <i>For approval</i>	Chair
4		Action log To note any outstanding actions from the previous meeting not yet completed <i>For review, update, and approval</i>	Chair
5	15:15	Lived Experience Representation <i>For discussion</i>	Karen Barker & Mark Burgis
6	15:30	ICB Long Term Dental Plan 2024 – 2029 <i>For information</i>	Fiona Theadom
7	15:45	VCSE Integration Programme and Assembly Update <i>For endorsement</i>	Emma Ratzer & Mark Burgis
8	16:00	People and Communities Approach Refresh <i>For endorsement</i>	Emily Arbon
9	16:15	North Norfolk Place Board Update <i>For information</i>	Dr James Gair & Heather Farley
Standing Items			
10	16:30	Population Health and Inequalities Board Update <i>For noting</i>	Dr Frankie Swords
11	16:35	Ageing Well Programme Board Update <i>For noting</i>	Janice Shirley & Stephanie Dibley
12	16:40	Healthwatch Updates <i>For noting</i>	Alex Stewart Andy Yacoub

.13	16:50	Any Other Business 13.i Norfolk and Waveney Health Inequalities Strategic Framework for Action	Chair Tracy Williams
Date, time and venue of next meeting: Monday 22 July 2024, 1500-1700hrs via MS Teams			
Any queries or items for the next agenda please contact: rachael.parker9@nhs.net			

Parker Rachael
16/05/2024 16:35:18

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 NHS FT				Indirect	My son-in-law, Richard Wharton, is a consultant surgeon at NNUHFT	2004	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Hear Norfolk	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	Present	
		Derrett Consultancy Ltd	X			Direct	I am the Director of Derrett Consultancy Ltd	2018	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
		MIND				Indirect	My husband, Robin Derrett, is the HR Director at Norfolk & Waveney MIND. MIND holds contracts with the N&W ICB	2021	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		MoldovaDAR Ltd	X			Direct	I am Director of MoldovaDAR Ltd	2019	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
		St Stephen's Gate Medical Practice			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Catherine Armor	Non-Executive Member, Norfolk and Waveney ICB	Educational Association			X	Direct	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
		Norwich University of the Arts			X	Direct	Deputy Chair of Council, Norwich University of the Arts	2019	Present	
		Evolution Academy Trust			X	Direct	Trustee, Evolution Academy Trust	2022	Present	
		Cambridge University Press Pension Schemes		X		Direct	Trustee, Cambridge University Press Pension Schemes	2018	Present	
		East of England Ambulance Service NHS Trust				Indirect	Daughter-in-law is Technician for East of England Ambulance Service NHS Trust		Present	
		Brundall Medical Practice			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Paula Boyce	A representative from the Health and Wellbeing Partnerships	Great Yarmouth Borough Council	X			Direct	Employee of Great Yarmouth Borough Council	2023	Present	To be raised at all meetings to discuss prescribing or similar subject. Risk to be discussed on an individual basis. Individual to be prepared to leave the meeting if necessary.
		Emmaus, Norfolk and Waveney			X	Direct	Trustee and Board member of registered homeless charity Emmaus, Norfolk and Waveney	2023	Present	
Paul Benton	Director of Quality for care	Nothing to declare					N/A			N/A

Parker Rachael
16/05/2024 11:35:48

Mark Burgis	Executive Director of Patients and Communities, Norfolk and Waveney ICB	Drayton Medical Practice			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Lakenham Practice				Indirect	Wife is Nurse Prescriber who is currently undertaking occasional locum work at Lakenham Practice in Norwich	Aug-21	Present	Declare at any relevant meetings and remove myself from any significant discussions or decisions relating to the practice
Suzanne Meredith	Associate Director – Population health Management	Norfolk County Council	X			Direct	Employed by Norfolk County Council as Deputy Director of Public Health	2014	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		UKPHR		X		Direct	As part of Public Health professional requirements - Fellow of the Faculty of Public Health and professional registration on UKPHR	2014	Present	
		Hellesden Medical Practice			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Emma Ratzer	Partner Member - VCSE	Access Community Trust	X			Direct	I am the Chief Executive Officer of Access Community Trust, an organisation which holds contracts with NWICB	2009	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards Community Access Trust
		VCSE Assembly			X	Direct	I am CEO of a voluntary sector organisation operating in NWCCG and Independent Chair of NWVCSE Assembly	2021	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
Alex Stewart	Chief Executive, Healthwatch Norfolk	Member of Holt Medical Practice			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Dr Frankie Swords	Executive Medical Director, Norfolk and Waveney ICB	Norfolk and Norwich University Hospitals		X		Direct	Honorary Consultant Physician and Endocrinologist at Norfolk and Norwich University Hospitals NHS FT (1 day a week)	2008	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest
		Multiple patient charities		X		Direct	Ad hoc Clinical Advisor for multiple patient charities - Addison Self Help Group - Pituitary Patient Support Group - Turner syndrome Society	2008	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest
		British Medical Association		X		Direct	Member of the British Medical Association	1999	Present	Inform Chair and will not take part in any discussions or decisions relating to BMA
		Emerging Futures and St Martin's Housing Trust				Indirect	Husband is a mental health counsellor and undertakes work independently and with the private provider Better Help, and VCSE providers: Emerging Futures and St Martin's Housing Trust	Sep-22	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of counselling services by Emerging Futures, St Martin's Housing Trust or Better Help

Parker Rachael
16/05/2024 16:35:18

		Long Stratton Medical Partnership			X		Patient at a Norfolk and Waveney GP Practice	Ongoing	To be raised at all relevant meetings where discussions/decisions relate to the conflict declared	
Tracy Williams	Health Inequalities Advisor	One Norwich Practices	X			Direct	Employed 10 hours a week by One Norwich Practices as a clinical Lead in the Inclusion Hub for vulnerable adults service .PCN Health Inequalities lead	Jul-20	Present	All potential conflicts are declared at each meeting. For any related items, individual would not participate in discussions, voting, procurements etc
		Norfolk and Norwich University Hospital		X		Direct	Clinical lead for Health inequalities and inclusion health N&W ICB , Attend Quality and Safety Committee and ICP Partnership/H&WB Board, Norwich Place Clinical Adviser	Apr-23	Present	
		Queens Nursing Institute		X		Direct	Member of the Queens Nursing Institute	2012	Present	
		Royal college of Nursing		X		Direct	Member of the RCN	1987	Present	
		Faculty of Homeless and Health Inclusion		X		Direct	Member of the Faculty of Homeless and Health Inclusion awarded an Honorary fellowship March 2022	2014	Present	
		Norfolk and Norwich University Hospital				Indirect	Sister employed registered nurse at NNUH		Present	
		Norfolk and Norwich University Hospital				Indirect	Brother employed in an administration role at NNUH		Present	
Andy Yacoub	Chief Executive, Healthwatch Suffolk	Nothing to Declare	N/A				N/A	N/A	N/A	
Tricia D'Orsi	Executive Director of Nursing	tbc								

NHS Norfolk and Waveney Integrated Care Board
DRAFT Minutes of the Patients and Communities meeting
Held on Monday 25 March 2024
Meeting in Public

Committee members present:

- Aliona Derrett (AD), Non-Executive Director and Chair of the Patients and Communities Committee, NHS Norfolk and Waveney Integrated Care Board
- Mark Burgis, Executive Director of Patients and Communities, NHS Norfolk and Waveney Integrated Care Board
- Suzanne Meredith (SM) Deputy Director of Public Health, Norfolk County Council and Associate Director of Population Health Management, NHS Norfolk and Waveney Integrated Care Board
- Tracy Williams (TW), Clinical Lead for Health Inequalities and Children, Young People and Maternity, NHS Norfolk and Waveney Integrated Care Board
- Cathy Armor (CA), Non-Executive Member and Deputy Chair of the Patients and Communities Committee, NHS Norfolk and Waveney Integrated Care Board
- Andy Yacoub (AY), Chief Executive Officer, Healthwatch Suffolk
- Dr Frankie Swords (FS), Executive Medical Director, NHS Norfolk and Waveney Integrated Care Board
- Emma Ratzer (ER), Chief Executive Officer, Access Community Trust and representing the VCSE
- Alex Stewart (AS), Chief Executive, Healthwatch Norfolk

Participants and observers in attendance:

- Amrita Kulkarni, Senior Programme Manager, NHS Norfolk and Waveney Integrated Care Board for item 8
- Nadia Jones, Public Health Principal – Prevention, Norfolk County Council for items 8 and 11
- Dr Sarah Gentry, Public Health, Norfolk County Council for item 7
- Jon Punt, Complaints and Enquiries Manager, NHS Norfolk and Waveney Integrated Care Board for item 6
- Carly West-Burnham, Director of Strategy and Integration, The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust for item 9
- Luke Bacon, Research and Business Development Officer, Healthwatch Suffolk for item 10i
- Shelley Ames, Senior Integration and Partnerships Manager, NHS Norfolk and Waveney Integrated Care Board for items 5 and 8

Attending to support the meeting:

- Rebecca Champion (RC), Senior Communications and Engagement Manager (Partnerships), NHS Norfolk and Waveney Integrated Care Board, and for item 13
- Rachael Parker (RP), Executive Assistant, NHS Norfolk and Waveney Integrated Care Board (Minutes)

Parker Rachael
16/05/2024 16:35:18

1.	Chairs welcome and apologies for absence	
	Aliona Derrett (AD) began by welcoming everyone to the Patients and Communities Committee. AD reminded attendees that the committee is a meeting in public (not a public meeting) and encouraged people to send questions relating to the agenda in advance of the meeting. Any questions raised during the meeting which the committee were unable to answer would be followed up after the meeting. Apologies for absence had been received from Karin Bryant, Associate Director of Local Commissioning, NHS Norfolk and Waveney Integrated Care Board, and Paula Boyce, Executive Director – People, Great Yarmouth Borough Council.	
2.	Declarations of Interest	
	None declared.	
3.	Agree Minutes from the Previous meeting and Matters Arising	
	The minutes of the previous meeting were approved as an accurate record	
4.	Action Log	
	The action log was reviewed, and the updates added to the log accordingly.	
5.	Spotlight on: Great Yarmouth – Insights and Experiences	
	AD welcomed Shelley Ames (SA) to the meeting to provide an overview of the Community Voices (CV) insights generated from Great Yarmouth and key themes. A presentation had been circulated in advance of the meeting that was taken as read. It was noted that the ICB and Healthwatch Norfolk had been exploring working together on CV and HWN is now part of the CV steering group. The primary purpose of CV is to improve access to services by listening and feeding back insights into the central bank, to strengthen understanding of a particular place or thematic area. Alex Stewart (AS) shared with the committee details of some specific work in Great Yarmouth speaking to groups and families for whom English was not their first language. AS highlighted an appalling encounter for a Ukrainian family who had been using interpreters to communicate with a practice which resulted in an unsatisfactory outcome for the family (that was resolved swiftly). AS also highlighted an issue relating to interpreters not being booked to support people with hearing impairments attend GP appointments therefore rendering the appointment completely useless. AS also mentioned the work being undertaken to help general practice have a better understanding of health inequalities. Some practices in north Norfolk had already received training which had been well received. Questions and comments from committee members: AD was pleased that SA and AS had discussed the similarities and differences between the two projects to demystify any misunderstanding.	

Parker Rachael
16/05/2024 16:35:18

- AD sought clarification that in relation to CV and the prevention and early intervention element, it is not the ICB who delivers those elements, but it is delivered via organisations who have connections with and understanding of their local communities. SA confirmed this was correct.
- AS made the comment that one thing the system doesn't do particularly well is accountability. Strategies are being published but baseline information is not being looked at properly, and until it is it will be difficult to determine if progress is being made. AD supported AS comment adding we should know what we're going to measure from the outset. Having strategies in place without knowing what and how we're going to measure is a weak strategy.
- AD shared concerns linked to AS comment regarding interpreters and accessibility, highlighting the Disability Discrimination Act which is a legal requirement, and also the NHS Accessible Information Standards Framework which practices, trusts and the ICB must comply with and implement. AD added there is not really any excuse for anyone not getting the right support whether that be language, physical or whatever, to be able to access their healthcare.
- Frankie Swords (FS) commented CV was an incredibly valuable bank of information. If people know about the CV, they may not have to undertake a separate engagement exercise as we will often already have that insight.
- FS highlighted where the CV partners had been used in a completely different way linked to research, identifying the barriers for people joining in research and how can we design our research better to be more inclusive. FS gave an example of a project looking at how to include people in medical research who lack capacity e.g., people who are end of life or those people systematically excluded from research, because it's difficult to get their consent for whatever reason.
- Mark Burgis (MB) commented the real success is when we take this information and do something with it for our population. The bank of information is so valuable, and we can really start to make a difference for people.
- Tracy Williams (TW) agreed with previous comments regarding ensuring the information is acted upon. The join up with the work Healthwatch Norfolk and Healthwatch Suffolk are doing will help where there are areas which need more focussed work. TW felt there was also an element of triangulation with some of the complaints we might receive and some of the concerns from our patient and communities, not only to the ICB but to provider organisations and this needs to be linked together. We also we need to ensure that we're not missing out any underserved communities with some of those insights.
- AS praised the complaints team who have been invaluable in supporting Healthwatch with queries and reassured TW that Healthwatch and the complaints team do work collaboratively.
- AD requested that SA work with Andy Yacoub (AY) and Healthwatch Suffolk to replicate the information provided today for Waveney, to provide a full picture for Great Yarmouth and Waveney Place. AD encouraged both Healthwatch's and CV to continue working together and is looking forward to hearing how the partnership develops.

The update was noted.

Parker Rachael
16/05/2024 16:35:18

6.	Complaints Report	
Parker Rachael 16/05/2024 16:35:18	Jon Punt (JP) introduced the report which had been circulated ahead of the meeting and was taken as read. JP highlighted the exponential rise in formal complaints received by the complaints team, which was a direct result of full delegation of handling complaints and concerns regarding primary care from NHS England to ICBs. JP also highlighted the nature of the enquiries being received, and the way in which members of the public present themselves towards the complaints team - they can be incredibly frustrated and have an expectation of primary care services that isn't necessarily always able to be delivered. JP also felt there might be some expectation and reality issues in terms of the complaints team's ability to deliver messages, which has become difficult because people are very frustrated with the services that they have received. Questions and comments from committee members: • AD was upset to see the staff attitude for continuing healthcare as being one of the reasons for complaints. • FS offered congratulations to JP for the improvement in target response times with 78% of complaints now receiving a response within the target, and every complaint is acknowledged within time which has a huge impact on the experience of those people who've taken the time to feedback. • FS asked if statistical process control (SPC) charts could be used in future reports to plot numbers and to identify themes over time. JP acknowledged FS request and advised SPC charts had previously been considered but was not felt to be beneficial at that time due to the irrelevance of the data, however SPC charts will be used from 1 July. • MB thanked JP for the report and offered congratulations on the response times. MB reflected on the themes in the report and how access and communication is a real challenge; many of our teams are currently battling to sustain services and having to take quite extraordinary steps and efforts, for example dentistry. MB felt it was important to consider how some of the strong themes that are coming through to the complaints team are taken forward and swiftly brought to this committee; it's important the committee has sight of things quickly and as soon as they arise. MB encouraged JP to link with the committee on this. AD agreed with MBs comment. • TW reflected on the complaints coming through for primary care, general practice, and dentistry, and how it correlates to what AS and HWN have experienced, as well as some of the insights around access. TW felt the detail of those insights should be shared with primary care colleagues as some of them might be simple things that can be easily corrected. • JP agreed with TW adding there are some very good GP practices in terms of how they manage their inbound demand, even though their issues around the availability of appointments and capacity are the same. Should we be identifying where there might be pockets of good practice and seeing if that shared learning can be taken into Places. • AD agreed with JP and felt that HWN and HWS might be able to help with that but bringing thinking together and supporting each other is a very good step forward. • AD asked about those complaints that go directly to the ICB without going through the provider of the service – are they sent back to the provider or	

	are they asked to raise a complaint with the provider first. JP explained the national complaints regulations are quite specific, that people have the right to complain to either the provider or the Commissioner, but not both. However, the complaints team will look at it on a case-by-case basis and see what is probably the best outcome for that complainant. • AY added that for all complaints, Healthwatch are the last resort because and as soon as a complaint becomes formal, Healthwatch are unable to intervene. Whereas if it's a comment that's being shared with Healthwatch, and if you can direct people to us more so through provider or commissioning websites, we can potentially signpost people, and there are chances for moderation that might lead to a resolution before it becomes a complaint. AS added in Norfolk, HWN has direct links with every GP practice already and is on their websites, and practices will automatically direct people to HWN if they have a query. From our statistics we know that people are doing that. The report was noted.	
7.	Population Health Management Strategy	
	Suzanne Meredith, Associate Director for Population Health Management for the ICB and Deputy Director of Public Health for Norfolk County Council and Dr Sarah Gentry presented this item. A paper had been circulated in advance of the meeting which was taken as read. SG highlighted some key points. The Population Health Management Strategy was developed as a collaborative process involving several engagement events. The reason for developing a population health management strategy was that the Norfolk Waveney Joint Forward Plan contains an objective under ambition one to develop a strategy by the end of March 2024. The strategy that has been circulated was developed through engagement events. The output from all the engagement events were collected and analysed to identify key themes and these have been incorporated throughout the strategy. The strategy was developed and overseen. the PHM oversight group and the content has been endorsed by the Population, Health and Inequalities Board. Questions and comments from committee members: • FS thanked SM and SG in particular for leading the superb engagement process to build the strategy and helping people understand what was required, because there is a lot of confusion around the difference between population health, health inequalities and risk stratification. • AS really liked the strategy but was confused about who was aimed at. SM advised that in general it was aimed at stakeholders and professionals within the ICB. • CA asked how would recurring problems or concerns e.g., inadequate housing for people in temporary accommodation be flagged within the system and how does it all join up? SM advised there is join up; there are close links with the health inequalities framework, and we will be working with the health inequalities team to develop programmes of work, and using linked up data to identify people who would benefit from certain interventions.	

Parker Rachael
16/05/2024 16:35:18

	- AD asked how will local people and the VSCE organisations be involved in the implementation of the strategy. SM advised that local people will be involved during the project planning phase and local involvement will depend on the project and who needs to get involved. AD suggested this was made clearer in the strategy document to avoid any misunderstanding. Agreed: The Patients and Communities Committee: - Received and approved the Population Health Management Strategy	
8.	Community Voices Update	
	Shelley Ames (SA), Amrita Kulkarni (AK) and Nadia Jones (NJ) presented this item. A presentation had been circulated in advance of the meeting which was taken as read. SA and AK provided the committee with a brief overview of the Community Voices work to date including some of the specific projects, several of which had already been completed and evaluated. Several projects are in progress at the moment, but no insights have been collected as yet. There are two projects in pipeline one is focused on Women's Health and the other is looking at how access to the targeted lung health checks in Great Yarmouth and Waveney can be improved. NJ gave the perspective of an organisation that has used the CV service for a project relating to smoking cessation and improve understanding of what the barriers and enablers are for people who are smokers. The CV work helped NCC to understand what the evidence base is for the services that are currently commissioned. Questions and comments from committee members: - AD asked in relation to the access to bowel screening project, had the outcomes been measured for the individuals who took part. SA advised the outcomes had not been measured as CV doesn't collect any personal identifiable information. The most important element was the engagement but that does limit the ability to follow up with individuals. - AD commented that is important to strike the right balance in supporting people and ensuring they get access to whatever they need without us necessarily knowing the outcome. But we need to ensure we have some understanding of the impact, not necessarily at a personal level. - TW added that those outcomes that impact are important. There is work ongoing with the voluntary sector through this approach, to upskill and support the voluntary sector to make those contacts count. The update was noted.	
9.	Place Board Updates – West Norfolk	
	MB introduced Carly West-Burnham (CWB), Director of Strategic and Integration at The Queen Elizabeth Hospital, who would be presenting the West update. MB and CWB had prepared some slides which had been circulated in advance of the meeting and were taken as read.	

Parker Rachael
16/05/2024 16:35:18

MB gave a brief outline of the role of Place which, simply put, is where much of the work gets done. Place-based partnerships bring together the NHS, local councils, voluntary organisations, residents, people who access services, carers, and families. These partnerships will lead the design and delivery of integrated services in their local area. The plan is to bring to the committee more examples of some of the work that is happening at Place because much of this work is not very visible to the rest of the system. By bringing it here as part of this committee's work, MB is hoping that will bring some real fullness and reality to some of the work that is happening.

CWB thanked the committee for opportunity to attend and speak on behalf of the West Place Board. CWB highlighted the key messages from West Norfolk. CWB advised the West has a strong and well-established Place Board which works very closely with its Health and Wellbeing Partnership. The complexities in the West are recognised, particularly from an acute perspective with the crossover into the borders for Cambridge, Peterborough, and Lincolnshire. So, it is important these are reflected.

In relation to the work in the West CWB advised there are some positive examples given the limited budget that Place currently has around the Community Transformation fund, and also the work that is happening within local communities. For example, out of hours palliative care support, leg ulcer nurses going out and supporting primary care, and care home support. Looking forward into the next financial year CWB felt the current positioning within the ICB is helpful for Place. The West has identified several priorities and some significant areas that it will need to focus on. Having a cohesive Marmot Town framework in place will really help the West along with wider system integration and the ICB support of Place to deliver, and ensuring the right conversations are happening in the right place rather than duplicating our efforts.

Questions and comments from the committee:

- TW felt the Health Inequalities Strategic Framework provided a good opportunity to link up between all five Place Boards and our partnerships which had been lacking for some time. TW was concerned that Place has been 'lost' a little because of time taken to get to its current position.
- TW felt it worth noting the dynamics of the central collaborative; the three Places within that are slightly different but the collaborative is certainly working collectively to prevent duplication.
- SM could see Population Health Management and Place working together in terms of Place being the point where interventions are planned and delivered in accordance with what meets the local requirements. SM will look at ensuring that colleagues working at Place level are able to access the data hub and anything else they need in order to look at the health needs of the local Place populations.
- MB admired the passion and enthusiasm at a Place level to drive and deliver change for the population and we really need to support that. He agreed with TW challenge around place losing its way, but MB felt the teams now in place across Norfolk and Waveney were getting behind the agenda. MB added there is a Director of Place role in the new ICB structure which will help to clarify where we're going and will work with colleagues across the system.

Parker Rachael
16/05/2024 16:35:18

	CWB added the West publishes a regular newsletter and is keen to share this more broadly, and to also have the conversations with colleagues because there is a real difference being made by partners working more collaboratively together. The update was noted.	
10.	Healthwatch Updates	
	i. Healthwatch Suffolk – Children and Young People’s Asthma Support in Waveney Luke Bacon (LB), Business Development Officer at Healthwatch, Suffolk introduced the item about a piece of research commissioned by Norfolk and Waveney linked to young people’s experiences with asthma. This was developed from a project commissioned originally by Suffolk and North East Essex ICB in collaboration with Healthwatch Essex. A paper and report had been circulated prior to the meeting which was taken as read. LB highlighted the three key messages from the report: - Promote the use of asthma plans - Provide accessible information about asthma to families and schools - Ensure appointments are accessible, follow up from hospital admission and a yearly asthma review Questions and comments from committee members: - AD asked where the report had been shared and what were the reasons for people not understanding their asthma plan. LB advised the report was promoted through social media, Facebook, Instagram and Healthwatch Suffolk website but LB was unsure with whom at the N&W ICB it had been shared. It had also been distributed to libraries, hospital leads and GP practices who were encouraged to share it. LB did not have the information to hand regarding the reasons for people not understanding their asthma plan. - AY added that consultants at Colchester and West Suffolk Hospitals were also involved in the project and have taken on board the report findings. - AD thanked AY and added the JPUH will be covering Waveney families potentially and hoped the report had been share with the Trust to share with its asthma specialists. - TW added that for one of the Community Voices projects, which is specifically working with children and young people, it would be good to join up some of HWS insights with the project to see what the system picture really is. - FS thanked HWS for the work on this project and asked for the report to be shared with the ICB CYP team. ii. Healthwatch Norfolk AS had provided a comprehensive update in advance of the meeting which was taken as read. In addition, AS highlighted that HWN is looking at introducing Power	

Parker Rachael
16/05/2024 16:39:18

	BI into its work. Brief analysis of the reports HWN has written demonstrates it has spoken to over 46,500 people which shows the breadth of work that Healthwatch is involved in. AS felt that by getting intelligence in a much more cohesive manner, would mean better value for money. Questions and comments from committee members: - AD asked how HWN approach obtaining patients ratings of surgeries. AS advised it was done in two ways, there will be passive ratings where the people will just come into HWN enquiries inbox, and they will say they will make a comment about the surgery. The other way in which HWN pick up intelligence is via the engagement team who will go out to a variety of places regularly and talk to patients on a one-to-one basis. - AS explained that the scoring is shared with Sadie Parker, the ICB Director of Primary Care. For example, if there is an area or a group of practises that we know are having problems, HWN will contact Sadie directly with its concerns and Sadie and the primary care team are invariably already well aware of what's going on, which could be lack of GPs or practice nurses. HWN will also attend Practice Manager meetings and share the good practice that's happening that it is picking up on. The report and updates were noted.	
11.	Health Inequalities Framework	
	Tracy Williams introduced Nadia Jones – Public Health Principal from Norfolk County Council who would be supporting TW with today's presentation. TW thanked NJ and SA for their role in developing the framework. TW advised the framework responds to the Joint Forward Plans requirement to develop a Health Inequalities Strategy by 1 April 2024. The framework has been designed following significant engagement across the ICS with over 100 organisations contributing, including the Place Boards, Health and Wellbeing Partnership and voluntary sector forums throughout the ICS. It is a collaborative approach and Public Health has had significant input into the planned approach. The Framework was presented to the Integrated Care Partnership on 6 March and received full endorsement by the partnership. The Framework was being brought to today's Patients and Communities Committee for endorsement along with a commitment to providing leadership and advocacy to the framework. The committee will receive regular updates of progress and delivery and will be asked to provide oversight as required. NJ highlighted some of the priority action areas undertaken during the first year to help reduce unwarranted variation in the way in which services are delivered. It was recognised the system hadn't necessarily been unified in its approach to date and the new framework would hopefully resolve that and it had been designed to be as simple as possible. Questions and comments from committee members: AD asked in relation to the participation action, what provision is being made for those people who do not belong to or engage with Community Voices or voluntary sector partners to enable them to contribute? NJ	

Parker Rachael
16/05/2024 16:35:18

	advised that most organisations, if not all, have some kind of engagement with communities or data and intelligence, but we need to recognise that we might not necessarily utilise it as well as we might. This is where Community Voices comes in, reaching out to those communities that traditionally wouldn't be heard. Services should know who they are not speaking to and have a good understanding of where those health inequalities are. With the level of data already available NJ is reasonably confident that overall, we have a good idea of the areas to target and will approach these by utilising structures such as Community Voices and the VCSE assembly. - ER provided further context by advising the framework forms quite a significant part of the VCSE Assembly work plan that is being worked on currently and will come to this committee in May. All members of the Assembly Board have been involved and worked very hard with the health inequalities team to get the framework this far. The model the assembly is working on for the next 12 months is built around this framework so that some of the areas TW and NJ have talked about in terms of getting those more challenging people to engage with, ER would hope that some of that comes out in the Assembly model going forward. - AD asked what tools will be put in place to monitor the outcomes. TW advised Suzanne Meredith was closely involved for Population Health Management and the data hub. Shelley Ames added that we need to be realistic about the timeline in which we're going to see impact on some of the outcomes e.g., life expectancy. Agreed: The Patients and Communities Committee: - Received and endorsed the Health Inequalities Framework	
12.	Population Health and Inequalities Board Update	
	FS updated, in terms of the Population, Health Management and Health Inequalities Board, there are three positives and two concerns. The first positive is that both the Population Health Management Strategy and the Health Inequalities Framework for Action have been recommended for approval / endorsement. The second positive is the need to procure new population, health management software which is finally progressing well and will be a vital tool. The third positive is to acknowledge the ICB vaccination programme and colleagues in that team, because the COVID and Flu vaccination programme last winter ranked first in the East of England and third in the whole of England. The two concerns which need escalating relate to: - The risk around long-term ring-fence funding of Health Inequalities funding and the difficulties in reserving funding for this area. It is an ongoing challenge, and it is important the committee is aware of it. - There is still no real robust mechanism through the PMO for recording and undertaking quality impact assessments. We're getting a lot of help and advice and are hoping to have a good update next month, but that is an area of risk for us as an ICB. Questions and comments from committee members:	

Parker Rachael
16/05/2024 16:35:18

	- AS asked how the ICB would be promoting the news regarding the vaccination programme and when the next round of Covid vaccinations will commence. FS advised the ICB follows the national vaccination programme and is currently awaiting further guidance on the new round of Covid vaccinations. RC confirmed the Comms and Engagement Team would be happy to promote the success of the vaccination programme. - AD sought confirmation that FS was escalating Risk HI05 to the committee. FS confirmed this is correct and felt the committee needed to be sighted on this risk. AD asked MB to ensure risk HI05 was added to the Patients and Communities Risk Register. - AD asked for the full PH&HI Board Risk Register to be shared for awareness with the PH&HI Board report for the next committee. Action: Risk HI05 - No HI ring fencing of NHSE funding allocations to be added to the Patients and Communities Risk Register Action: PH&HI Risk Register to be shared for awareness with the PH&HI report for the next meeting The update was noted.	MB FS
13.	Ageing Well Programme Board Update	
	FS introduced the item, explaining that at the previous meeting the committee had approved the Ageing Well Strategic Framework and the framework was now being implemented. An update had been circulated in advance of the meeting which was taken as read. Questions and comments from the Committee: - MB was supportive of the numerous different projects going on in care homes and welcomed the recent discussions at the North Place Board. FS added that each Place should be using the ageing well strategic matrix to identify any support needs. - CA asked if the funding for this work is part of the normal ICB funding, or is it special funding and is there a risk it could be switched off at some point putting the strategy in jeopardy. FS advised there was no funding for the work, it's about doing things differently and using existing resources in a more coherent and more coordinated way. But it is one of the Joint Forward Plan priorities, so it does need prioritising. - AD asked in relation to the care homes workstream and the second objective, why is hearing not mentioned, particularly for those people in care homes whose hearing has deteriorated due to the ageing process. AD was surprised that the whole issue about healthy hearing did not appear in this programme somewhere. FS advised the care home work stream is the highest priority and although it has not been listed in the strategy dealing with poor hearing is certainly part of that work. The update was noted.	
14.	Any Other Business	
	14.1 People with Lived Experience Recruitment – Update	

	Rebecca Champion (RC) provided an update on the current position regarding the recruitment of lived experience representatives for the Patients and Communities Committee. • The representatives were going to be included under the ICB general rewards and recognitions policy and would be offered financial rewards and significant support. • Following the example of other Trusts, the ICB tried to pursue HMRC to assist with tax, National Insurance and other issues so that people on benefits would still want to come forward, and would not be financially disadvantaged by doing so. • HMRC have come back on several occasions and asked questions and the ICB has tried to answer those questions. There is also some regional work looking at policies - it's an issue for all ICBs. • All the recruitment materials are sitting ready, we just need to know what is the status of the people recruited, because they are different to everybody else that comes to this committee at present. Questions and comments from the committee: • AD commented it is disappointing that HMRC haven't given any real guidance, but the time has come to revisit this issue, not just for this committee, but across the ICB because through different strategies we are talking about involving our population through co-production and as contributors. However, this will not happen unless there are proper policies and processes in place to ensure people can get involved without any detriment to their financial position. We need to look at the ICB wide position and take some steps because we've made the commitment to have people with experience as part of our committees, and we want them to participate in other pieces of work, so this must be resolved. Action: AD / MB / CA to revisit and discuss with Karen Barker, Finance, and Ema Ojiako / REMCO The update was noted.	MB
Date, time, and venue of next meeting: Monday 20 May 2024, 1500-1700hrs via MS Teams		

Minutes agreed as accurate record of meeting:

Signed: Date:
Chair

Parker Rachael
16/05/2024 16:35:18

				Code RED Overdue AMBER Update due for next Committee GREEN Update given BLUE Action Closed PURPLE Action has a longer timescale	Improving lives together Norfolk and Waveney Integrated Care System			
Norfolk & Waveney ICB Patients and Communities Committee								
Action Log								
No	Meeting date added	Description	Owner	Action Required	Action Undertaken / Progress	Due date	Status	Date Closed
11	24.7.23	Children & Young People update to come to a future meeting	R Hulme	Update to include service user / patient feedback and examples of progress made, impact and outcomes and the difference the improvements are making to residents	15.1.24: Awaiting confirmation whether R Hulme can update at May's meeting 18.3.24: R Hulme unable to attend in May, awaiting confirmation whether another member of the CYP team can provide an update instead 25.3.24: Deferred to July meeting	July '24		
16	25.9.23	Integration with VSCE	M Burgis	M Burgis to pass on AD thoughts from the meeting to D Williams around clarifying issues and improving engagement with the VCSE sector	27.11.23: MB has feedback to D Williams and the wider team and this is being acted on. VCSE Assembly update to be an agenda item for January's meeting 18.3.24: Update deferred to a future meeting 25.3.24: Agenda item for May's meeting	20.5.24 ~~22.1.24~~ ~~27.11.23~~		
19 (actions 4 & 10 merged 27.11.23)	27.11.23 action 4 raised 30.1.23 action 10 raised 24.7.23	Lived experience representative	PH / RC	(Action #4) Committee members to provide feedback to PH. Reflect at March meeting as to where we are and what adaptations have been made to the current plan to take this forward (Action #10) MB and PH to ensure lived experience representation for the PH&I Board is linked into the Patients and Communities Committee lived experience representation work currently underway	The pack has been finalised and shared widely for comment with partner organisations, stakeholders and forums. Comments will then be factored into the final pack. Roles expected to be advertised late March 2023. 22.5.23: Working through some HMRC issues relating to payment method and policy, but hopeful that a policy already in use in some London trusts and HMRC approved, can be used in Norfolk and Waveney. 24.7.23: Ongoing. Continuing to work with HMRC and ICB Finance colleagues to ensure suitable policy is in place prior to recruitment commencing 25.9.23: Draft recruitment packs have been circulated to the committee. Still awaiting confirmation from HMRC regarding a suitable policy 27.11.23: HMRC has requested to have sight of the paperwork the ICB will use to pay lived experience representatives 27.11.23 Actions 4 and 10 merged as both linked to Lived Experience Representatives 15.1.24: ICB Finance team still awaiting a response / update from HMRC 25.3.24: AD / MB / CA to revisit and discuss internally to bring this to a conclusion. Agenda item for next committee	20.5.24 ~~25.3.24~~ ~~22.1.24~~ ~~27.11.23~~ ~~25.9.23~~ ~~22.5.23~~ ~~23.3.23~~		
22	25.3.24	Population Health and Inequalities Board Update - Risk HI05	MB	Risk HI05 ring fencing of NHSE funding allocations to be added to the Patients and Communities Risk Register		20.5.24		
23	25.3.24	Population Health and Inequalities Board Update	FS	PH&HI Risk Register to be shared for awareness with the May's PH&HI update	13.5.24: Risk Register included in May's agenda pack	20.5.24		

Agenda item: 6

Subject:	ICB Long Term Dental Plan 2024 – 2029
Presented by:	Fiona Theadom, Head of Primary Care Commissioning
Prepared by:	Fiona Theadom, Head of Primary Care Commissioning
Submitted to:	N&W ICB Patients and Communities Committee
Date:	20 May 2024

Purpose of paper:

To inform the ICB Patient and Communities Committee about the ICB's Long Term Dental Plan for improving resilience and stability in local NHS dental services and to improve access for our population.

Executive Summary:

The ICB became responsible for all primary services under a Delegation Agreement with NHS England in April 2023, including primary, community and secondary care dental services.

The ICB's Short Term Dental Plan was published in September 2023 following engagement with the dental profession and key stakeholders and is currently being implemented. A commitment was made at the time to publish a Long Term Dental Plan by Spring 2024 and this has recently been approved by the ICB's Primary Care Commissioning Committee.

To help inform the ICB's Long Term Plan, a survey was undertaken in early 2024 that was shared with Norfolk and Waveney's local population and key stakeholders. More than 2000 responses were received and 92.3% agreed or strongly agreed that the ICB priorities were the right ones for the next two years. The ICB has continued to engage with the local dental profession and other key stakeholders through conversations and meetings and the ICB's Dental Development Group.

This paper sets out an overview of the ICB's recently agreed Long Term Dental Plan (LTDP) which describes our aims for next two years and outlines our plans from April 2026 onwards. The plan will be reviewed and updated annually reflecting how

access is improving together with the ICB's plans to build a sustainable workforce and improve oral health prevention working in collaboration with system partners. A link to the relevant reports on the ICS website:

[Dental Services in Norfolk and Waveney - Norfolk & Waveney Integrated Care System \(ICS \(improvinglivesnw.org.uk\)\)](https://improvinglivesnw.org.uk/)

The detailed plan and Committee papers can be found here:
improvinglivesnw.org.uk/~documents/route%3A/download/1065/.

The ICB's Primary Care Dental Workforce Plan for 2024/2025 is also recently agreed. Successful delivery of both plans is critical to support access improvement and workforce recruitment and retention.

Report

The ICB is currently updating its Primary Care Strategy and the proposed Long Term Dental Plan will form part of this wider strategy seeking to build a fully integrated primary care system for Norfolk and Waveney.

The recently agreed Long Term Dental Plan (LTDP) sets out the ICB's priorities for the next two years and our aims for the following three years. It has been developed through active engagement with the dental profession, key stakeholders and the public over the past year.

1 Background

In 2023, the ICB took on responsibility for all primary care services including NHS dental services under a Delegation Agreement with NHS England (NHSE). Dental services include general dental services, community dental services, Level 2 services for more complex treatments and secondary care services.

Each dental provider has an agreed annual activity (units of dental activity or units of orthodontic activity) and annual contract value. A provider must deliver at least 96% of their contracted activity or face clawback up to 100% of their contract value. In 2022/2023, 70% of practices fell below this threshold largely due to workforce recruitment challenges. Achievement for 2023/2024 is forecast to improve slightly. Other services such as community dental and Level 2 are contracted in different ways.

From early engagement with the Local Dental Committee and Local Dental Professional Network, the ICB team committed to three priorities in February 2023:

- to listen to the views of the dental profession through an open and honest discussion about the future of dental services in Norfolk and Waveney and how we can support them.
- to consider how we can retain our local dental workforce and allow them to develop their skills and expertise, offer opportunities for them to provide some

Parker Rachael
16/05/2024 16:35:18

services in a different way where possible, and also to encourage individuals to come and work in our area.

- to listen to our patients and their lived experience, and to ensure our local population has access to oral health prevention advice and dental treatment when needed.

Engagement with the profession and our local population through the Joint Forward Plan engagement process led to the development of the ICB's Short Term Dental Plan (STDP) in Sept 2023.

Locally, NHS dental services are facing significant challenges with recruitment and retention and has been described as a "dental desert" nationally in terms of access for patients. Beginning to understand these challenges and how we can address them has helped to inform our plans since April 2023.

- **Short Term Dental Plan Achievements**

The ICB rapidly commissioned an Urgent Treatment Service pilot which now delivers 1800 appointments per month by 23 providers across the ICB area. The service is currently being reviewed to see how improvements can be made to the pathway for patients and providers.

During 2023/2024, the ICB successfully recruited and retained 14 dentists as a result of a number of schemes delivered through the Primary Care Workforce Plan.

We piloted an initiative for children's oral health and prevention and supported dental practices through quality improvement and varying contracting arrangements to support resilience.

A Task and Finish Group has been set up to look at establishing Child Focused Dental Practices working alongside community dental services and general dentists to improve access for children requiring more complex dental treatment. The ICB is also working closely with Norfolk County Council Public Health team to review existing schemes around children's oral health and primary prevention so that more children have access to oral health advice in the future. Initial discussions have also taken place with Suffolk County Council around children's oral health in Waveney.

The key challenges to improving access for our local population however remain, that is, building a sustainable workforce model to attract dentists and dental care professionals to come and work in Norfolk and Waveney and to remain here. This relies on the ICB commissioning services to support upskilling and professional development of dentists and dental care professionals to build a skilled multi-disciplinary workforce.

Since the ICB agreed its STDP, the national Dental Recovery Plan was published in February 2024 ([Faster, simpler and fairer: our plan to recover and reform NHS dentistry - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/consultations/faster-simpler-and-fairer-our-plan-to-recover-and-reform-nhs-dentistry)) aimed at improving access to NHS dental services. Many of the proposals such as a minimum UDA value, Golden Hello and new patient premium have either been implemented or are included in ICB plans.

2 Public and stakeholder involvement

Following on from the feedback received during public and stakeholder engagement around the ICB's Joint Forward Plan in 2023 (summary included in the LTDP), we felt it was important to engage further about our specific plans. From 24 January – 21 February 2024, the ICB ran a period of public and stakeholder engagement to gain feedback on the ICB's long-term plans to commission NHS dental services in Norfolk and Waveney.

The aim of the engagement was to seek feedback on our planned priorities and approach to commissioning dental services, and to hear what stakeholders think about our planned priorities for NHS dental services over the next two years. We also asked for respondent's views on what priorities they want us to consider in our five-year long-term plan.

Additionally, we also sought feedback from those who've used the Urgent Treatment Service to inform future development of that service.

We were pleased to receive more than 2000 responses, of which 92.3% Agreed or Strongly Agreed that these were the right priorities. The feedback has helped inform our LTDP objectives.

A summary slide report is attached as Appendix A.

3 Long Term Dental Plan 2024 – 2029

NHS dental services in Norfolk and Waveney remain fragile and ensuring that our existing services are sustainable and resilient remains the ICB's key priority.

In light of the continuing challenges, the LTDP sets out our plans for next two years and describes our aims for the following three years. We recognise that a five year plan is just the beginning of the journey, improving access for our whole population remains a challenge and will take time to achieve.

The LTDP sets out our vision linking to the ICB's Joint Forward Plan:

- To build stability and resilience across our NHS dental services
- To improve access to oral health care for Norfolk and Waveney's population
- To reduce health inequalities

Our long term aim is to reduce the need for an urgent treatment service as a consequence of improving access to general dental services for the ICB population, and to provide the right opportunities for our workforce to develop their professional skills and expertise encouraging them to remain in Norfolk and Waveney.

The LTDP is a wide-ranging plan that covers primary, secondary and community dental services. In the first two years, the focus will be on:

Parker
16/05/2024 16:35:18

- Improving access to services with an initial focus on children and young people, pregnant mothers and those living in areas of deprivation (reducing health inequalities) and our most vulnerable population;
- Oral health education and prevention for children and young people, and adults working in collaboration with system partners;
- Continuing workforce recruitment and retention efforts to build up the number of dentists and dental care professionals coming to live and work in Norfolk and Waveney;

The plan also encompasses key areas such as:

- Further development and expansion of a range of Level 2 services locally;
- Collaboration between Secondary Care dental services (acute dental services) to manage waiting lists, and also with Level 2 services to deliver training and education;
- Special Care dental services; and
- Orthodontic services.

It sets out the high level actions, timescales where possible, and the benefits and expected outcomes if successfully achieved. Detailed plans for each service area are needed to support development, mobilisation, training and implementation as appropriate.

The ICB has not set targets for the first year of our plan however it describes the benefits and outcomes that we hope to achieve. Our intention is to review the plan in early 2025 to monitor progress and determine if targets can be set out in more detail then. Measures such as improving contract activity achievement year and year and the number of new patients seen in a two year rolling period are easily monitored.

Risks and Challenges

Norfolk and Waveney faces a number of challenges on its journey to improve dental access for our local population and to build a resilient and stable NHS dental service, continuing engagement with the local dental profession and key stakeholders is critical to achieving success. The key challenges are:

- Ability to build a sustainable workforce of dentists and dental care professionals working with local higher education institutions and colleges;
- Access to high quality data to inform commissioning intentions at local level;
- Resources and capacity within the ICB
- Continuing commitment from local dental providers to the NHS
- Affordability of NHS dental services
- Ability to improve access and expand NHS dental service provision unless a dental workforce is in place; and
- Ability to reduce health inequalities through affordable NHS dental services.

Some aspects remain outside the control of the ICB such as contract reform and long-term workforce planning, and the increasing costs of NHS dental treatment for

Parker Rachael
16/05/2023 16:15:18

many of our population which is a concern for those not eligible for free or partially free treatment.

The ICB however has an opportunity to make a difference at a local level using flexible commissioning whenever possible to encourage NHS dental service providers to remain within the NHS.

Continuing Engagement with key stakeholders

Successful delivery of both the LTDP and Workforce Plan involves continuing engagement and collaboration with key stakeholders such as NHS England (NHSE), the dental profession, local authorities and higher education institutions for Norfolk and Waveney and the voluntary sector. Whilst the ICB has identified its own local priorities for improving resilience and stability of our local NHS dental services, there are benefits in working collaboratively across the East of England region with NHS England and other ICBs to share learning and best practice and commission collaboratively where beneficial to do so. These opportunities are highlighted in the ICB’s LTDP.

There will be an ongoing conversation with the profession and the public about LTDP as progress is made in delivering the individual elements and the ICB plans to refresh engagement with the public in 2026 to assess whether change is being seen and to inform further development of the LTDP.

There are also opportunities to have conversations with the voluntary and community sector to see how we can work together to identify the barriers and put in place measures to improve access for our local population.

Recommendation to the Committee:

To note the ICB’s Long Term Dental Plan and the outcomes of the patient and public survey undertaken in early 2024.

Key Risks	
Clinical and Quality:	Failure to invest in improving access in NHS dental services will result in poor oral health for children and adults leading to long term medical and mental health problems, increase in dental tooth decay and an increase in secondary care referrals. Supporting quality improvement in NHS dental services will ensure service delivery is good quality and sustainable.
Finance and Performance:	Investment for 2024/2025 is being funded through the ICB’s dental underspend.
Impact Assessment (environmental and equalities):	Focus on reducing health inequalities and children and young people in the first two years to ensure vulnerable patient groups have access to NHS

	dental services and oral health prevention and education. Net zero plans are set out in the LTDP to encourage NHS dental service providers to think about their responsibilities to build a more sustainable NHS dental service
Reputation:	Failure to invest in NHS dental services will significantly impact the ICB's reputation with its local population and key stakeholders
Legal:	n/a
Information Governance:	N/A
Resource Required:	Primary Care Commissioning, Primary Care Workforce, Quality, Finance, Comms and Engagement
Reference document(s):	National Dental Recovery Plan, Delegation Agreement with NHS England, NHS England Dental Policy Handbook and Guidelines for Commissioners – Flexible Commissioning
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	PC18 – Dental Resilience

Governance

Process/Committee approval with date(s) (as appropriate)	
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Parker Rachael
16/05/2024 16:35:18

Norfolk and Waveney Long-Term Dental Plan 2024 - 2029

Summary

Parker Rachael
16/05/2024 16:35:18

Background

- The ICB took over delegated commissioning responsibility for dentistry (primary, community and secondary dental services) from NHS England in April 2023.
- There are currently 102 primary care dental providers, community dental services / special care dental services, Level 2 (enhanced services) and 3 acute hospitals in Norfolk and Waveney providing NHS secondary care and orthodontic services to the local population. Individuals may also be referred outside Norfolk and Waveney for certain services, such as endodontics and periodontics or to a London hospital.
- Nationally, all primary care services (which includes dentistry) are facing greater challenges than ever in workforce shortages, an increasingly complex workload, and demand for services exceeding capacity. In Norfolk and Waveney, the impact of these challenges is an acute lack of access to NHS dental services – oral health advice, prevention and treatment - for our local population who do not already see an NHS dentist regularly.
- The workforce challenges that are felt across the country are particularly acute in Norfolk and Waveney, where for the last decade the number of dentists has declined compared to the Eastern region and England. This decline has a greater impact here due to higher levels of need, areas of deprivation, and a higher number of residents in later life.
- Challenges with recruiting and retaining the dental workforce impact our ability to ensure that access to services is the same for residents no matter where they live in our area. It also impacts our ability to address health inequalities, and to commission adequate service provision based on the health needs of our people and communities.

What we have achieved so far

- Mobilised an urgent treatment service to improve access for any individual in dental pain through a new pilot scheme that will run for 12-18 months (using £1.05m of funding).
- Uplifted the amount we pay dentists to provide NHS care, to a minimum of £30 per Unit of Dental Activity (UDA), higher than the national recommended value of £28 per UDA.
- Funded local dental providers to undertake children's oral health initiatives (using £600,000 of funding).
- Put in place immediate recruitment and retention plans to support dental practices and completed a Training Needs Analysis (using £600,000 of funding for workforce incentives). Successful recruitment and retention of 14 dentists in 2023/2024
- Secured two Clinical Dental Fellows to support ICB workstreams about children and young people and health inequalities, as well as to provide coaching and mentoring for dental teams and continuous professional development opportunities.
- Put in place quality improvement support for primary and community care dental services and their teams.
- Agreed to extend orthodontic services contracts for a further three years from April 2024, and to extend minor oral surgery services for a further two years from April 2024.
- Started to develop a pathway for oral health stabilisation and treatment for individuals with medical needs, for example for patients with cancer.
- We are also committed to collaborating with ICBs in the region to agree a common commissioning approach where beneficial

Developing our Long-Term Plan

- Following early engagement with local dental teams and their representative bodies, and taking account of patient feedback, the ICB published its [Short-Term Dental Plan](#) in September 2023. It focussed on quick investment decisions that the ICB could take to help stabilise dental services and improve patient access to urgent treatment while we continued to develop our longer-term plans for commissioning dental services.
- We wanted to supplement the feedback we had received so far and give people the opportunity to inform our longer-term planning. We asked for the views of local people about our immediate priorities that we had identified as important to include in our long-term plans. These included **urgent care; developing capacity in our dental teams; improving access for children and young people and with a focus on reducing health inequalities; and promoting good oral health.**
- People shared their views through a short anonymous survey between 24 January - 21 February 2024, which people were able to complete using both non-digital and digital methods. Over 2,000 responses were received – **thank you!** You can find out more about the key themes from the report [here](#).
- The majority of respondents thought our early priorities were the right ones – 92.3% Agreed or Strongly Agreed that these were the right priorities.
- Our Long-Term Dental Plan builds on these key priorities, and supports the actions recommended in the national NHS Dental Recovery plan.
- The Long-Term Dental Plan recognises the importance of using evidence-based commissioning, a data-led approach, and system collaboration to develop integrated solutions to improve oral health prevention and access to services for our people and communities.

Our vision – what do we want to achieve in 5 years?

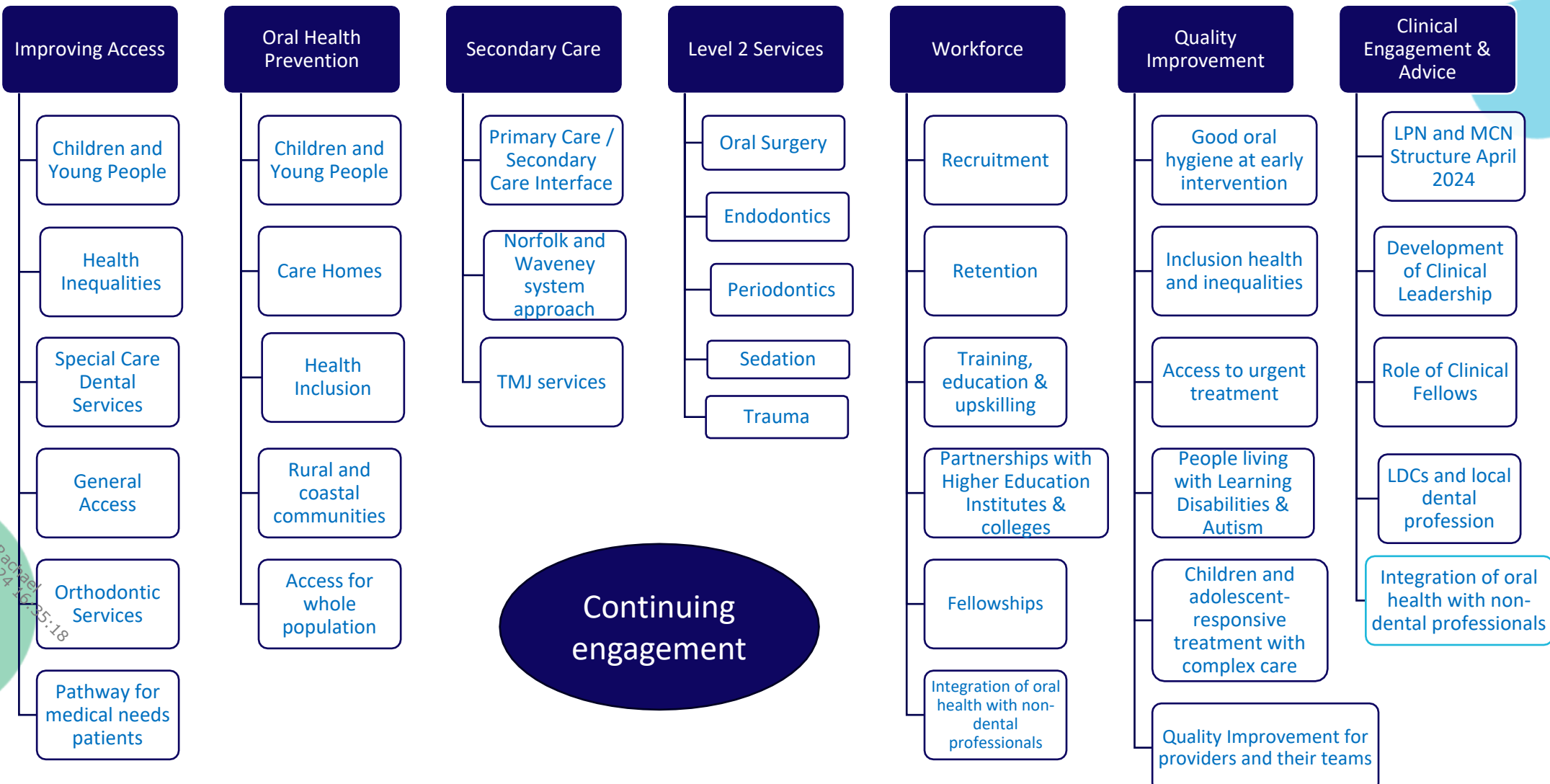
Our vision:

- To build stability and resilience across our NHS dental services
- To improve access to oral health care for Norfolk and Waveney's population
- To reduce health inequalities

Parker Rachael
16/05/2024 16:35:18

Long term opportunities 2024 - 2029

Resilience and Stability of NHS dental services in Norfolk and Waveney



Parker Rachael
16/05/2024 16:25:18

Three key areas of the Long-Term Dental Plan

Change will take time, there are difficult challenges ahead

The ICB aims to support recovery of access to NHS dental services by focusing on three key areas:

1. Build capacity through working with system partners to improve recruitment and retention of the dental workforce.
2. Begin to improve access for our Children and Young People, and those living in deprivation
3. Empower and support our population to manage their own oral health, working with local Public Health teams and system partners



Parker Rachael
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The pace of change

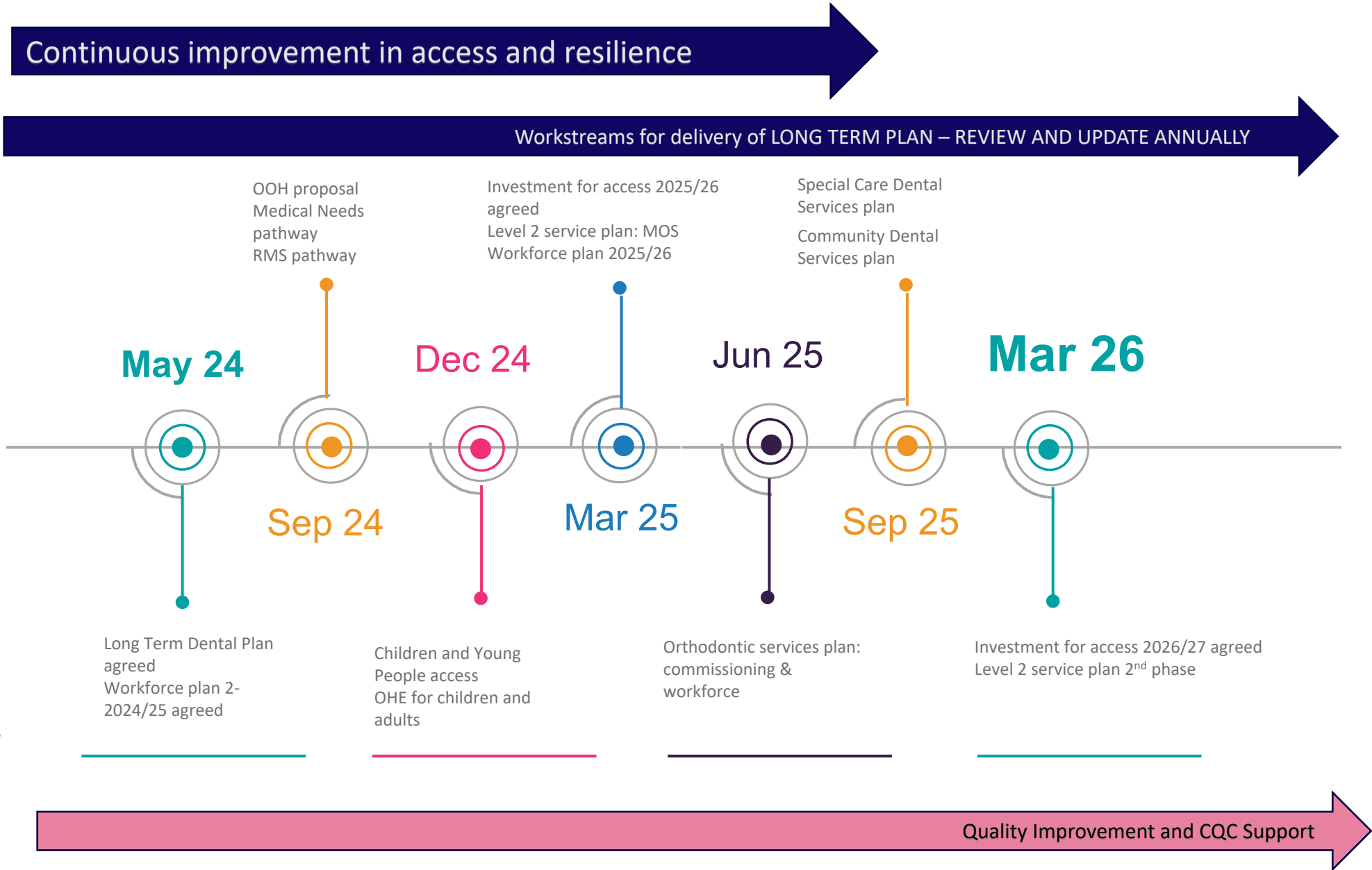
- The purpose of this Long-Term Dental Plan is to set out the priority areas that the ICB and system partners will focus on over the next 2-5 years.
- We know that access to NHS dental services is very challenging right now. We are committed to improving local access to oral health prevention and treatment services.
- There's a lot of work to do and many challenges to overcome, so we need to tackle them step by step – this Long-Term Dental Plan maps out the steps that we will start to take first.
- Change will not happen overnight.
- Wide-spread improvements in general access to NHS dental services for our whole population will take longer than the lifetime of this Plan.
- By investing our effort and resources into the priority areas outlined in this Plan now, we are laying the foundations to make real and lasting improvements in access to NHS dental services for the people and communities of Norfolk and Waveney.

Parker Rachael
16/05/2024 16:35:18

Our focus for the next two years

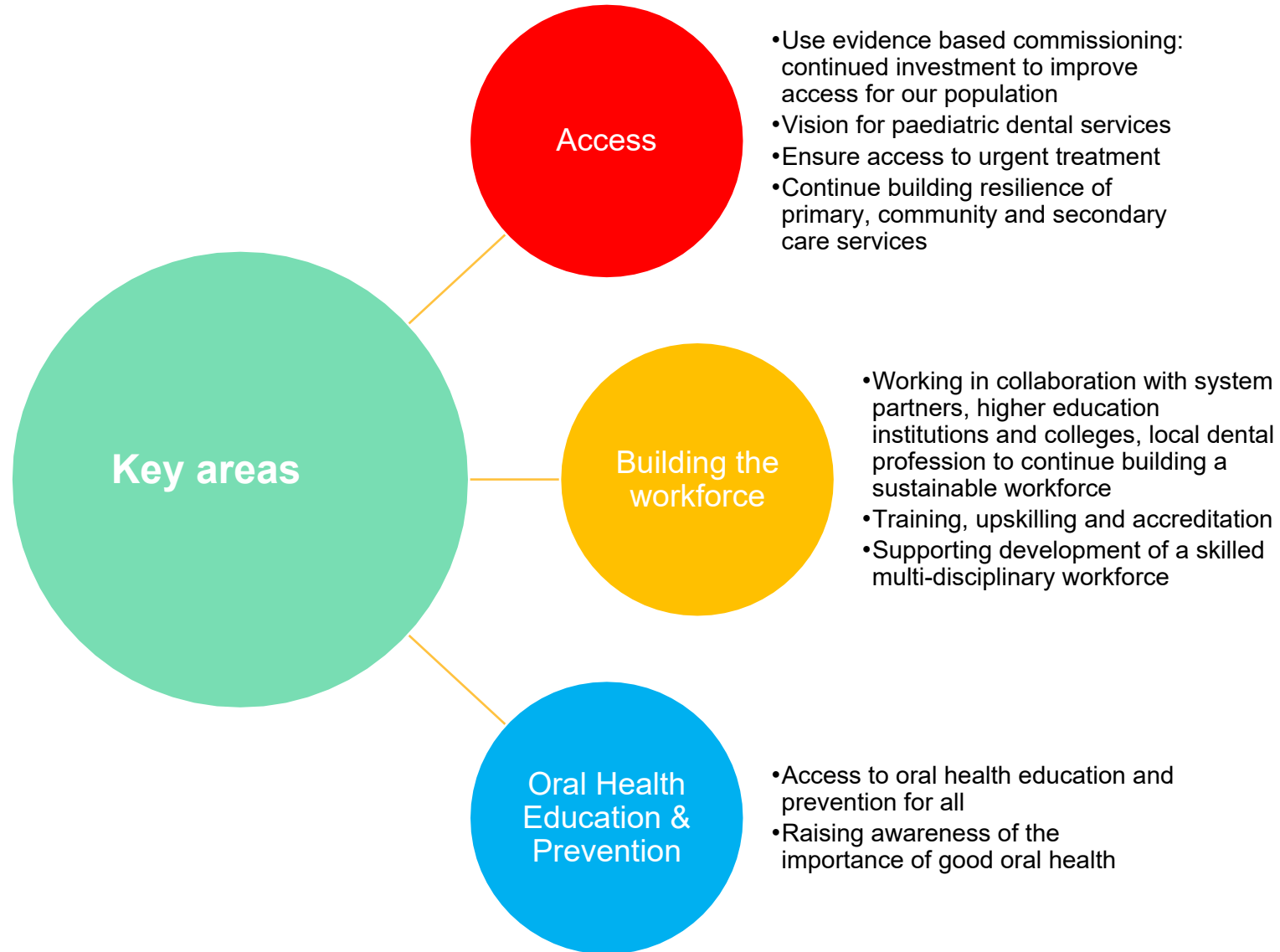
Area	By When?	What/How – Summary Overview
Children and Young People	March 2025	Implementing the East of England vision for Paediatric Dentistry. Improve access to oral health care: prevention, education and treatment in collaboration with system partners. Establish a network of Child Focused Dental Practices working with Community Dental Services during 2024/2025
Build the Dental Workforce	March 2024 – 2026	Invest in training, education, recruitment and retention plans and initiatives to build capacity year on year building on successful schemes in 2023/2024.
Begin to improve access	During 2024/2025 and beyond	- For those living in areas of deprivation, rural and coastal communities with limited access, vulnerable and inclusion health groups, children and young people, and pregnant mothers. Continue to invest to improve access beyond March 2025 for wider population to reduce health inequalities. - Secure arrangements for urgent treatment services from April 2025.
Improving access for vulnerable patients	September 2024 - September 2025	Undertake needs assessment, develop workforce plans and agree commissioning intentions by Sept 2025 to provide oral healthcare for our most vulnerable patients, including individuals with Learning Disabilities and Autism, mental and physical disabilities.
Securing access to out of hours services	December 2024	Agree and mobilise new Out of Hours arrangements across Norfolk and Waveney.
Oral health education and prevention for adults	April 2024 – March 2026	Undertake needs assessment and develop Programmes over next two years for vulnerable adults, those living in deprivation, and those with additional needs.
Level 2 enhanced dental services	April 2024 – March 2026	Laying the groundwork for future development of all Level 2 services starting with oral surgery. Commissioning and mobilising a Referral Management Service, evaluating trauma pathways, and agreeing long-term commissioning intentions and workforce plans.
Orthodontics for children and young people under 18 years	October 2024 - June 2025	Undertake a needs assessment, develop long-term commissioning intentions and workforce plans to secure sustainable service model for orthodontic care in Norfolk and Waveney.
Secondary Care services (Oral Surgery and Maxillo Facial Services)	Ongoing	Implement the recommendations from NHS England East of England and work in collaboration with other ICBs and with local trusts to secure sustainable secondary care services.

Timeline in summary



Parker Rachael
16/05/2024 16:35:18

What will we be working on from March 2026?



Parker Rachael
16/05/2024 16:35:18

What does success look like?

Increase in:



- New patient access
- Patient and public satisfaction
- Individuals in pain can access urgent treatment within 48 hours of initial contact
- Workforce morale improving
- Number of dentists and dental care professionals coming to work, and remaining, in Norfolk and Waveney
- Sustainable Out of Hours service model to meet population need
- Access to enhanced Level 2 services locally within Norfolk and Waveney and hospital care when needed
- Improving oral health in children and adults

Decrease in:



- Shift to private dental practice
- Number of dentists and dental care professionals leaving
- Reduced referrals to secondary care for extractions in children
- Urgent treatment activity down as a result of improved access
- Waiting lists for treatment
- Oral cancer rates

Parker Rachael
16/05/2024 16:35:18

The challenges to achieving success

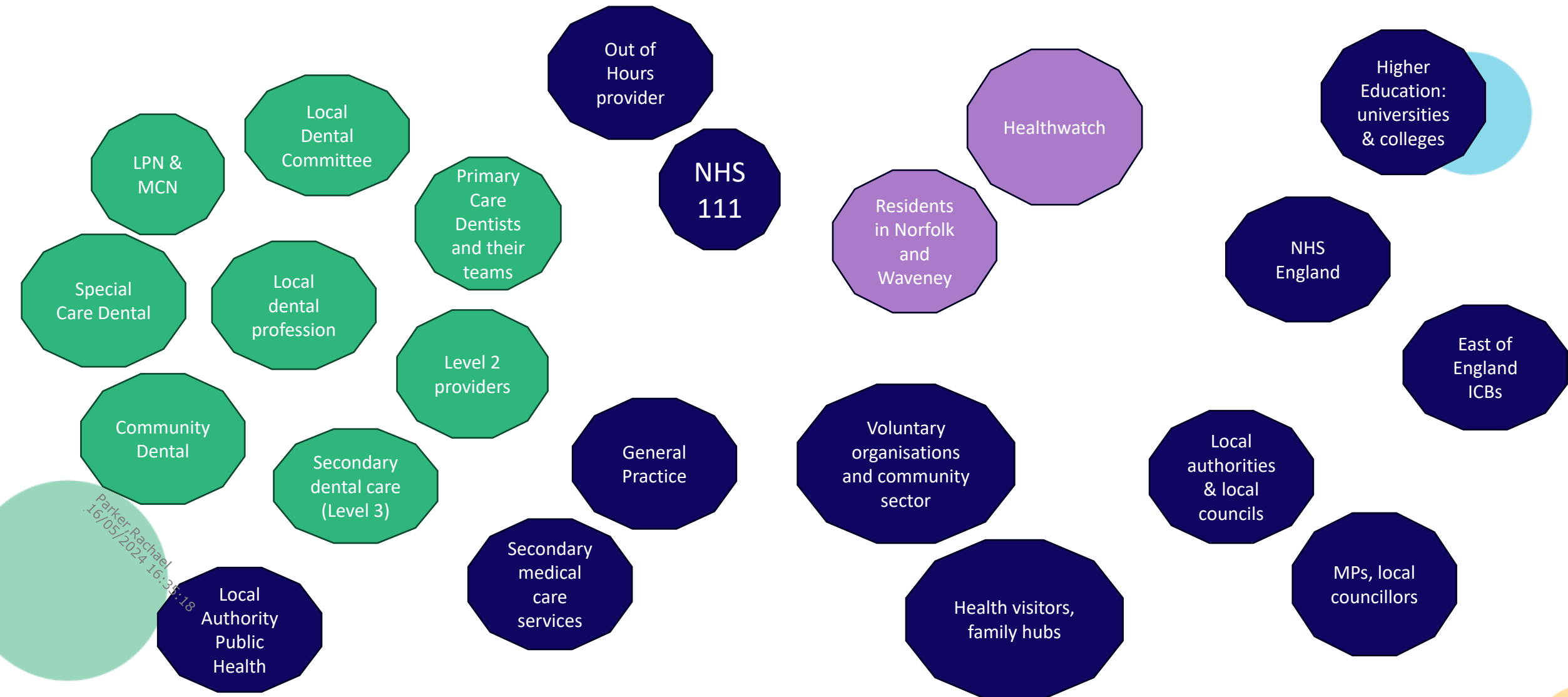
Challenges we face include:

- Ability to build a sustainable workforce of dentists and dental care professionals
- Access to high quality data to inform commissioning intentions
- Resources and capacity within the ICB
- Continuing commitment from local dental providers to the NHS
- Affordability of NHS dental services
- Ability to expand NHS dental services provision unless workforce in place
- Ability to reduce health inequalities through affordable NHS dental services

There are some challenges outside of our control:

- Dental contract reform
- Dental treatment costs
- National workforce plans to expand training places for dentists and dental care professionals

Key stakeholders: **engage, involve and inform**



Have your say on our long-term plans for NHS dental services

Summary Report on feedback received from the dental engagement survey

Parker Rachael
16/05/2024 16:35:18

Background

NHS Norfolk and Waveney Integrated Care Board (ICB) ran a period of public and stakeholder engagement from 24 January – 21 February 2024.

The aim of this engagement was to gain feedback on our long-term plans to commission NHS dental services in Norfolk and Waveney.

We asked for feedback on three areas:

1. The priority areas that we had identified to focus on over the next **two years** to begin to improve access to NHS dental services. These were developed with feedback we had received from dental professionals, as well as local people and our local Healthwatch organisations.
2. We asked what people would like to see included in our longer-term **five-year plan** for NHS dental services to help shape how this is developed.
3. We asked for feedback from people who have used the **Urgent Treatment Service** to inform how that service is developed.



Parker Rachael
16/05/2024 16:35:16

How responses were received

We asked people to provide feedback in print and through an online survey.

The survey received a total of **2,054 responses**.

- People completed the survey in the following ways:
 - Digital survey
 - Printed copies posted to the ICB through a Freepost address
 - Copies emailed to the ICB's Patient Experience team
- An electronic copy of the survey and an Easy Read version of the survey were available on the ICS website.
- Printed copies, alternative formats and translations were available on request from the ICB's Patient Experience team.
- The emailed and printed copies received were manually input to the digital survey to contribute to the total overall number of responses for analysis.
- No requests for alternative formats or translations were received.



Who responded?

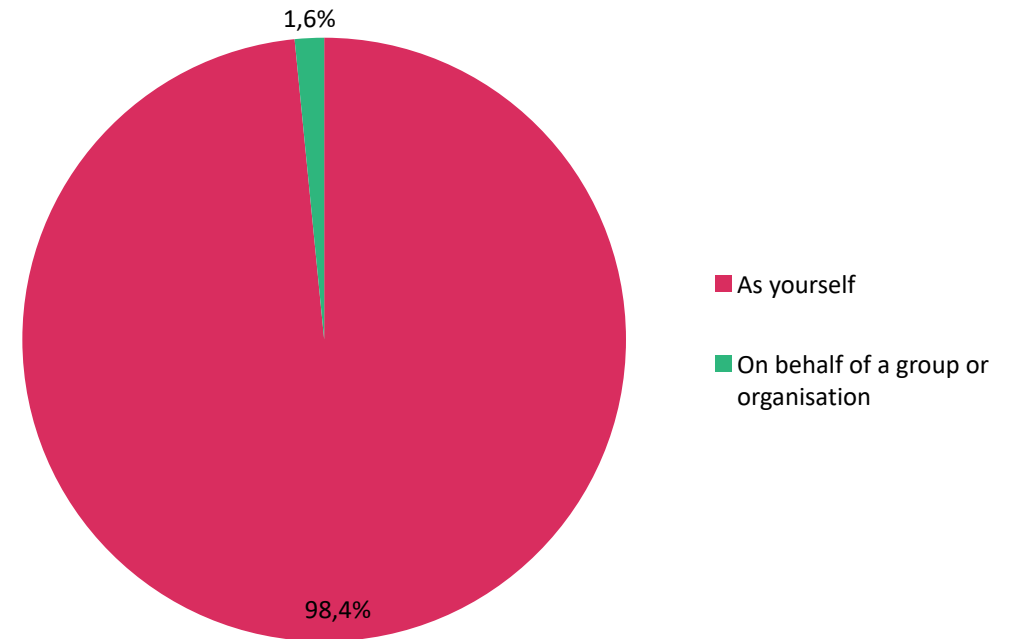
Question 1

We asked people if they were responding as themselves, or on behalf of a group or organisation.

- 2,015 surveys were completed “As Myself”;
- 7 surveys were left blank;
- 32 responses were completed on behalf of a group or organisation.



Total responses = 2,054



Parker Rachael
16/05/2024 16:35:18

Feedback on our early priorities

We gave a summary of our priorities for oral health and dental care services for the next two years.

These will be the areas where we plan to invest our resources to have the greatest impact, and to help to improve patient access to NHS dental care.

The four priority areas are:

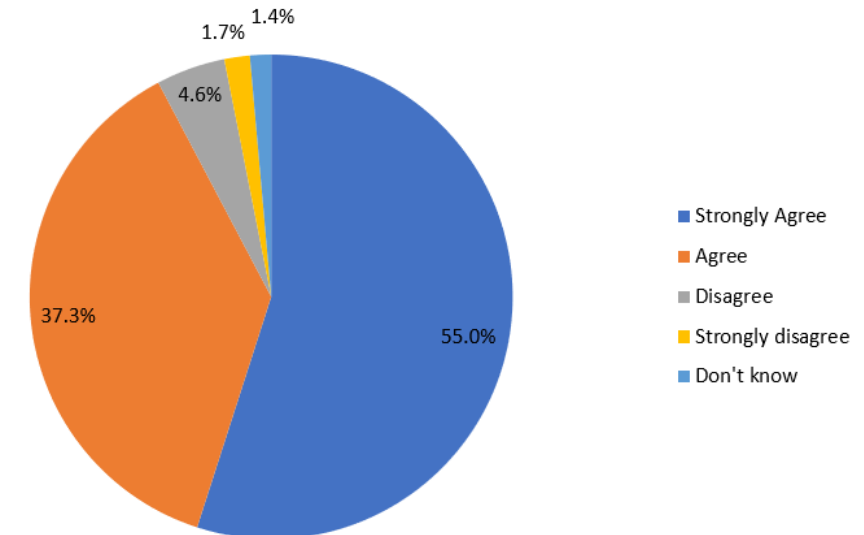
- Urgent Care;
- Developing Capacity in our Dental Teams;
- Improving Access; and
- Promoting Good Oral Health

Question 2

We asked to what extent people agreed or disagreed that these were the right priorities.



- 92.3% Agreed or Strongly Agreed that these were the right priorities.
- 6.3% Disagreed or Strongly Disagreed that these were the right priorities.
- 1.4% were unsure.



Feedback on our early priorities

We asked people to provide comments on our four early priorities.

743 comments were provided, which have been grouped by themes:

- ✓ More NHS dentists are needed NOW to improve access for everyone.
- ✓ Too many dentists are turning to private practice, which respondents said is unaffordable for many people.
- ✓ Increasing the number of NHS dentists needs to happen before access can improve.
- ✓ Improving access to an NHS dentist, including regular check-ups, is urgently needed.
- ✓ Prioritise access for children now, and children up to 18 should receive free NHS care.

Parker, Rachael
16/05/2024 16:35:18

Feedback on our early priorities - continued

- ✓ The elderly and those on low incomes or who receive benefits should be prioritised for access.
- ✓ Where is the plan to deliver on these priorities? Is it possible to achieve these priorities? Is it possible to achieve them in 2-5 years?
- ✓ More local services that are accessible for people with learning disabilities and autism, and an adequate number of specialist dentists and sedation clinics.
- ✓ The ICB can't influence the NHS dental contract, which many respondents believe is necessary for any improvements to be made.
- ✓ Promoting good oral health for children and young people is a good priority.

Parker Rachael
16/05/2024 16:35:18

Our longer-term plans

Question 3

We asked what people would like to see in our five-year plan for NHS dental services in Norfolk and Waveney. We asked what matters most to them.

1,870 comments were provided, which have been grouped by themes:

- ✓ More NHS dentists so that ALL people can access regular NHS dental care.
- ✓ Access to regular check-ups and preventative care – which will reduce the need for urgent treatment
- ✓ Children should be guaranteed a place with an NHS dentist where they receive treatment for free.
- ✓ Make sure that access to NHS care isn't stopped by dentists moving to private practice.
- ✓ NHS dental treatment must remain affordable.

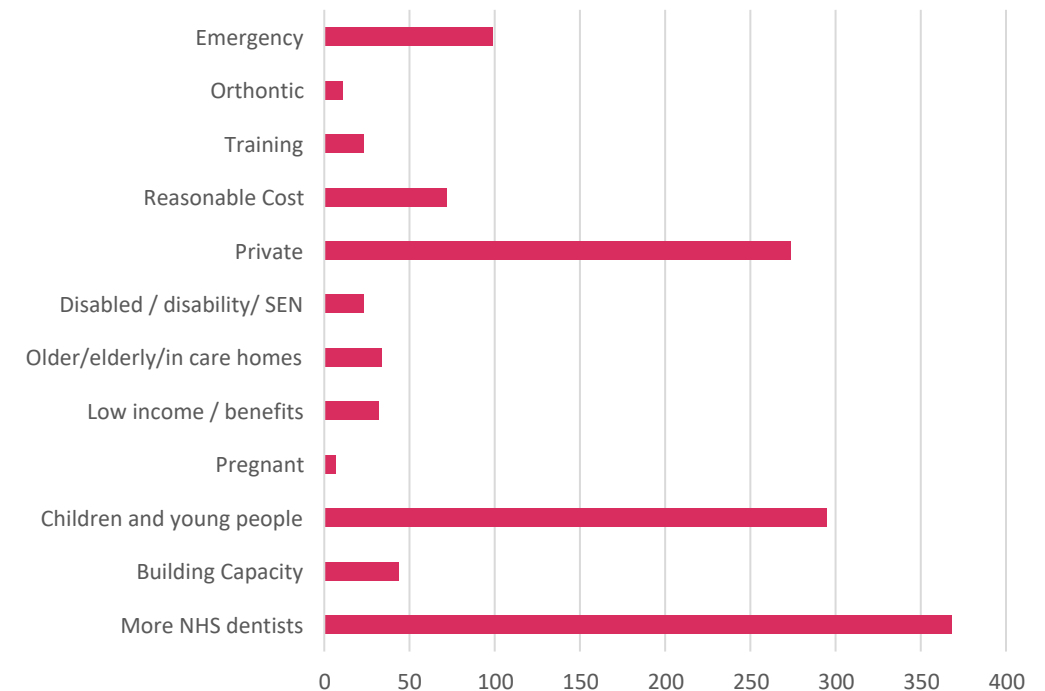
Our longer-term plans - continued

Continued: Themes of what people said they want to see in our longer-term plans for dental services

- ✓ Urgent means urgent. Make sure people in pain can access emergency care quickly, without having to wait days (or longer), or travel long distances.
- ✓ Reduce long waiting times for orthodontic treatment (currently 2-5 years).
- ✓ Make sure there are enough dentists for these groups to be able to access regular NHS dental care:
 - people with learning disabilities and autism;
 - pregnant people;
 - the elderly; and
 - those on low incomes or receiving benefits.

The graph below shows how often themes were mentioned in the feedback:

Themes for what is important in longer-term plans for NHS dental services



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16/05/2024 16:55:18

The Urgent Treatment Service

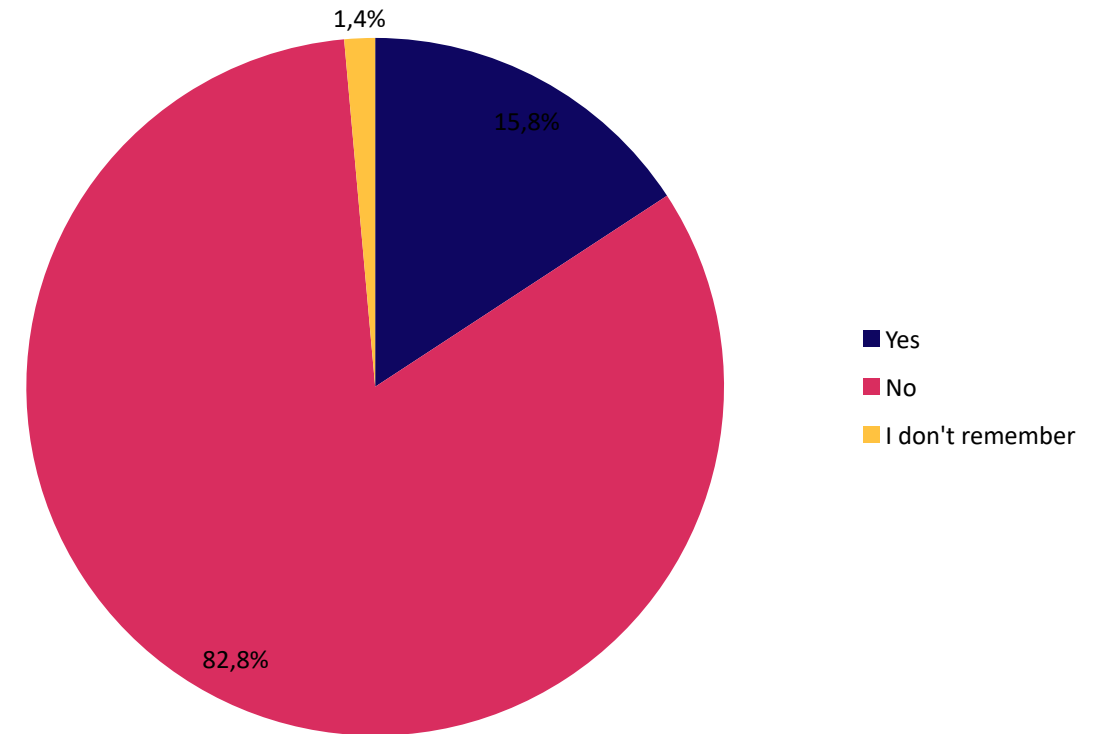
Question 4

The Urgent Treatment Service (UTS) was set up in the Autumn 2023 after we published our Short-Term Dental Plan. We asked people if they had used it.

Yes – 15.8% (322 responses)

No – 82.8% (1,690 responses)

I can't remember – 1.4% (29 responses)

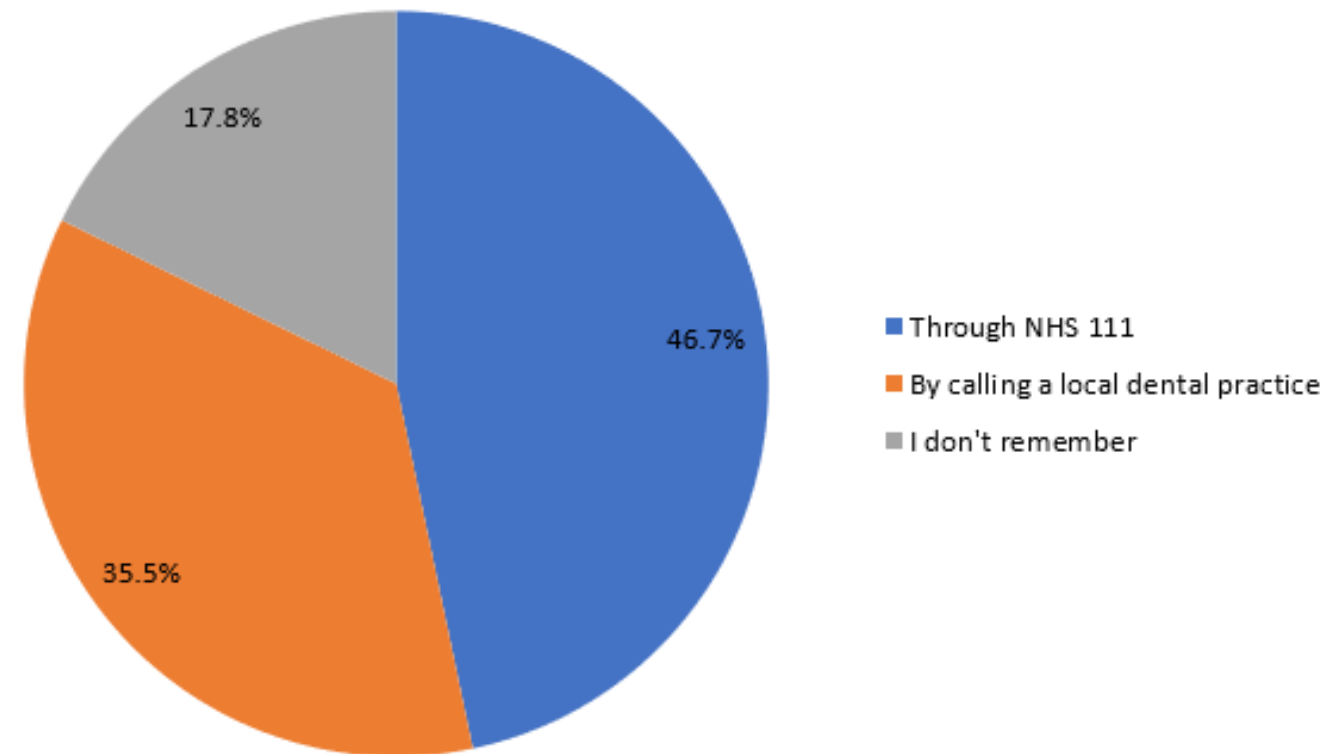


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16/05/2024 16:35:18

The Urgent Treatment Service

For people that said “Yes,” we asked how they had accessed the Urgent Treatment Service

- Just under half of respondents accessed the UTS through NHS 111 (46.7%).
- 35.5% had accessed the service by contacting a local dental practice.
- 17.8% of respondents couldn't remember how they had accessed the service.



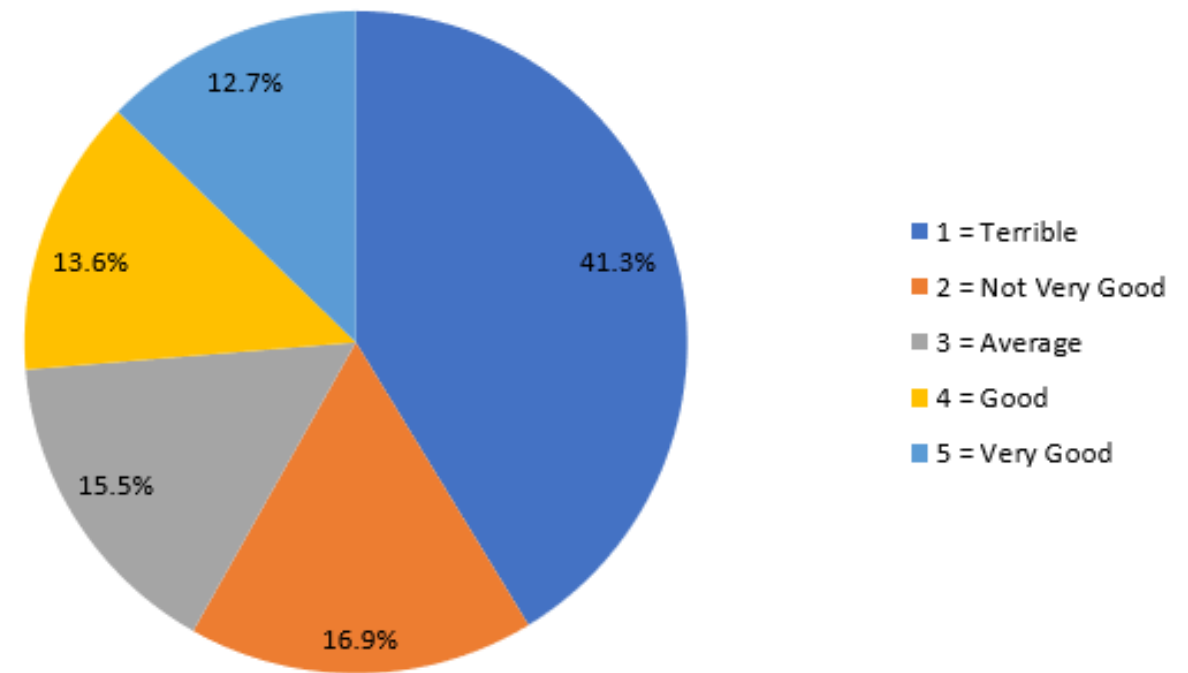
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16/05/2024 16:35:18

The Urgent Treatment Service

We asked people to rate their experience of the Urgent Treatment Service if they had used it.

We asked people to rate their experience between 1 - 5, where 1 = Terrible and 5 = Very Good

- 58.2% rated their experience as Terrible or Not Very Good
- 26.3% of respondents rated their experience as Good or Very Good
- Just over 15% (15.5%) rated their experience as Average.



Parker Rachael
16/05/2024 16:35:18

The Urgent Treatment Service

We asked people to provide comments on the Urgent Treatment Service (UTS) if they had used it

We received 343 comments, which have been grouped into themes. Note that there were several comments on urgent treatment that had been received before Autumn 2023 when the UTS was set up.

- ✓ Couldn't get an appointment and had to use another health service (Walk-in Centre, A&E)
- ✓ Couldn't get an appointment and had to manage their issues themselves (painkillers/ self-removal / go private/ just wait).
- ✓ People were given telephone numbers of dental practices that weren't offering the UTS, or phone numbers they couldn't get through on.
- ✓ Urgent appointments take too long to get.
- ✓ Appointments are too far away to be accessible (examples given were London, Cambridge, Ely, Wisbech, as well as Norfolk locations).

The Urgent Treatment Service

Continued: Themes of feedback received on the Urgent Treatment Service (UTS)

- ✓ A small number of respondents said the service they received was good or excellent, although many of those also said that the process of getting the appointment wasn't good.
- ✓ A larger number of respondents reported having a bad experience. This included the process of getting the UTS appointment as well as the service received.
- ✓ A small number of patients got an appointment but were then unable to access treatment at the appointment (they were told to go elsewhere)
- ✓ Several people who responded didn't know the service existed. If they had they would have tried to use it.
- ✓ People were directed by NHS111 to practices that don't offer NHS services. Several respondents reported accessing the UTS but then being charged high rates for treatment (treatment not given under the NHS).
- ✓ NHS 111 advised them to contact their own dentist to request an urgent care appointment. This advice doesn't help people who aren't registered with a dentist.

- The feedback received from the public and stakeholder engagement has been submitted for internal review and consideration within the primary care team at NHS Norfolk and Waveney.
- The feedback received will support the ICB's longer-term plans for dental services commissioning.
- The feedback will help to inform how the Urgent Treatment Service is developed.
- The feedback will also help to inform additional engagement opportunities around future programmes of work both in dentistry and other primary care services.
- If you require this report in an alternative format, please get in touch with the Patient Experience team at nwicb.contactus@nhs.net.

Parker Rachael
16/05/2024 16:35:18

Agenda item: 7

Subject:	VCSE Integration Programme and VCSE Assembly
Presented by:	Mark Burgis, Exec Director Patients & Communities Emma Ratzer, Chair of VCSE Assembly
Prepared by:	Emma Ratzer, Chair of VCSE Assembly Shelley Ames, Senior Integration & Partnerships Manager
Submitted to:	Patient & Communities Committee
Date:	20 May 2024

Purpose of paper:

To request endorsement of the proposed next steps for both the VCSE Assembly and the wider VCSE integration work programme.

Executive Summary:

The attached document sets out the proposed next steps for both our VCSE Assembly model and our wider VCSE integration ambitions. The proposals are in line with NHS England's VCSE Partnering and ICS guidance.

Working collaboratively with VCSE sector colleagues we have defined 4 clear objectives to underpin our future work programme:

To establish a strong foundation we will focus initial energy on objective 1 and the proposal details a clear purpose and model for the VCSE Assembly, one which will strengthen engagement with the wider sector. This work will be supported by the new Health Inequalities & VCSE team.

It is proposed that the Assembly report directly to the Patient & Communities Committee, whilst a small strategic group oversees the wider VCSE integration programme, reporting to Population Health & Inequalities Board.

An appointment process for a new VCSE Assembly Chair will commence from June 2024, given that the current Chair has reached the end of their term.

Parker, Rachael
16/05/2024 16:35:18

Report:

The attached document sets out the proposed next steps for both our VCSE Assembly model and our wider VCSE integration ambitions. The proposals are in line with NHS England's VCSE Partnering and ICS guidance.

It is important to reflect that the VCSE Assembly model is part of a wider programme of work, which we need to further develop collaboratively with our ICS partners. This programme will be led by the new Health Inequalities and VCSE team, alongside the VCSE Assembly.

Also included in this wider programme of work are our Norfolk and Waveney infrastructure arrangements, which are commissioned via the County Councils, and seek to support sector resilience and growth, but do not include 'sector voice' arrangements. This is further described on page 7 of the proposal.

Working with VCSE sector colleagues that are from the Assembly Board, and following feedback from the wider sector and statutory colleagues, we have developed a shared vision and set of four clear objectives with associated actions:

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

It is proposed that a small VCSE Integration Strategic Group be established to drive the overall VCSE integration work programme, overseen by the Population Health and Inequalities Board (as outlined on page 10). The programme will be supported by the VCSE Assembly, which will report directly to Patient and Communities Committee, as agreed with the VCSE Assembly Chair. Delivery of the 4 objectives will be in part a function of the Assembly. There will be a clear delineation in functions driven by the Health Inequalities and VCSE team with oversight from the Integration Strategic Group.

Working with the sector we have outlined a clear **primary purpose** of the Assembly, which is to *support fair and equitable partnering and engagement with the VCSE sector as part of the Integrated Care System, embedding sector voice into planning and decision-making processes.*

The Assembly exists to support two-way connectivity between the sector, the ICB and the wider ICS, enabling sector voices and ensuring communication of key messages back to the sector. The proposed Assembly model and TOR have been developed following extensive review in support of the first stated objective.

Through development of a new TOR for the Assembly we will design and communicate clear processes to support sector engagement via the Assembly, so that colleagues across the ICS are clear on how to make requests for sector support and input. This will ensure the sector can feed insights into appropriate decision

making and governance structures. We have spoken to other systems to explore how these processes can work and include a case study on page 22.

Our refreshed Assembly model includes members who are ‘portfolio holders’ aligned to our Joint Forward Plan priorities. This approach will support strategic connectivity between appropriate existing VCSE forums and ICS governance structures, and enable sector voice and integration into planning, strategy, and programmes of work.

Included in the proposal (page 20) is the recommended process of appointing a new VCSE Assembly Chair, as the current Chair has reached the end of their term.

The work programme for objectives 2-4 will be further developed upon successful appointment of the Health Inequalities and VCSE team and the re-launch of the Assembly Board.

ICB EMT endorsed the proposal on 8th May 2024.

Recommendations:

The Patient & Communities Committee is asked to agree the following:

- The proposed objectives and suggested actions of the overall VCSE integration work programme.
- The proposed governance structure, to include VCSE programme oversight and a VCSE Assembly model.
- The proposed VCSE Assembly model, in pursuit of Integration Programme Objective 1.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	Sector resilience significant risk, particularly to social prescribing and non-clinical/early intervention services.
Impact Assessment (environmental and equalities):	The VCSE sector can support engagement with communities experiencing health inequalities – lack of integration of the sector places risk on genuine community engagement/patient voice.
Reputation:	Limited tangible outcomes in first 3 years of delivery. Significant risk of losing sector input and buy-in if we can not move to a space of collaborative action.
Legal:	ICS Design Framework sets out a requirement to have a formal agreement for engaging and embedding VCSE sector in system-level governance and decision-making arrangements, ideally by working through a VCSE alliance to reflect the diversity of the sector.
Information Governance:	<i>Data sharing agreements with VCSE sector required - work underway linked to Data Hub/Shared Care Record to support sector integration ambitions that requires resourcing</i>

Parker, Michael
16/05/2024 16:35:18

Resource Required:	No additional resources required.
Reference document(s):	Norfolk & Waveney VCSE Integration Programme – Development Proposal 2024
NHS Constitution:	
Conflicts of Interest:	
Reference to relevant risk on the Board Assurance Framework	Links to BAF risk 06

Process/Committee approval with date(s) (as appropriate)	
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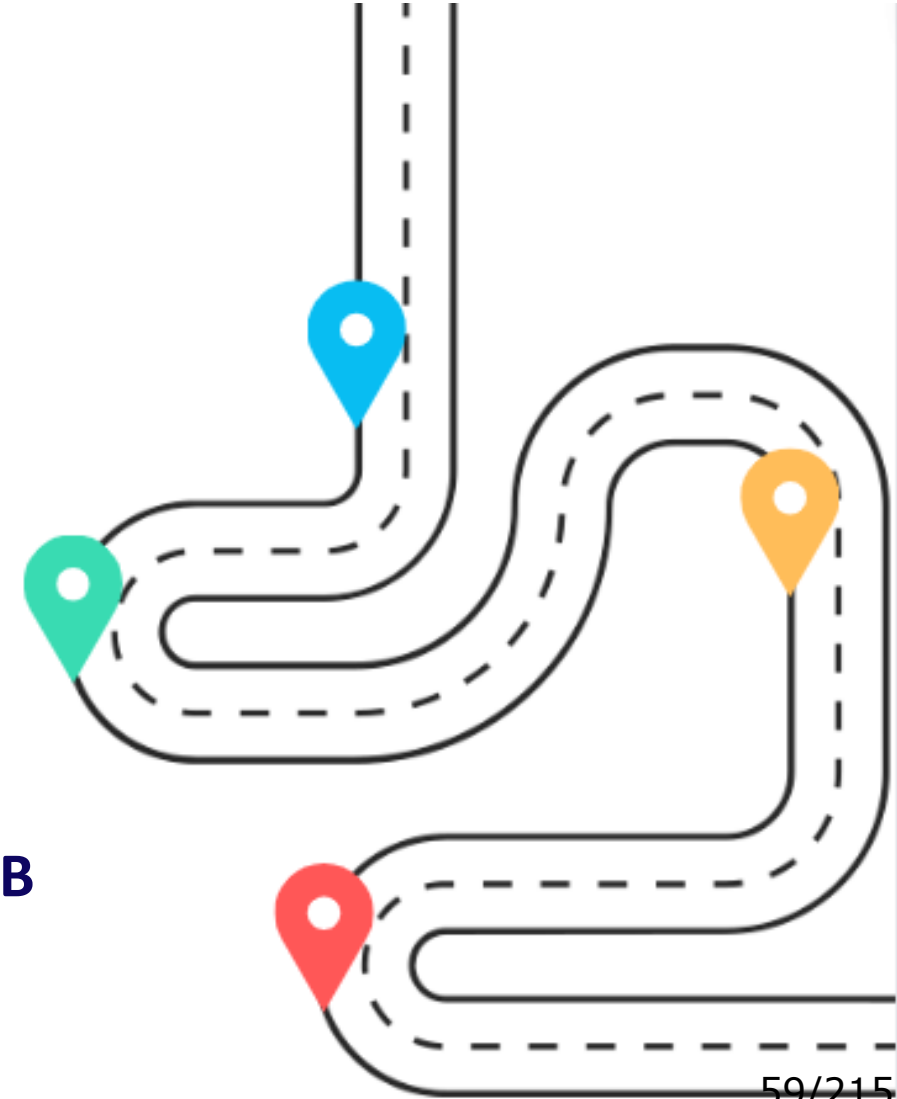
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16/05/2024 16:35:18

Norfolk & Waveney VCSE Integration Programme

Development Proposal 2024

Version 4.0

Prepared by: Shelley Ames, Acting Head of HI & VCSE - NWICB
Emma Ratzer, Chair - Norfolk & Waveney VCSE Assembly





Document Control

This document has been produced by the VCSE Assembly Board, VCSE Assembly Chair and Health Inequalities & VCSE team of NHS Norfolk and Waveney.

For further details please contact Shelley Ames, Acting Head of Health Inequalities & VCSE – shelley.ames@nhs.net

Revision History

Revision Date	Summary of Changes	Author(s)	Version Number
17.04.24	Additions following feedback from VCSE Assembly Chair – added slide 16 to explain engagement mechanisms	Shelley Ames	2.0
01/05/24	Additions following feedback from place team colleagues, VCSE Assembly Chair and VCSE Assembly Board members	Shelley Ames	3.0
02/05/24	Minor changes to finance information following feedback from Exec SRO	Shelley Ames	4.0

Approvals

Approval Date	Approval Body	Author(s)	Version Number
08.05.24	ICB EMT	Shelley Ames Emma Ratzer	4.0



Contents



Parker Rachael
16/05/2024 16:35:18

Slide No	Description
2	Document control
3	Contents
4	Introduction
5	Values and principles
5	Our VCSE Integration Programme Vision
7	Key strategic programme drivers
8	Programme summary
9	Key programme partners
10	Programme road map
11	Proposed governance arrangements
12	Objective 1
13	Key Assembly risks
14	Purpose of VCSE Assembly
15	Assembly functions
16	Assembly TOR summary
17	Assembly structure
18	Engagement mechanisms
19	Assembly Board members
20	Assembly Chair
21	Key Assembly actions 2024/25
22	Case Study
23	Finances
24	Appendix





Introduction

Integrated Care System guidance states that ***‘to build effective partnerships, ICSs should establish formal agreements that define engagement and embed VCSE involvement in decision making processes’.***

In recognition of this need to strengthen collaboration with the sector, a VCSE Assembly was established in 2021 with the appointment of a Chair following an extensive recruitment process. Much has been learnt, but now is the time to reset, seek to improve our engagement and use the newly developed Health Inequalities Framework for Action as an opportunity to establish some new ways of working whilst collaborating on something tangible.

In addition to supporting engagement and collaboration with the sector, the Assembly has a role in supporting the development of a VCSE integration programme, which is the responsibility of the wider system to come together to deliver.

Some progress has been made, but we are now looking to bolster capacity through the introduction of a Health Inequalities & VCSE team in the ICB, to work alongside other statutory partnerships with a role in supporting VCSE integration. We will reflect the learning from the first 3 years to further develop our shared agenda, so that we may move into the space of **collaborative action**.

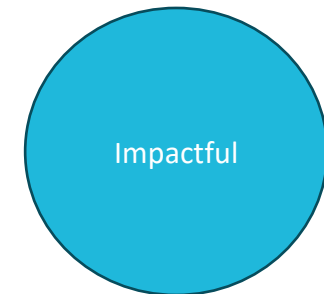
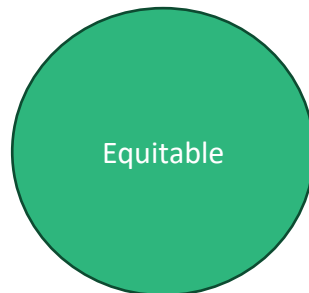
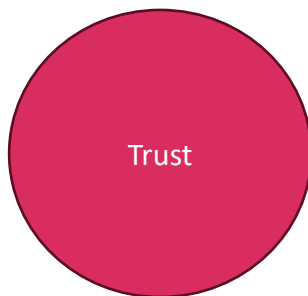
This proposal outlines the over-all focus of our VCSE Integration work programme, to reflect national guidance, as well as the proposed next steps to further develop our VCSE Assembly, which will support development of this programme of work.

Parker Rachael
16/05/2024 16:35:48



• Values and Principles

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



Parker Rachael
16/05/2024 16:35:18



Our ICS VCSE Integration Programme Vision

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

Parker Rachael
16/05/2024 16:35:18



Key strategic programme drivers

Local Strategies

The Norfolk & Waveney Joint Forward Plan recognises the unique role of the sector and commits the ICS to further development of the VCSE Integration Programme to enable a mutual benefit to equal partnering. The Integrated Care Strategy focuses on driving integration, prioritising prevention, addressing inequalities and enabling resilient communities and the case for strong alignment with VCSE sector achieve these ambitions is strong.

The newly developed ICS Health Inequalities Strategic Framework for Action further reinforces the important role of the VCSE sector and further underlines the requirement to enable equal partnering and more effective collaboration.

National Strategies & Guidance

The ICS design guidance sets out a requirement for ICSs to develop a formal agreement for engaging and embedding VCSE sector in system-level governance and decision making arrangements, ideally working through a VCSE Alliance to reflect the diversity of the sector. There is an expectation that these arrangements should build on the involvement of VCSE partners in relevant forums at place and neighbourhood level and be underpinned by a Memorandum of Understanding.

NHSE published VCSE Partnering Guidance in xx which sets out some key questions for consideration, as set out in Appendix 1 alongside a RAG of our current progress.



Programme summary

Norfolk & Waveney ICS VCSE Integration Programme

The overall VCSE Integration Programme underpins the arrangements we have in place with the sector to achieve 4 core objectives:

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

**Collaborate,
Co-produce
& Embed**

Norfolk & Waveney VCSE Assembly

The VCSE Assembly supports engagement with the VCSE sector, to embed sector voice into planning & decision-making processes, whilst providing sector oversight to the ICS VCSE Integration Programme by:

- Developing engagement mechanisms to connect the sector into the ICS, focused on Joint Forward Plan priorities and connecting to thematic system and place-based arrangements.
- Increasing influence and participation of the sector in design and delivery of services

**Listen &
Involve**

Norfolk & Suffolk VCSE Infrastructure arrangements

The infrastructure arrangements for Norfolk & Suffolk are commissioned by Norfolk & Suffolk County Councils. These arrangements seek to:

- Grow and enable volunteering for the ICS.
- Raise awareness and support the sector to access and maximise funding and income sources.
- Support sector resilience and growth through training and development.
- Provide financial support to grow, expand or innovate their services
- Provide opportunities for the sector to meet and collaborate

**Support,
nurture &
develop**

Parker, Rachael
16/05/2024 16:35:18



Key programme partners

Norfolk & Waveney benefits from a broad and diverse VCSE sector made up of registered charities, communities interest companies, societies and many 'below the radar groups'. Their contribution to an ICS is significant, with much of their work impacting on health & wellbeing.

The County Councils lead and commission a range of statutory services where the VCSE have an important role to play. Currently the County Councils also commission VCSE infrastructure arrangements. District/City/Borough councils also work closely with the sector and commission activity at a local level.

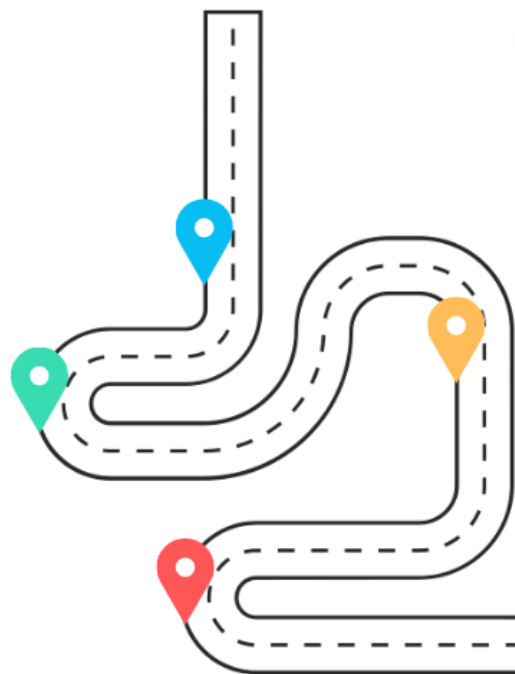


The Integrated Care Board has an important role to play as commissioner of services and enabling strategic development of the Integrated Care System. Ensuring equal partnering with the VCSE sector can support the achievement of numerous strategic ambitions.

The Place Boards & Health & Wellbeing Partnerships are an important conduit to locally based organisations such as district councils and health & care providers. Enabling decision making closer to communities will ensure a 'bottom up' approach to the development of the Integrated Care System.



Programme roadmap – how we will achieve our core objectives

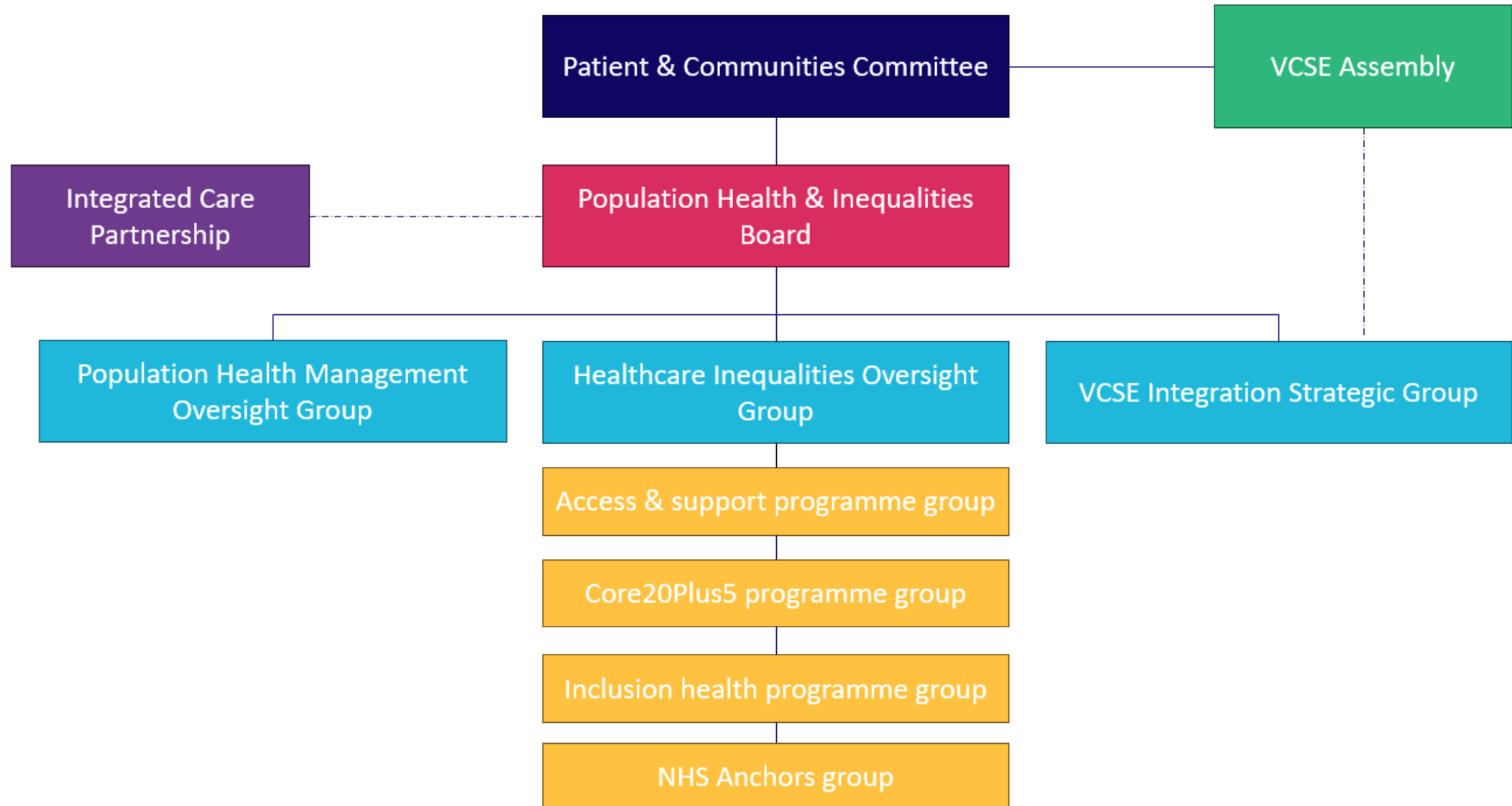


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- Review and relaunch VCSE Assembly - Recruit new Assembly Chair (current Chair reached end of term) - Development of VCSE portfolio holders, as part of Assembly, to support strategic input into system & place-based decision making and communications with wider sector. - Review ICS governance arrangements and ensure representation from VCSE sector as appropriate. - Develop and drive Assembly membership campaign to support sector comms. - Host bi-annual sector engagement events to develop Assembly membership and engage wider sector.	- Alongside Assembly agree process for supporting co-design of strategy, services and programmes with sector and communicate to ICS colleagues (i.e. how do statutory partners <i>request</i> input). - Support implementation of the Health Inequalities Strategic Framework for Action, specifically: - Communication of Framework to sector - Driving pledge uptake amongst the sector - Drive participation in system baselining exercise to understand our start position and measure our future impact - Supporting development of action plans for the 3 priority areas for action - Supporting development of outcomes measurement frameworks. - Development of strategic plans for social prescribing including role out of digital 'Joy' platform. - Supporting implementation of volunteering strategies for Norfolk & Suffolk, aligning with system workforce and HI programme.
3. Support and enable a thriving VCSE sector to play its part	4. Build strong, inclusive and empowering relationships through our partnership
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Proposed governance arrangements



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16/05/2024 16:35:18



Improving lives **together**

Norfolk and Waveney Integrated Care System

Objective 1

**Embedding the VCSE sector as
an equal partner in our ICS**

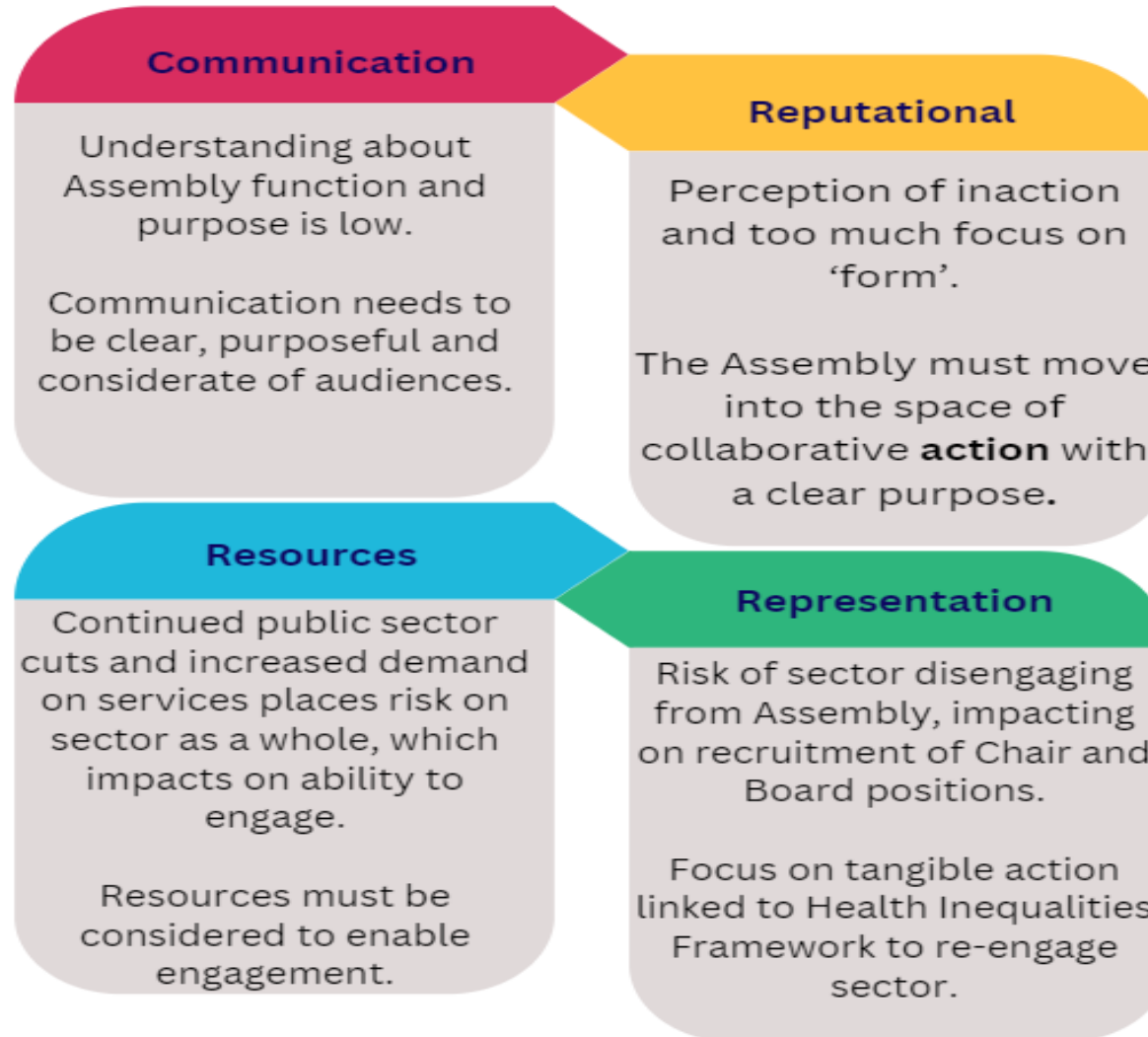


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Key Assembly Risks

It is important to recognise the current risks associated with the Assembly, given the current position and time spent reviewing scope and remit. These risks will be mitigated through the development of a robust implementation plan for the next iteration of the Assembly.



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16/05/2024 16:35:18



Purpose of VCSE Assembly

To support fair & equitable partnering and engagement with the VCSE sector as part of the Integrated Care System, embedding sector voice into planning & decision-making processes.

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16/05/2024 16:35:18



Assembly functions

- Support two-way connectivity between the sector, the ICB and the wider ICS – providing sector voice and ensuring communication of key messages back to the sector by:
 - Identifying appropriate representation on ICS governance structure (through a process)
 - Utilising local networks, forums and communications channels to communicate key information to and from the sector, supported by HI & VCSE team
 - Identifying strategic gaps in communication mechanisms/forums and leading development of solutions.
 - Lead annual/bi-annual sector engagement events to support wider sector engagement
- Support development of the VCSE Integration Programme, to achieve our overarching vision.
- Support development of ICS strategic ambitions, particularly those relating to the Integrated Care Strategy and Joint Forward Plan, via 'Portfolio Holders' that make up the VCSE Assembly Board who work alongside key statutory colleagues. Enable co-design of strategy and services as required.

To report progress and escalate risks to Patient & Communities Committee and ICP.

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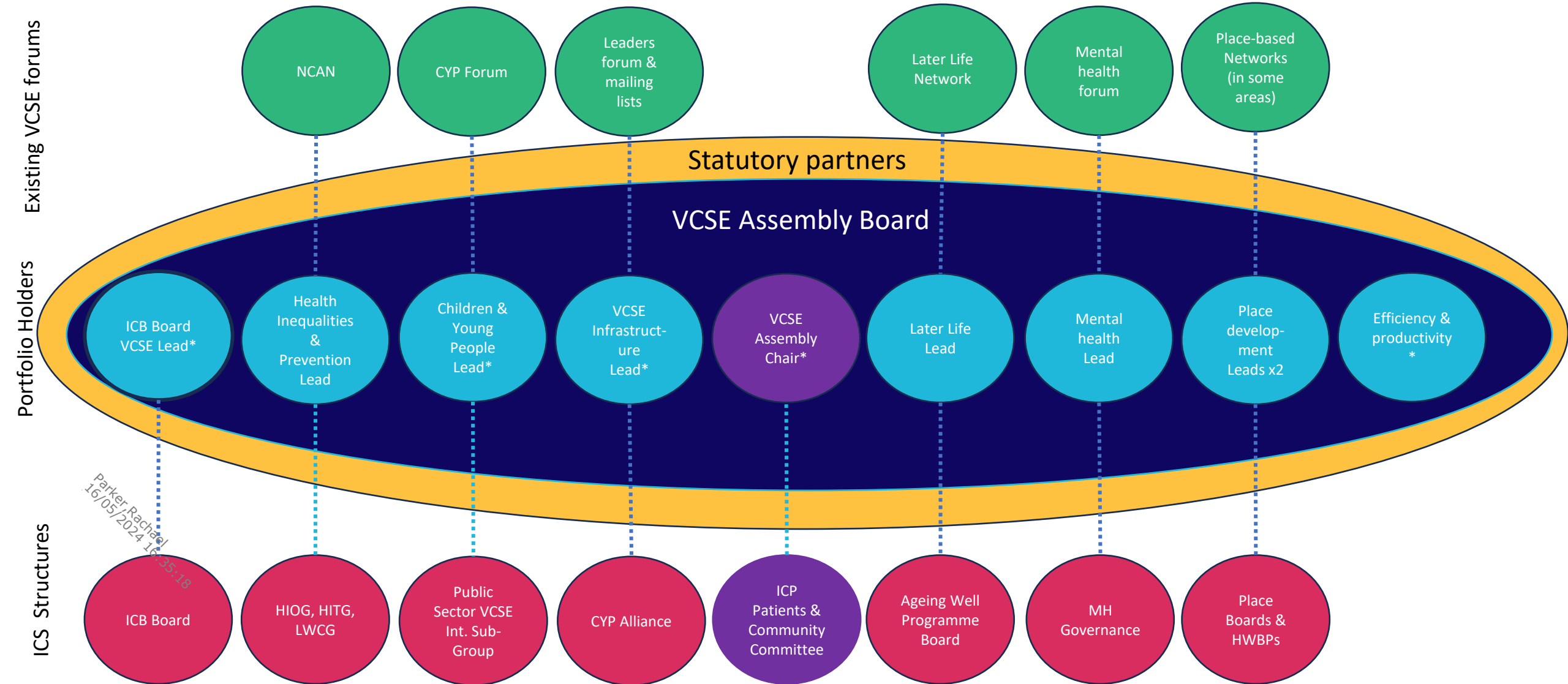
Assembly TOR Summary

- Formal Assembly Board to meet quarterly
- Opportunity for questions to be posed by VCSE and requests to be brought by ICS organisations (specifically requests for input into strategy, governance arrangements)
- Board to be made up of VCSE portfolio holders aligned to JFP priorities, to include:
 - VCSE Assembly Chair
 - Health Inequalities & Prevention
 - Children & Young People
 - Mental Health
 - Later Life
 - Productivity & efficiency (commissioning & finance)
 - Place development
 - VCSE infrastructure (finance, data sharing, training, evidence & evaluation)
- Portfolio holders will provide strategic connectivity to appropriate VCSE forums and ICS governance structures
- Public Sector representation to include ICB Board, Norfolk County Council, Suffolk County Council and a District Council representative.
- Two 'sub-groups' will support the work of the Assembly and provide 'safe space' for sector discussions, as well as ensure strategic alignment between public sector bodies with responsibilities around VCSE commissioning and infrastructure.
- The ICB Health Inequalities & VCSE team will support with administration and programme management, with support from public sector colleagues as appropriate.

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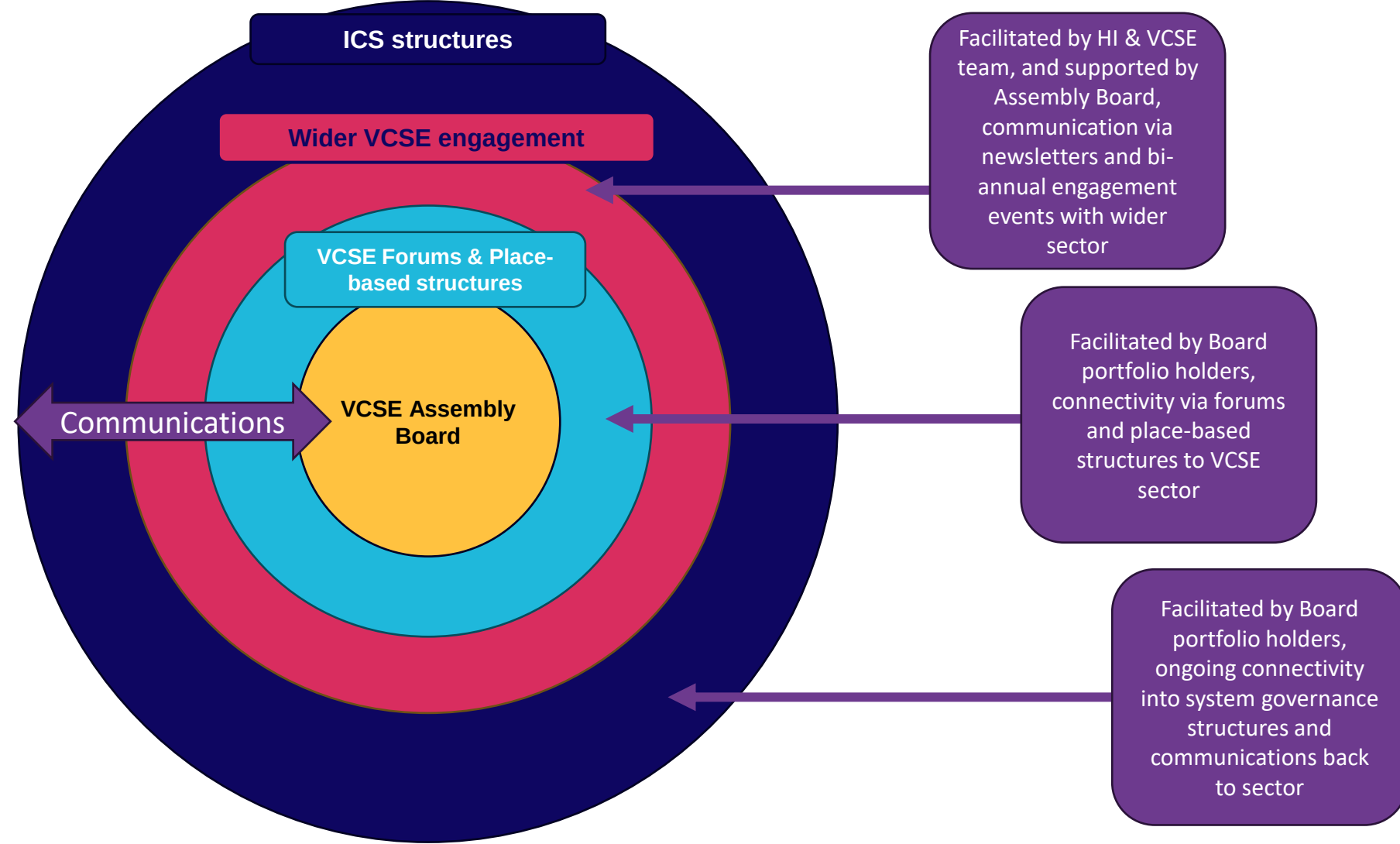


Assembly Structure





Engagement mechanisms



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Assembly Board Members/Portfolio Holders

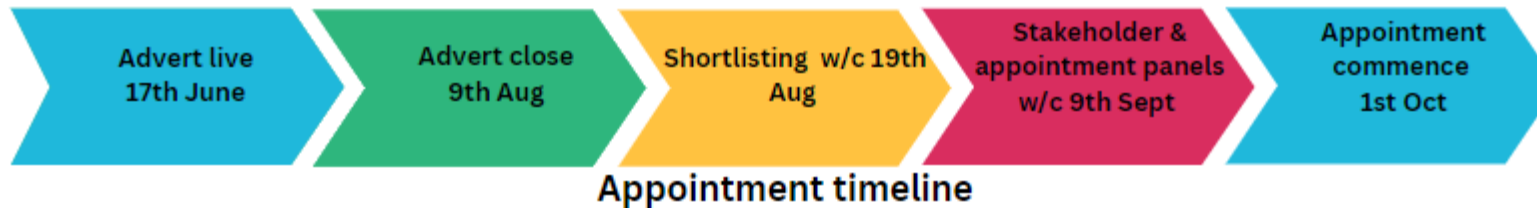
- VCSE Board members will be appointed by the Chair of VCSE Assembly
- All VCSE Board members will hold a portfolio
- Board members will serve a term of 3 years
- Where possible Board members will be made up of Chairs of existing identified forums
- Where forums do not exist an appointment process will be undertaken
- Board members will:
 - Attend VCSE Assembly Board and VCSE Strategic Group meetings.
 - Together support the development of the ICS VCSE Integration Programme.
 - Work with appropriate statutory partners to identify key priorities and deliverables aligned to portfolio i.e. specifically how Place portfolio holders can support development of Place agenda.
 - Work with appropriate statutory partners to support development of JFP ambitions, attending appropriate meetings and acting as a conduit to the wider sector.
- Board members (where appropriate) will be remunerated via a grant arrangement with VCSE infrastructure, aligning with NCC Empowering Communities arrangements.

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16/05/2024 16:35:18



Assembly Chair

- The VCSE Assembly Chair had a term of 2 years, but this has been extended to 3.5 years
- An appointment process will be launched in June 2024 to recruit a new Chair for the next 3 years
- The Chair will be appointed by the ICB on a 4 day per month basis
- The process will include
 - Advertising of position across the ICS with a candidate information pack Recruitment of VCSE leaders to support a stakeholder panel via a stakeholder briefing pack and EOI process
 - A shortlisting and interview panel, who will make the final decision of appointment, made up of VCSE and statutory sector leaders



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16/05/2024 16:35:18



Key Assembly actions 2024/25

- Appoint new Chair & portfolio holders
- Review existing VCSE representation on governance arrangements and establish policy and process for determining reps.
- Support relationship development between portfolio holders and key ICS leads to support strategic priorities and enable appropriate sector voice as required.
- Develop effective communications mechanisms to and from the sector, working alongside system partners i.e. via sector newsletters, existing forums and place-based networks and bi-annual engagement events.
- Establish robust reporting lines to Patient & Communities Committee and Integrated Care Partnership
- Support development of new infrastructure arrangements in Norfolk (and Suffolk?)
- Support implementation of year 1 actions related to Health Inequalities Framework for Action, including:
 - Inputting into appropriate governance structures, supporting planning and providing leadership as required
 - Leading communication around the HI Framework to the VCSE sector and driving VCSE sign up to the HI Pledge Programme
 - Participating, and supporting the sector to participate in, baseline self-assessment exercises
 - Develop case studies and showcase good practice to help shape the tools to address health inequalities
 - Enabling data sharing and supporting development of outcome measurement frameworks
- Develop 3-year VCSE Integration Programme with ICB Health Inequalities & VCSE team, Norfolk County Council & Suffolk County Council to include a VCSE Commissioning Strategy.

Parker Rachael
16/05/2024 16:35:18



Case Study

Lancashire & South Cumbria VCFSE Alliance

- The ICS has established a process for identifying VCSE representatives on ICS governance structures which includes:
 - Requests by statutory partners made via a form/request to Alliance
 - Expression of Interest link shared with sector via communications channel and shared via social media (Alliance has own accounts)
 - Board agree representation
 - Standard role description for representative roles developed and amended to suit requirements of each governance structure
 - All representation published, alongside TOR on Alliance website
<https://new.healthierlsc.co.uk/VCFSE/our-work/system-meetings>



Lancashire and
South Cumbria
**VCFSE
Alliance**

Connected • Supported • Influenced

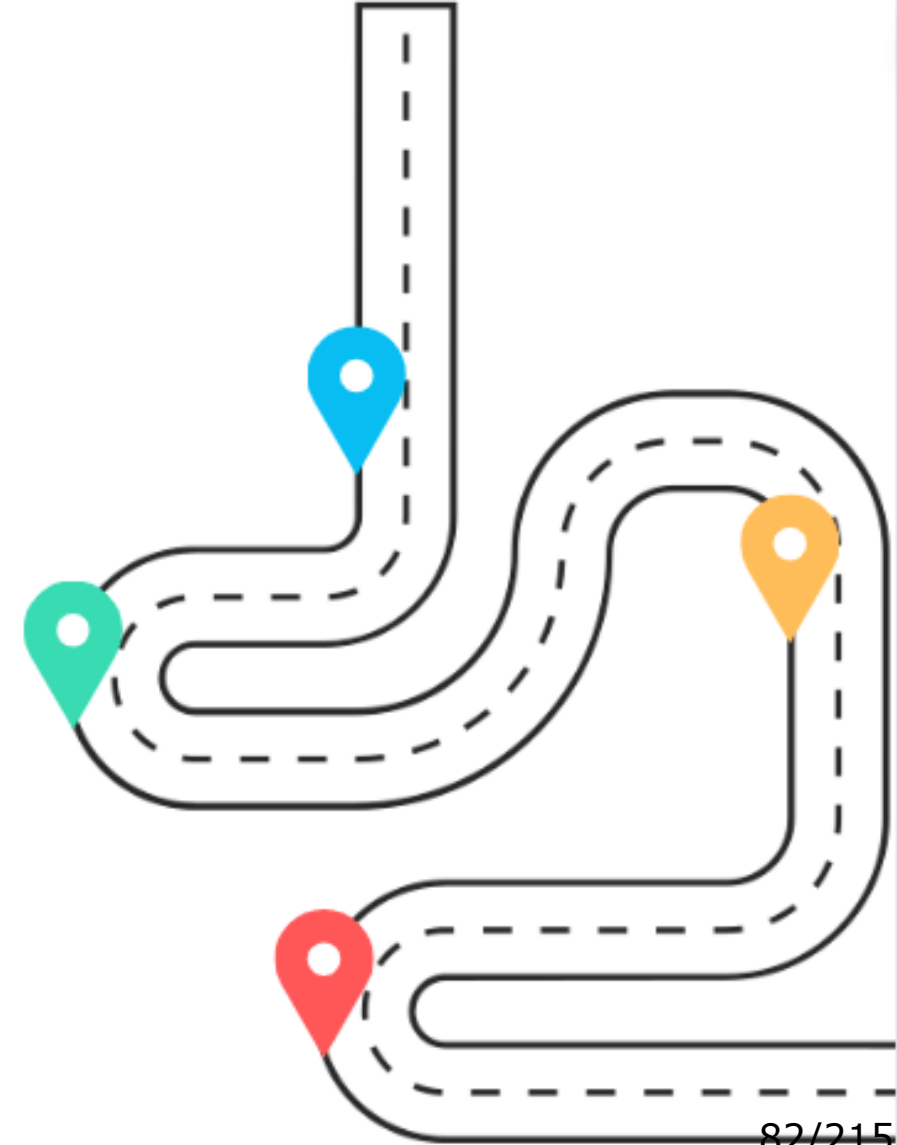


Finances

- In line with efficiency objectives, which have been applied, there is a recurrent budget identified which in 2024/25 equates £45,125 to support VCSE Integration activity.
- It is recommended that this is granted to VCSE infrastructure (Voluntary Norfolk) to administrate VCSE Assembly activity, to include spend on:
 - Remuneration of VCSE board members time to support attendance at Assembly Board and key ICS meetings
 - Bi-annual Assembly events to support engagement with wider sector
 - Communications activity
- Opportunities to align with future infrastructure contracts will be explored in 2024/25.

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Appendix





Where we need to get to - national VCSE Partnering guidance



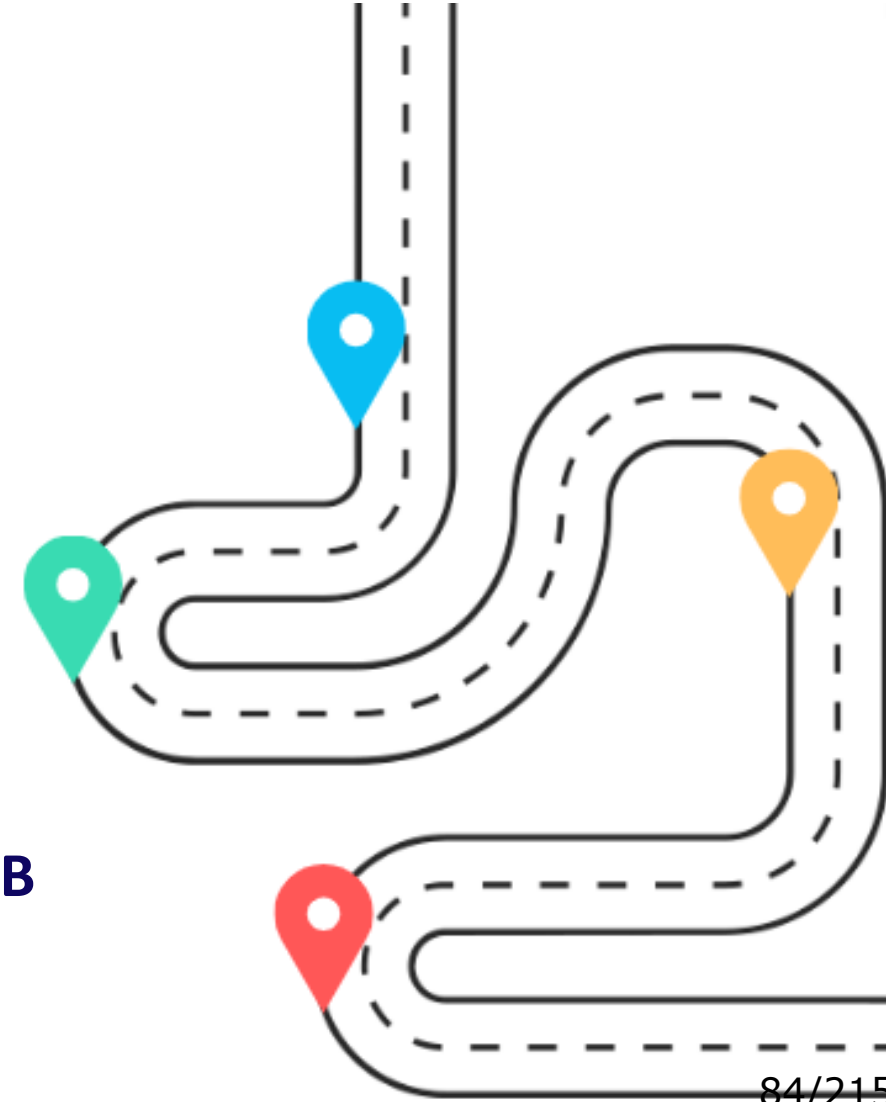
Action	RAG Rating
Is there VCSE sector involvement in system wide workstreams, service redesign, place-based partnerships, provider collaboratives?	
Have you mapped VCSE Stakeholders and the contribution and resources brought by the VCSE sector to the ICS?	
Are you working with VCSE groups relevant to the priorities you are tackling and the population groups you are trying to support?	
Are you building on existing structures and networks, such as VCSE representation on health and wellbeing boards and local VCSE infrastructure organisations?	
Have data sharing agreements been put in place between health, care and VCSE partners?	
Do you actively support NHS anchor institutions to work in partnership with the VCSE sector and involve the sector in networks to take joint action on the social determinants of health?	
Do you have a co-ordinated system approach to developing and sustaining effective social prescribing, developed with input from VCSE sector leaders, local authority and health commissioners, primary care networks, referral agencies and the health and wellbeing board?	
Does the ICS support a sustainable VCSE sector through market development, strategic grants and investment in VCSE infrastructure and alliances, whilst understanding where communities are not served or advocated for by the VCSE?	
Are you being proactive in commissioning VCSE organisations to deliver services including with innovative approaches to population health management and service transformation?	
Can you develop non-financial support for VCSE organisations, such as their inclusion in leadership and quality training, workforce diversity and wellbeing initiatives, secondments and supported leadership opportunities on system workstreams?	
Do you have a consistent approach to measuring the impact of VCSE partnerships as part of a wider social value approach?	
Does the ICS have a strategy to support and increase volunteering in both public and VCSE sectors?	

Norfolk & Waveney VCSE Integration Programme

Development Proposal 2024

Version 4.0

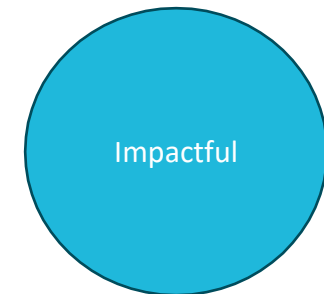
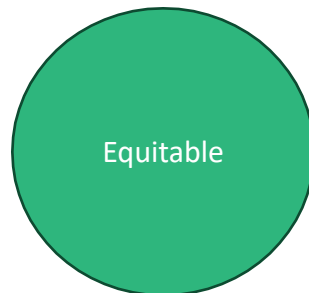
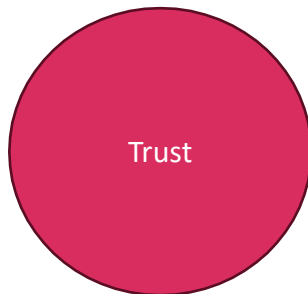
Prepared by: Shelley Ames, Acting Head of HI & VCSE - NWICB
Emma Ratzer, Chair - Norfolk & Waveney VCSE Assembly





• Values and Principles

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



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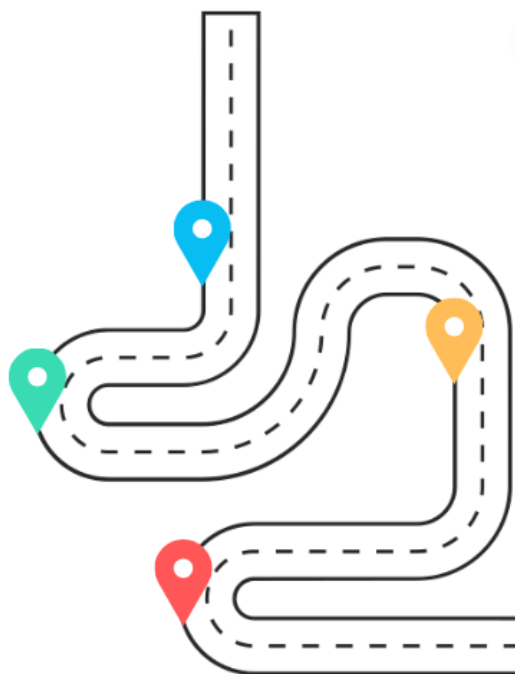
Our ICS VCSE Integration Programme Vision

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

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Programme roadmap – how we will achieve our core objectives

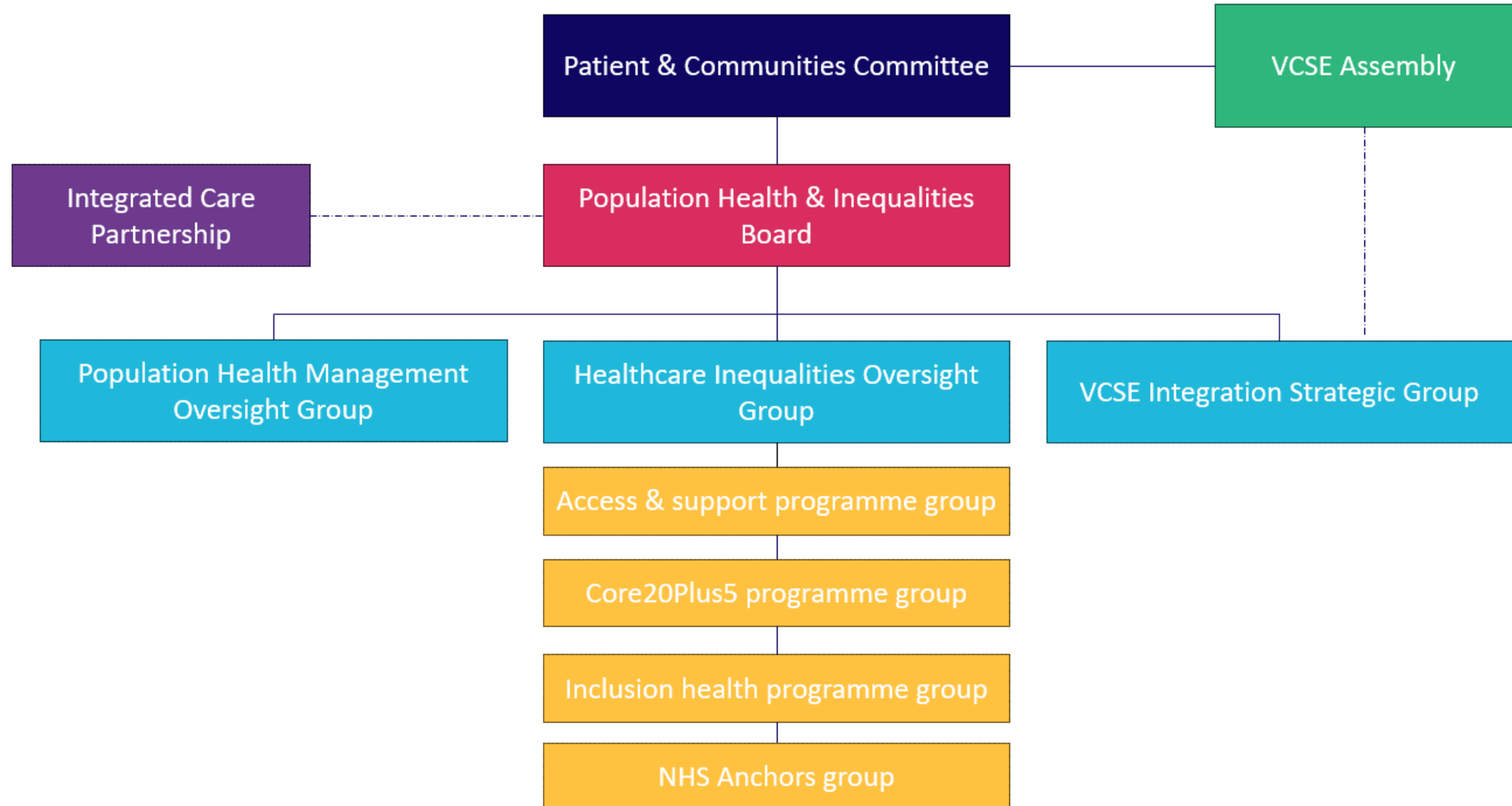


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Proposed governance arrangements



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16/05/2024 16:35:18



Improving lives **together**

Norfolk and Waveney Integrated Care System

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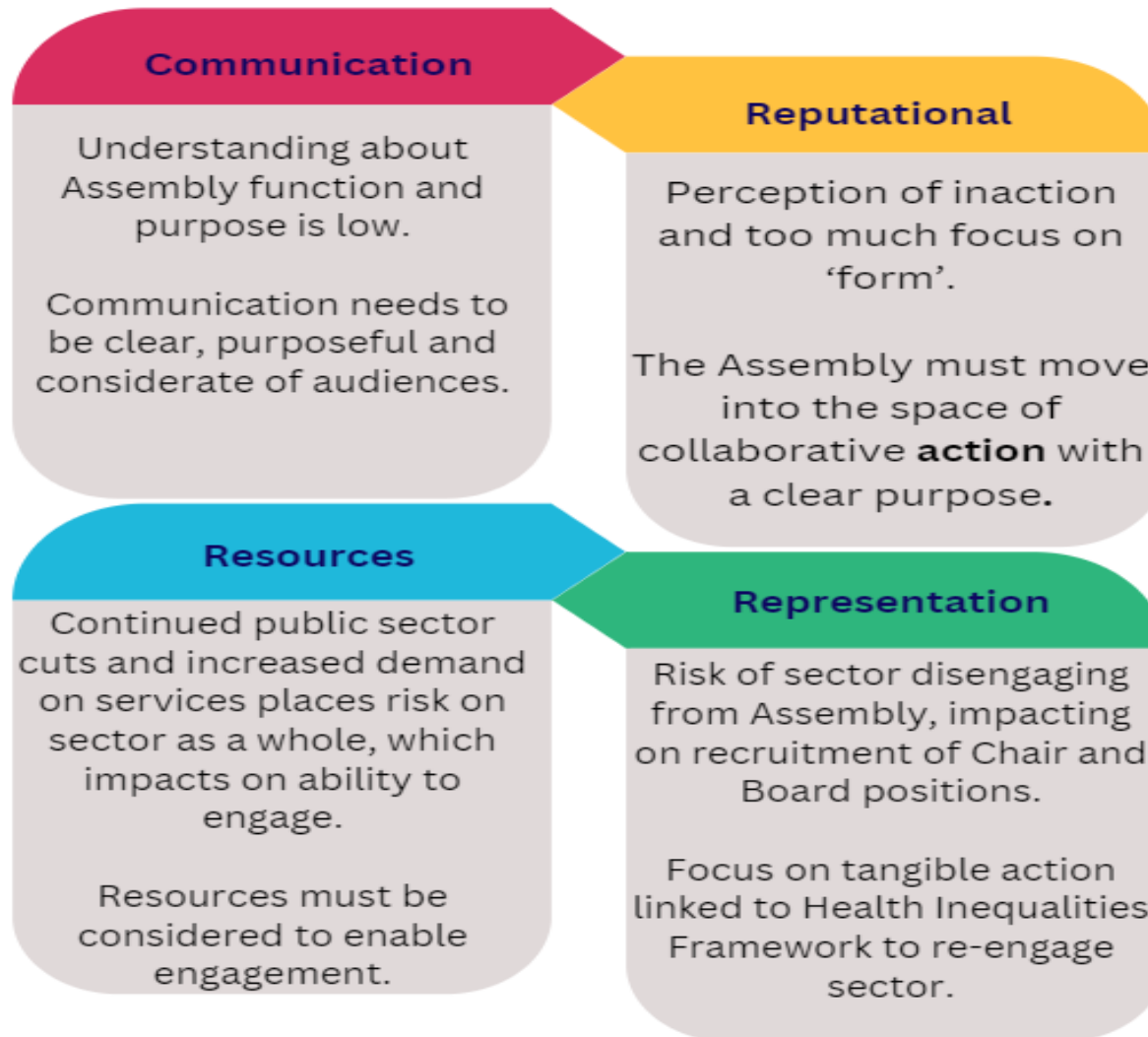


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16/05/2024 16:35:18



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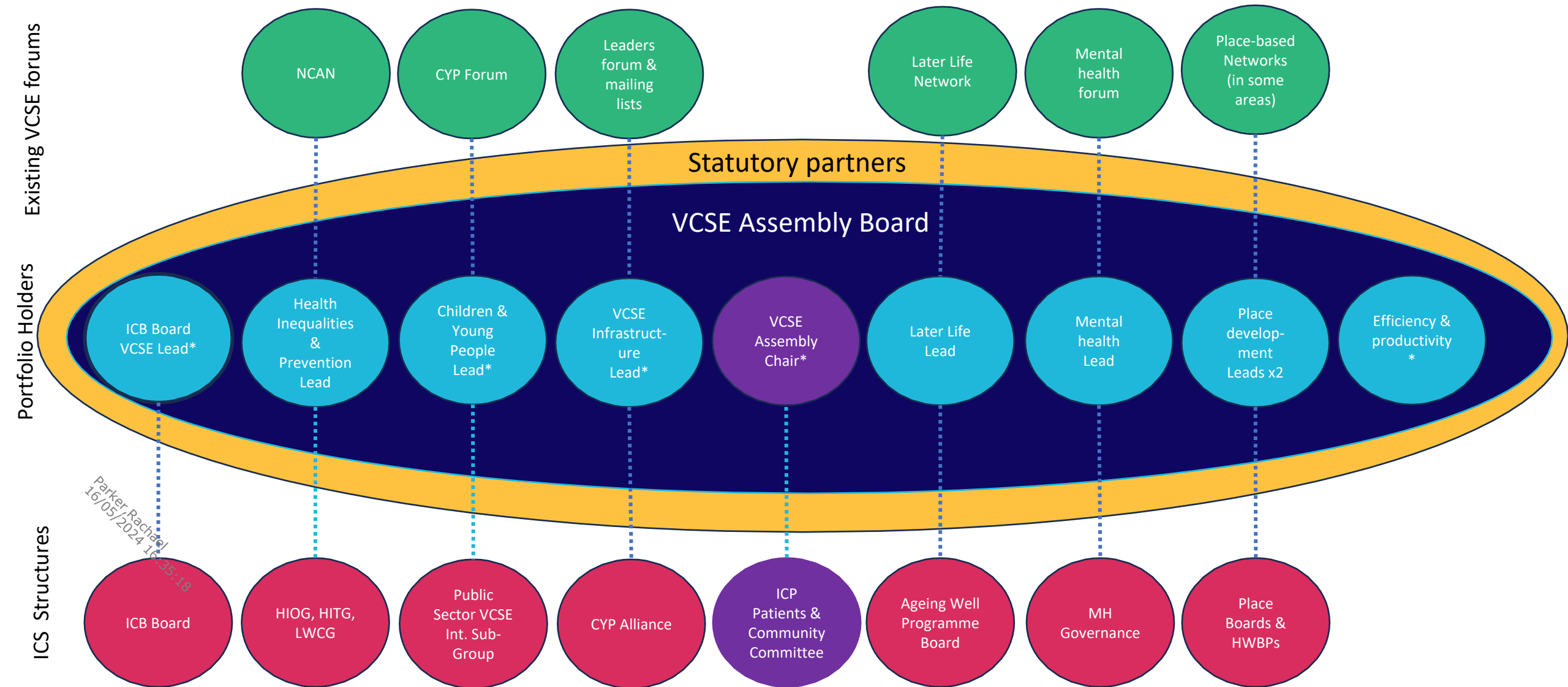
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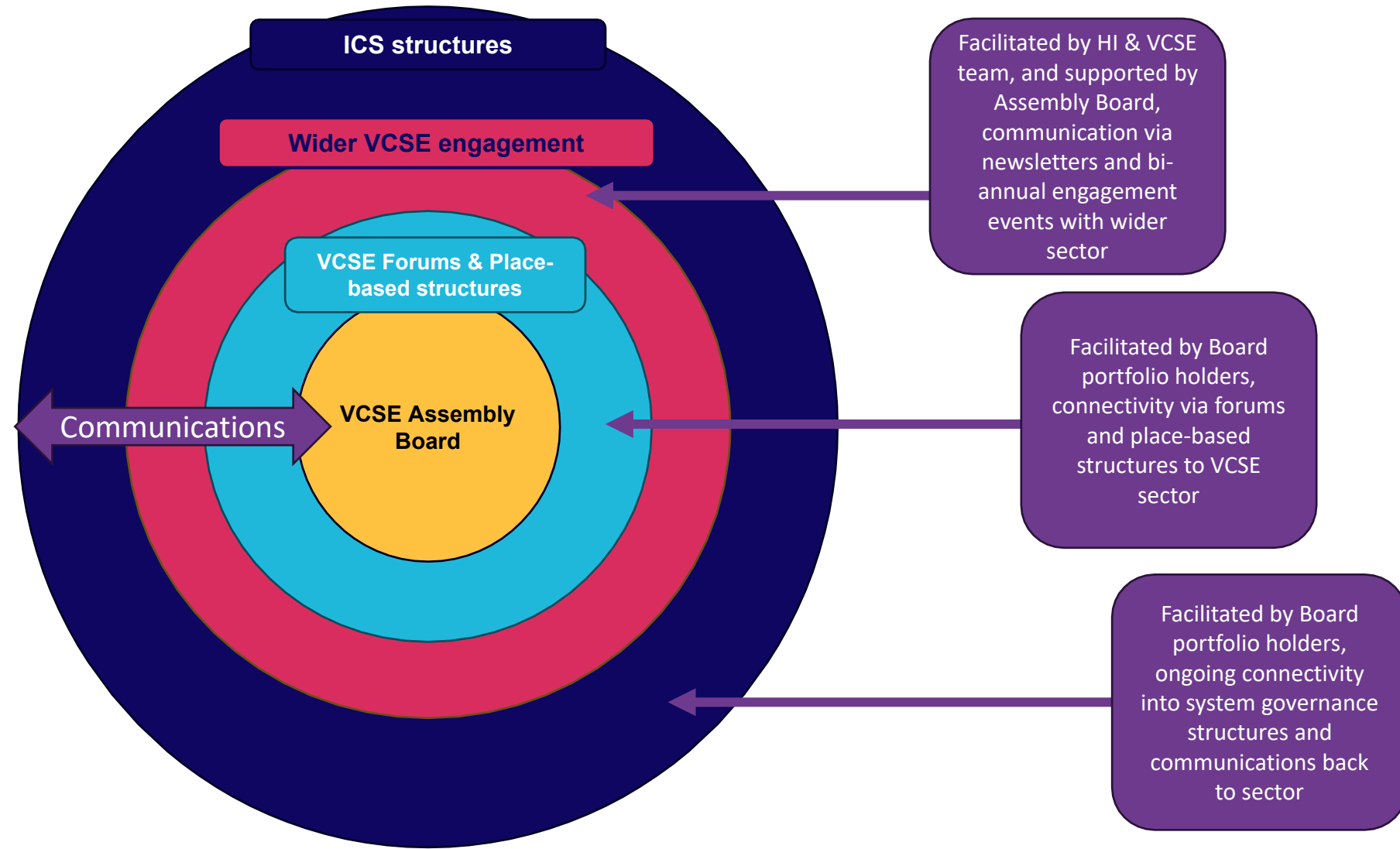


Assembly Structure





Engagement mechanisms

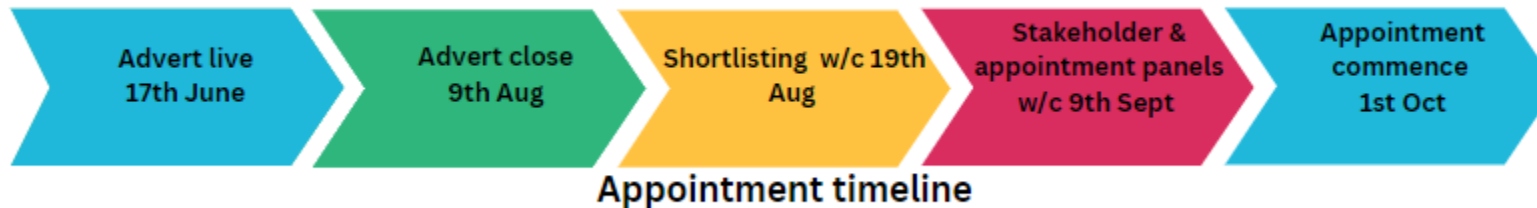


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Parker Rachael
16/05/2024 16:35:18

Agenda item: 8

Subject:	Norfolk and Waveney People and Communities approach refresh
Presented by:	Emily Arbon, Head of Communications
Prepared by:	Rebecca Champion, Senior Communications and Engagement Manager - Partnerships
Submitted to:	Patients and Communities Committee
Date:	20 May 2024

Purpose of paper:

To update the Patients and Communities Committee on the refreshed People and Communities Approach Document, in line with the Working with People and Communities ICS guidance, and in anticipation of the forthcoming Improvement and Assessment Framework (IAF) relating to consultation and engagement.

Executive Summary:

The NHS England 'Working with People and Communities' guidance aimed to ensure that the voice of local people was embedded in emerging integrated care systems.

Norfolk and Waveney developed an approach that recognises the importance of building on existing good practice across the system, and working with local people, stakeholders and partners to develop sustainable and mutually supportive partnerships. [Our approach](#) was submitted to NHS England in May 2022 for assessment, and received [very positive feedback](#). It is built around the idea that all the partners in our ICS are talking and listening to people & communities every day. Our ultimate vision is that people would tell their story of lived experience once and it's heard by everyone in the ICS.

Since the original approach document was developed progress has been made and a refreshed document was required. This version reflects progress over the last two years, with particular reference to the following areas:

- **Co-production** – the development of a [co-production hub](#) on the ICS website as a focal point for the system to promote resources and local and national examples of good practice. There is also emerging systemwide interest with ICB membership of co-production networks led by Norfolk County Council and Health and Wellbeing Partnerships. There have also been successful examples locally

Parker Rachael
16/05/2024 16:25:18

including the co-production of the [Carers Identity Passports and Carers awareness training](#), and the [Mental Health Co-production Strategy and Toolkit](#).

- **Norfolk and Waveney Community Voices** – the development of the programme has meant that there has been development towards the vision of a systemwide insight bank as a listening tool to collect and promote existing feedback especially from our quieter communities.
- **The People and Communities Hub** – the development of a [hub on the ICS website](#) as a focal point for the approach the ICB is taking to fulfil the national guidance and to discharge our legal duties to consult and involve in Norfolk and Waveney.
- **5-Year Joint Forward Plan** – inclusion of the [engagement](#) undertaken to include local people and communities in the [JFP as a key planning document](#) for local services. The plan was published after the original people and communities approach was developed.

Report

Please refer to the document included below.

Recommendation to the Committee:

To note the progress so far towards implementing our approach to working with people and communities. To endorse the refreshed approach document.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	
Legal:	
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A

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Reference to relevant risk on the Board Assurance Framework	N/A
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Governance

Process/Committee approval with date(s) (as appropriate)	Audit Committee for information.
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16/05/2024 16:35:18

Our Approach to Working with People and Communities in Norfolk & Waveney

Working DRAFT v11 April 2024



Parker Rachael
16/05/2024 16:35:18

Version control	Date	Author	Status	Comments
V1	March 2022	Rebecca Champion	Draft	Initial draft shared with evidence pack to NHSEI
V5	April 2022	Rebecca Champion	Draft	Draft shared with system partners for comment
V7	19 May 2022	Rebecca Champion	Draft	Submitted to system oversight group for comment
V8	27 May	Rebecca Champion	Working Draft	Submitted to NHSEI
V8	8 June – 18 July 2022	Rebecca Champion	Working Draft	Draft shared with public and stakeholders for comment including easy read summary version
V9	23 June 2022	Rebecca Champion	Working Draft	Draft updated to reflect new map & changes to names and structures for inclusion in the governance handbook
V10	23 January 2023	Rebecca Champion	Working Draft	Updated to reflect feedback from public engagement & system developments. Submitted to Patients & Communities Committee
V11	02 April 2024	Rebecca Champion	Working Draft	Updated to reflect system changes and ICB reorganisation. This draft will be submitted to the Patients and Communities Committee & engaged on alongside the JFP Refresh later in 2024.

This is a working draft which describes an approach to working with people and communities in Norfolk and Waveney. This document and the design of the approach are still under development as local discussions continue, as it is recognised that this approach will take time to fully develop and embed. A version of this document was shared with NHS England as a working draft on 27 May 2022 as part of the strategic assurance around working with people and communities.

It received [very positive feedback](#) as well as some suggestions for improvement that have been reflected in subsequent versions.

Key Definitions:

[Integrated Care System \(ICS\)](#) - new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

[Integrated Care Board \(ICB\)](#) - an organisation with responsibility for NHS functions and budgets. Membership of the board includes 'partner' members drawn from local authorities, NHS trusts/foundation trusts and primary care

Integrated Care Partnership (ICP) - a statutory committee bringing together all system partners to produce a health and care strategy. Representatives include voluntary, community and social enterprise (VCSE) organisations and health and care organisations, and representatives from the ICB board.

Health and Wellbeing Partnerships (HWP) - are local place-based partnerships work on addressing the wider determinants of health, reducing health inequalities and aligning NHS and local government services and commissioning.

Lived experience - knowledge gained by people as they live their lives, through direct involvement with everyday events. It is also the impact that social issues can have on people, such as experiences of being ill, accessing care, living with debt etc.

More definitions are included in our short **[glossary](#)** in Appendix 2 and in our comprehensive version online **<https://improvinglivesnw.org.uk/about-us/website-glossary-of-terms/>**.

Parker Rachael
16/05/2024 16:35:18

Norfolk and Waveney Integrated Care System

What is integrated care?



Integrated care involves partnerships between the NHS, local authority, and VCSE sector as they come together to plan and deliver joined up health and care services to improve the lives of people in their area.

Our mission



To help the people of Norfolk and Waveney live longer, healthier, and happier lives.

Our ICS includes:

17 Primary Care Networks

NHS Provider Collaboratives

Place-based partnerships

Integrated Care Partnership

Integrated Care Board

Local health and wellbeing partnerships

Our goals

1



To make sure that people can live as healthy a life as possible.

2



To make sure that you only have to tell your story once.

3

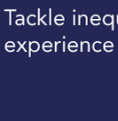


To make Norfolk and Waveney the best place to work in health and care.

We will work to:



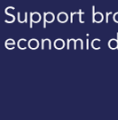
Improve outcomes in population health and healthcare.



Tackle inequalities in outcomes, experience and access.

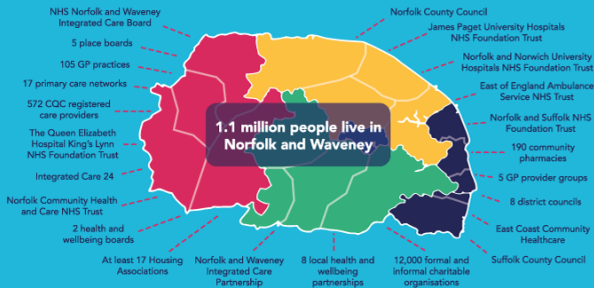


Enhance productivity and value for money



Support broader social and economic development.

Our geographical area:



Parker Rachael
16/05/2024 16:35:18

Summary – What is this document saying?

People with lived experience tell their story once and it is heard across the ICS

Integrated Care Systems were created to help everyone involved in supporting health and care work together better. Listening to the lived experience of the people and communities in Norfolk and Waveney is vital in helping people live longer, healthier and happier lives. It also helps us make sure that the care and support offered in Norfolk and Waveney is designed around our population.



All the partners in our ICS are talking and listening to people & communities every day. Our vision is that people would tell their story of lived experience once and it's heard by everyone in the ICS. We want to develop on-going relationships with communities to learn what matters to them, and work together to address waiting times, improve access to services and support people to live the healthiest life possible.

We want to build on the existing engagement and insight that happens across all our system partners and find ways of working together to share and learn from this insight.

Working together will also mean we can pool our resources and work more efficiently across the ICS.

We learnt during the COVID-19 pandemic that we need to get better at listening to what really matters to our people and communities, especially if we are going to address health inequalities. A really effective way to do that is to use trusted communicators, people who are part of the local community – 'people like me'. A good way to do that is by working with Voluntary, Community & Social Enterprise (VCSE) organisations who already have long standing relationships and networks throughout Norfolk and Waveney.

We recognise that to do all this we will need to use good quality, innovative communications, that are accessible for everyone and available in a range of formats. Whilst we see the value of offering lots of digital opportunities in a large rural area like Norfolk and Waveney, we are also aware that not everyone has a good mobile signal or access to broadband connections and that some people just are not able to access information online. We will all use a range of methods of going out to our people and communities so we can move forward as an ICS together.

NHS Norfolk & Waveney ICB oversees and works with ICS partners to make sure that we constantly listen to and engage with people and communities – as one whole system. That is why this document sometimes refers to structures and processes in the ICB. Our glossary at the end of this document is designed to help with the new terms and language used.

We hope you enjoy reading about our approach to working with people and communities in Norfolk and Waveney!

Parker Rachael
16/05/2024 16:35:18

Introduction

[Integrated Care Systems \(ICSs\)](#) are partnerships between the organisations that meet health and care needs across an area. These partnerships will help to coordinate services and to plan in a way that improves the health of people and communities and reduces inequalities between different groups.

The purpose of this document is to outline the strategic approach being undertaken in Norfolk and Waveney ICS to working with people and communities, so that we can achieve the ambition laid out in the [guidance](#) that partners in an integrated care system (ICS) should work together to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services.



This strategic approach will follow the recommendations of the [NHS Confederation in 'Building Common Purpose'](#). It will give us a way of working with all our partners to ensure that how we work with people and communities, how we respond to their views and experiences, and how we identify and share the impact of what we learn, are aligned.

Building on learning during the COVID-19 pandemic, our vision is to improve our collective ability to listen to what people are saying across Norfolk and Waveney about what matters to them. We can do this by going out to the communities we serve, and by building on existing community engagement assets among our ICS partners including the VCSE sector. Feedback and insight can be joined up across ICS partners and channelled into decision making structures, so that insight shared in one part of the ICS is gathered and heard by other partners across the system.

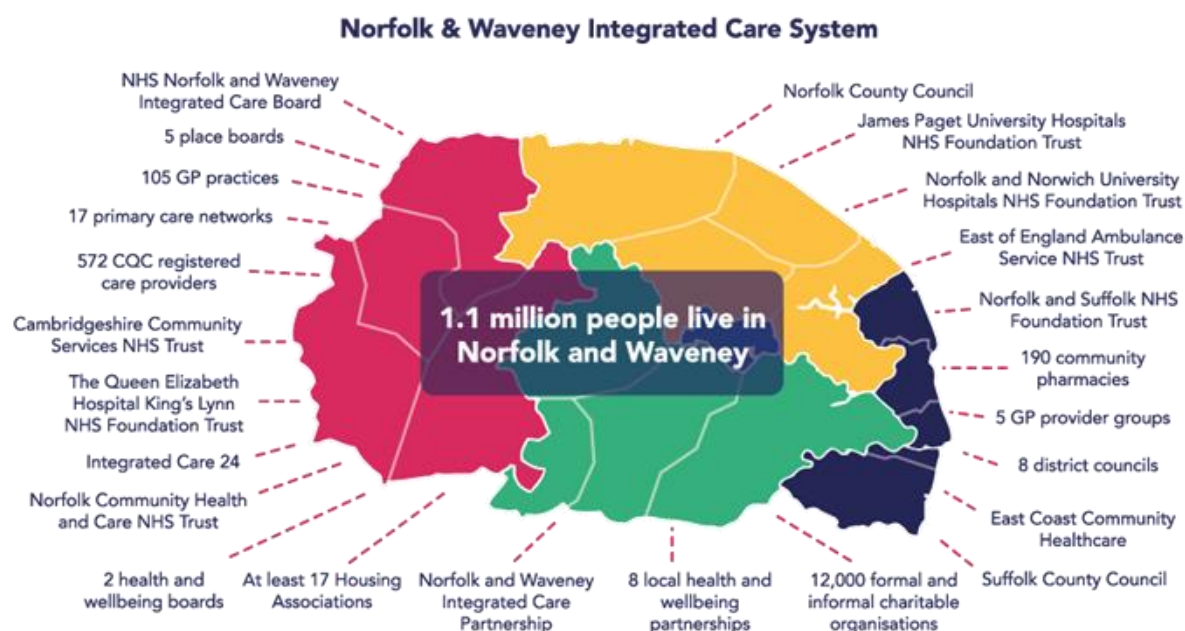
Some aspects of the approach described in this document already exist, some are under development and others are still at an early, visionary stage. It will be made clear how far each area is developed. We are taking an evolving approach which is being designed together, with ICS partners and with the people and communities we serve.

It will take time to fully achieve our vision - it's a huge task – but we are starting from a good place as there's lots of good work and enthusiasm in Norfolk and Waveney already. The COVID-19 pandemic has strengthened existing relationships and helped us forge new ones, so we work together to consistently give our people and communities a voice across the ICS.

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Our ICS

The Norfolk and Waveney Integrated Care System is made-up of a wide range of partner organisations, working together to help people lead longer, healthier and happier lives. From 1 July 2022, our Integrated Care System will include the following organisations:



[Appendix 1](#) has a more detailed overview of our population.

Over and above everything else we want to achieve; we've set ourselves three goals:

1. To make sure that people can live as healthy a life as possible.

This means preventing avoidable illness and tackling the root causes of poor health. We know the health and wellbeing of people living in some parts of Norfolk and Waveney is significantly poorer – how healthy you are should not depend on where you live. This is something we must change.

2. To make sure that you only have to tell your story once.

Too often people have to explain to different health and care professionals what has happened in their lives, why they need help, the health conditions they have and which medication they are on. Services have to work better together.

3. To make Norfolk & Waveney the best place to work in health & care.

Having the best staff, and supporting them to work well together, will improve the working lives of our staff, and mean people get high quality, personalised and compassionate care.

Like all Integrated Care Systems in England, we will work to:

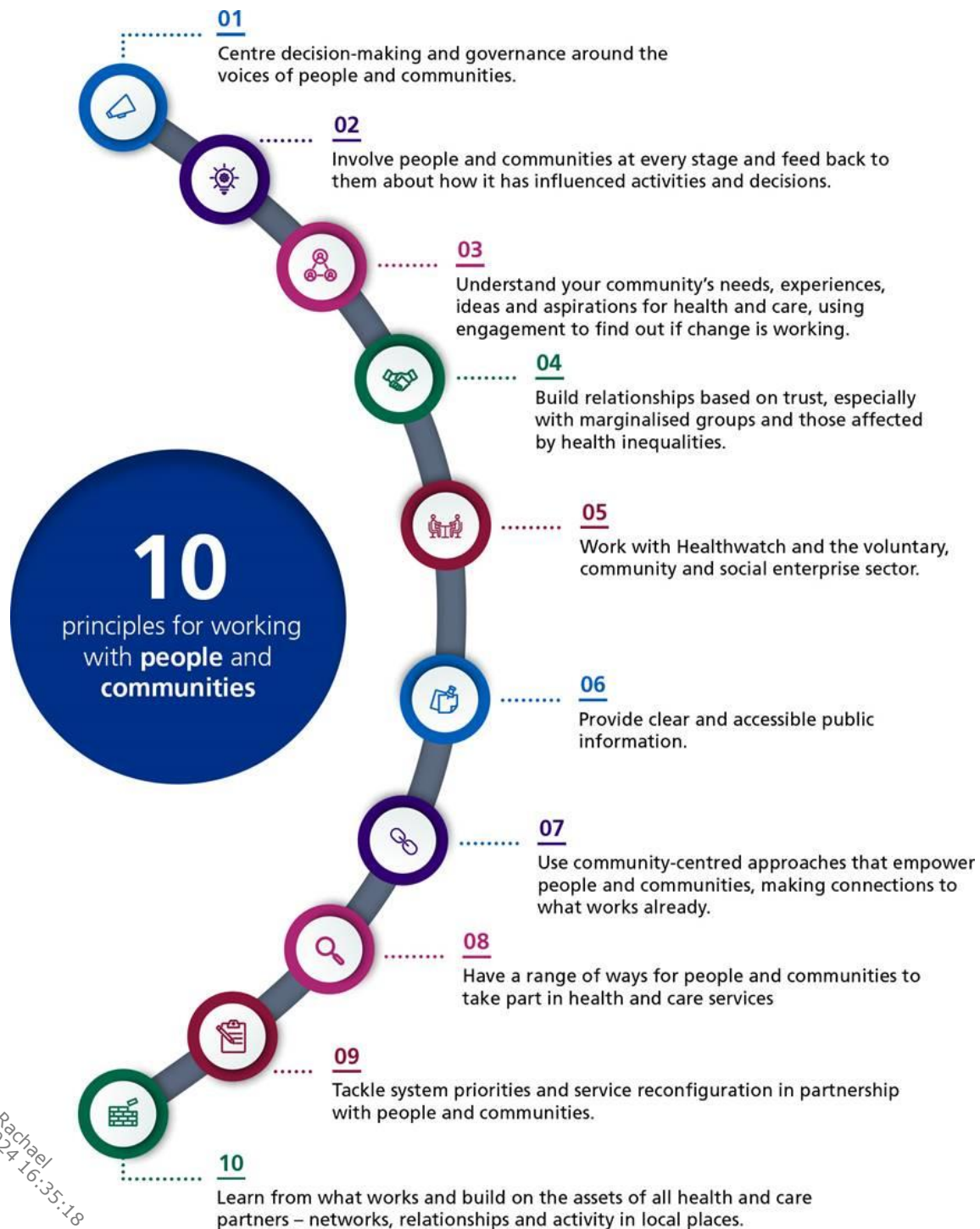
- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

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Aims and principles

The overarching vision for working with people and communities in Norfolk and Waveney is that all ICS partners will consistently collaborate to share insight and learning. This will maximise resources and ensure that the voice of local people, especially from inclusion groups, is shared as widely as possible.

We will work towards the following [10 principles from national ICS guidance](#) when working with people and communities at neighbourhood, place and system level. These will be tested with local people as this approach develops and adapted to reflect local aspirations and our [5-Year Joint Forward Plan](#) as needed.



This is where we are currently with our work towards delivering the ten principles:

1. **Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.**
 - **We have** appointed a Director of Patients and Communities to oversee the all the work with our people and communities. Our [Patients and Communities Committee](#) meets in public every other month and will soon include two lived experience members. It is chaired by [a non-executive member](#) of the ICB Board.
 - **We will** continue work to align communications & engagement resources at place level with local system partners to co-produce shared plans and continue to develop the ICB structures to ensure voice of people and communities reflected at all tiers.
2. **Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions.**
 - **We have** created a systemwide communications & engagement group to work together as a system wherever possible in planning and feeding back. We have a '[You Said, We Did](#)' section on our [people and communities hub](#).
 - **We will** continue to develop our communications and engagement toolkit for ICB staff to underline the importance of working with people and communities, and system partners as early as possible in developing plans, and of feeding back the difference this has made.
3. **Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.**
 - **We have** developed [population health management](#) and data review processes in partnership across the system, for example [Protect NoW](#).
 - **We will** continue to develop the insight bank as part of the [Norfolk & Waveney Community Voices Programme](#) to systematically record qualitative data collected by system partners to build a 3-dimensional picture of lived experience and improve our ability to listen to informal feedback for example by using social media monitoring tools.
4. **Build relationships with excluded groups, especially those affected by inequalities.**
 - **We have** made strong links with the Health Inclusion Group chaired by Public Health Norfolk about how they can support this approach to working with people and communities. Our Health Inequalities Oversight Group (HIOG) monitors our emerging Health Inequalities Framework for the ICS for engaging communities that experience health inequalities, to enable their voice and support access to our services.
 - **We will** look for specific opportunities to develop better relationships with specific communities with quieter voices, for example working across the ICS to support our [armed forces community](#) and their families and carers.
5. **Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners.**
 - **We have** already developed good working relationships with Healthwatch Norfolk and Healthwatch Suffolk who are both members of our Patients and Communities Committee, and with the VCSE partners involved in the Norfolk & Waveney Community Voices Programme.
 - **We will** continue to invest in the VCSE Assembly and with VCSE partners at Place Board in working with people and communities.

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16/05/2024 16:35:18

6. **Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.**
 - **We have** developed a website for the ICS which includes accessible information available in a range of innovative and accessible formats. It includes the [people and communities' engagement hub](#) and contains information about the [Norfolk and Waveney 5-Year Joint Forward Plan](#).
 - **We will** continue to work with our partners to use every available network to reach people who do not or cannot access information online. Much of this will build on partnership work during the COVID-19 pandemic, such as the Great Yarmouth Community Champions and working with our local library service.
7. **Use community development approaches that empower people and communities, making connections to social action.**
 - **We have** learnt a great deal from the COVID-19 pandemic which has led to the [Norfolk & Waveney Community Voices Programme](#).
 - **We will** build on the relationships with our district councils and system partners to empower our people and communities using community development approaches through our [Health and Wellbeing Partnerships](#).
8. **Use co-production, insight, and engagement to achieve accountable health and care services.**
 - **We have** many examples of good practice in working with experts by experience within Norfolk and Waveney as showcased on our [Co-production Hub](#). A new Patient Experience team in the ICB Corporate Affairs Directorate will develop the use of insight from complaints across the system.
 - **We will** work towards an ICS model of co-production using a set of co-produced principles and standards, building on & learning from examples of best practice currently operating within the system.
9. **Co-produce and redesign services and tackle system priorities in partnership with people and communities.**
 - **We have** worked with system partners on a [carers co-production project](#) to tackle issues for informal unpaid carers around discharge from hospital settings and to promote personalisation and carer awareness training. We are supporting the development of a [Mental Health Co-production Strategy](#) and interactive toolkit for system partners to use when developing services.
 - **We will** use this approach to tackle other system priorities including urgent and emergency care, and quality improvement.
10. **Learn from what works and build on the assets of all ICS partners – networks, relationships, activity in local places.**
 - **We have** based our entire approach to working with people and communities on this principle as we are aware that all our system partners listen to and gather insight from the people they support every day.
 - **We will** continue to look for different digital and non-digital ways to develop this idea.

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16/05/2024 16:35:18

Listening to 'Quieter Voices' in Norfolk & Waveney - How we think working with people and communities can tackle health inequalities

Norfolk and Waveney ICS is working to draw together the various sources of data available within the system. Building on existing [Public Health guidance](#), this will drive much of the ICS activity and will go a long way towards identifying need. Through working with people and communities we want to use the people's voice to test and assure the data is reflecting what matters to local people. This will enable us to move beyond information about 'treatment' & 'services' to hear people's whole lived experience.



Health Inequalities Conversation – Developing a Health Inequalities Strategic Framework

In July 2023 Norfolk and Waveney ICS started an on-going 'Health Inequalities Conversation' with stakeholders and people and communities from across the system. The initial engagement gave a strong steer that a Strategic Framework for Action should be produced.

Our Health Inequalities Conversation has reached all parts of the system and has included conversations with the eight Health and Wellbeing Partnerships, the five Place Boards, numerous VCSE led forums, as well as focused engagement with our ICS organisations. The Community Voices programme, which works with trusted communicators in our VCSE sector, has asked some of our most vulnerable and underserved communities what matters to them, and we have engaged with people with lived experience.

As a system we have shaped a high-level vision, a set of guiding principles and our 'building blocks' for action – creating clarity of purpose and a sense of shared ambition.

The vision for the Health Inequalities Strategic Framework is that the system will come together to tackle unfair and avoidable differences in health outcomes between residents. We will do this by listening to communities, prioritising prevention, and taking action together, making health inequalities everybody's business.

It will adhere to the following guiding principles:

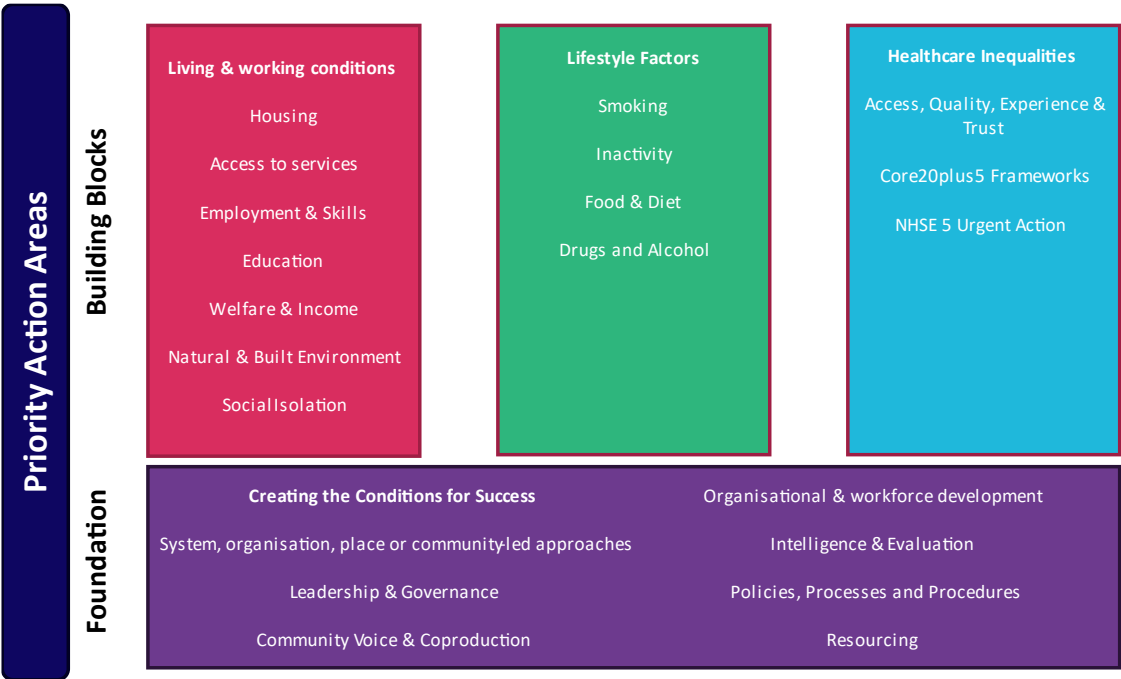
- ✓ Everyone needs something, some people need more.
- ✓ Enabling communities to have a voice is key and requires creativity and persistence.
- ✓ We will work as close to people and communities as possible.
- ✓ We want to achieve the right person, the right action, at the right time.
- ✓ We strive for accessible services for those in greatest need.
- ✓ We know we can make a difference, and this is a long-term commitment.
- ✓ Leading for change requires shared responsibility and enduring focus.
- ✓ Understanding who is accessing our services, who isn't and why in order to act.
- ✓ Recognising the building blocks for good health & wellbeing are not just in health services.
- ✓ Building fairer services means supporting change in our organisations.

The Framework will act as a catalyst for change; it includes a clear call to action to come together and take collaborative, as well as organisational level action. It also includes actions that can support and empower communities to take action themselves. These actions include considerations around community voice and coproduction, taking intelligence & data led action, and ensuring we have the policies, processes and procedures in place to tackle

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health inequalities in everything that we do. the Framework requires a whole-system commitment, we must continue our Health Inequalities Conversation, and drive further action.

The organisations involved in the development of the HI Strategic Framework have agreed the following four building blocks for action. Firstly, we have to build the foundations and create the **conditions for success**. This will prepare us to act on the agreed building blocks for good health: **living and working conditions**, **lifestyle factors** and **health & care services**. As this is a long-term commitment, our actions may change and respond to need.



Building on existing good work

The following are examples of how the ICS has already developed new ways of addressing health inequalities that are built around insight from local people:



Norfolk and Waveney Community Voices (NWCV) Programme – Norfolk and Waveney has many different communities of interest often living alongside and merging with each other. This can make talking and listening to the different people very challenging. We are aware that although they still provide useful insight, the more traditional methods of engaging tend to have a ‘response bias’ where it is more likely you will hear from people if they are better educated, older, wealthier and white British.

During the COVID-19 pandemic we learnt that to reach people who are less likely to engage with us we had to use trusted communicators at very local levels, often street by street or

village by village. We learnt we have to focus on the hardest to hear, underserved and more vulnerable groups and actively go to them to find out what their priorities are.

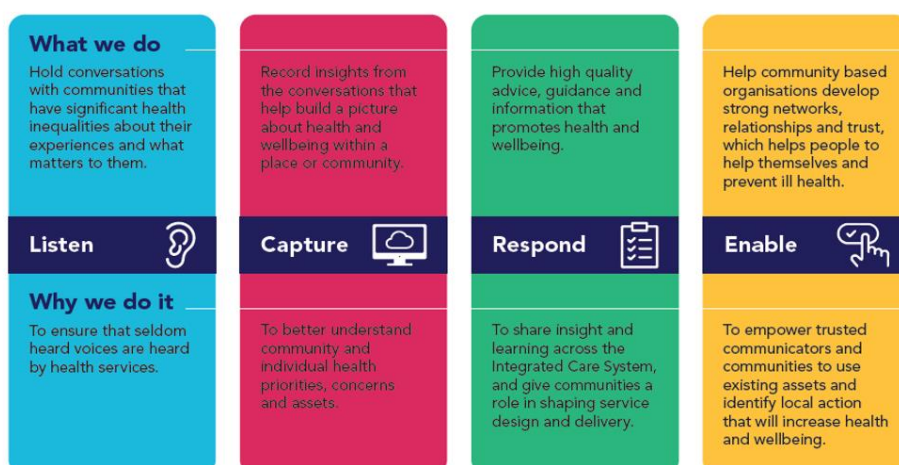
NWICB is working with District Councils and the local Voluntary, Community and Social Enterprise (VCSE) sector to develop and deliver a new engagement programme to help us listen to our communities and better understand experiences and opinions of accessing healthcare. It started during the COVID-19 pandemic to help us understand vaccine uptake but has since looked at a range of services such as bowel cancer screening and stop smoking.

Community Voices, works with trusted communicators to speak with communities who may not already engage with the NHS and other statutory bodies to hear what is important to them. We have learned that when talking to people about health services they also talk about a range of other issues that affect their health and wellbeing, such as housing and employment. We are designing ways to capture all this insight and make sure it is shared with people who design and deliver a range of services across Norfolk and Waveney. We expect to hear about the challenges faced by local people in accessing services, and about the issues that prevent wellbeing across a range of factors, including those outside the direct health sphere such as housing, employment and finances.

Norfolk and Waveney Insight Bank – All the qualitative data we collect as part of the NWCV programme is being stored in an ‘insight bank’. This is currently a survey collection tool but the vision is that it will be developed into a much wider bank of insight for use across the ICS housed within a robust data platform. The qualitative data is already being shared with ICB staff through a Power BI platform, however it is envisaged that it will eventually provide anonymised information useful for all ICS partners giving insight on a street, neighbourhood, place and system level which will be useful for health and care planning and other services too.

Our vision

Norfolk and Waveney Community Voices 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.



How we do it

- By facilitating the right training and providing an infrastructure which works well – with networks, access to good quality resources and time to reflect on good practice.
- By building good quality insight data that can be shared appropriately across partner agencies
- By evaluating the effectiveness of what we do, why we do it and how we do it.
- In partnership with good governance and support from all the sectors involved.
- By recognising that good health is influenced by a range of factors.



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Case Study – Norfolk and Waveney Community Voices

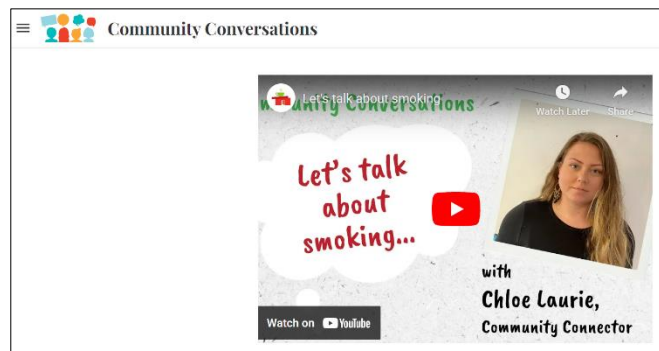
Discovering People's Experiences of Smoking & Quitting Smoking in Areas of Deprivation

From August to the end of September 2023, Community Connectors ventured out into local 'bumping spaces', pubs and community spaces in some of Norwich's most deprived communities to have conversations with residents about their experiences of smoking and quitting smoking. They were recruited and supported to do this by [The Shoebox Enterprises CIC](#).

The Connectors had received Community Voices training and smoking cessation training to help equip them with the knowledge needed to hold community conversations with residents on this topic. Their flexible approach means they can reach people where they are instead of expecting people to come to them.

The Connectors had over 100 conversations in their neighbourhoods with a wide range of people aged 18 and over who considered themselves occasional or regular smokers as well as those who had quit smoking. The conversations undertaken by Connectors through the Community Voices programme demonstrates how they can reach people who are often overlooked in communities and who typically may not engage with traditional surveys or focus groups. By operating in a non-judgemental way and just listening and being curious about people's experiences the Connectors have been able to obtain rich insights into people's realities and their complex relationships with smoking and experiences of attempting to quit.

To find out what they learned and hear from the connectors about what its like to reach out to people in this way, read the full case study on the Community Connectors website:



<https://www.communityconversations.info/project-information/stories-of-impact/exploring-experiences-of-smoking>

Working with people and communities at 'place'- level - how all the different voices of our people & communities can be part of local decision-making - The vision is to create a thriving environment for conversations with our people & communities using a spectrum of opportunities. Conversations about 'the place where I live' are often much richer.

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By joining up and sharing insight gathered across the system we can hear the voice of people from all over the ICS alongside data on Place Boards, and to support the work of the [Health and Wellbeing Partnerships](#). We have the opportunity to use new sources of insight from different ICS partners, with the ambition to develop a platform(s) to enable the insight to be searchable by themes, postcode etc.

The pandemic helped all partners across Norfolk and Waveney better reach out to and hear from our more vulnerable, marginalized, underserved communities, who are better reached at place and neighbourhood level. This is especially the case if the conversations are facilitated by trusted intermediaries as referenced in the NWCV project above.

Communications and engagement resources from across the ICS are being brought together at place level to ensure the right people and communities are working in partnership to improve local health and wellbeing.

Protect NoW - The [Protect NoW programme of work](#) uses data-led, [population health management](#) approaches and comprises a growing number of distinct projects, each focused on a common cause of mental and/or physical ill health. It uses behavioural and Public Health insight to establish specific population needs and develop effective interventions through co-production with clinicians, system partners, wider stakeholders, patients and service-users.

Norfolk and Waveney Health Inclusion Group – is a multi-agency group that builds on partnership working during the COVID-19 pandemic and includes many ICS partners outside the NHS. Professionals from statutory and VCSE organisations come together to hear the voice of and understand the needs of vulnerable and health inclusion groups and align services accordingly. This group offers grassroots support to work with health inclusion groups to understand what matters to them as part of the people and communities work in Norfolk and Waveney.

Equality Impact Assessments (EIAs) – we will continue to support the production of EIAs for projects and transformation within the engagement function of NHS Norfolk & Waveney Integrated Care Board (ICB). These have been recognised as key to reference that due thought has been given to protected characteristics and communities of interest, and also to highlight areas where the voice of people and communities is missing. They will be a key part of the Health Inequalities Strategic Framework, and are reviewed and monitored by the Health Inequalities Oversight Group (HIOG).

Listening to the voice of people in or leaving prison - it's important that we recognise that the population of Norfolk and Waveney includes a significant number of prisoners. These are vulnerable people who have very little control over how their health appointments are managed outside of the prison. They experience inequality related to prison transfers which can disrupt planned care, they cannot control when or where their appointments take place, their appointment always depends on the prison being able to provide escort staff and so are regularly cancelled causing delays, and appointments are often not confidential due to escort staff having to be present.

Accessing care and support outside the prison is a really different and difficult experience for them, so it is important that we find a way for their voice to be heard in a meaningful way. Patient engagement and experience leads are working with healthcare provider representatives from the prisons in Norfolk and Waveney to improve communications channels between local health services and the prison population.

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The importance of accessible and good quality communications



The local health system recognises that good communications is at the heart of everything we do. It helps build confidence with local services and care professionals. It is essential for effective partnership working and will help build trust. It provides patients with the information that they need to be empowered and so make positive choices and take control of their health.

Good communications involves:

- fostering a culture of good two-way communication, engagement and involvement;
- informing and empowering key stakeholders;
- being honest and realistic;
- recognising and meeting the different information needs of groups and individuals;
- working with other agencies to co-ordinate communication.

We live our lives and communicate online as well as through more traditional media. In Norfolk and Waveney, it is recognised that not everyone is able to, or wishes to, use digital platforms and we will continue to use traditional routes of communication such as newsletters, partner newsletters, leaflets and posters.

However, the digital space offers enormous reach and value for money. The ICS will therefore champion digital platforms to help patients interact with services or obtain the information they require. [The ICS website](#) is well designed, easy to navigate and a trusted source for information or links to information. This website now hosts the [people and communities hub for Norfolk and Waveney](#), which aims to develop and maintain a shared vision in listening to and working with local people across the ICS. The ICB communications & engagement team includes a post focusing on digital transformation which will help staff, people and communities understand how advancements in digital technology can help improve health and care experiences.

NHS Norfolk and Waveney ICB, as well as the wider ICS, will use social media such as Twitter, Facebook and other online platforms, to help communicate with local people, and where appropriate, as an engagement tool to stimulate discussion and feedback. A social media policy has been developed which makes clear how social media can be used effectively to contribute to the work of the local health system and to help staff participate online in a respectful, professional and meaningful way that protects the image and reputation of the health system when they are using social media on a personal basis. This has been done in line with similar policies for ICS partner organisations.

Good external communications will be vital in informing and empowering people about Norfolk and Waveney ICS, how public money is spent and how we are working with people and communities in the development of local healthcare services.

It is essential in an ever-changing NHS that patients and the public are able to

navigate their way through the services available to them. The ICB will be the custodian of the NHS brand locally, and our communications will support this. When producing any material for publication, the ICB will take account of the NHS Branding and Accessibility Guidelines to make sure that all our information is accessible to a wide variety of audiences. This includes use of our websites and any social media we may develop, and the need to produce our literature in a range of formats as required.

NHS Norfolk and Waveney ICB is striving to meet the [Accessible Information Standard](#) in all its communications and engagement. We are working with [Healthwatch Norfolk](#) and [Healthwatch Suffolk](#) to support the national accessible information campaign.

As a health and care system, it is also important to develop a local brand for the NHS in Norfolk and Waveney. This will help local people understand the role of the ICS and our work with our partners. It is important that the health and care system creates and maintains a reputation for delivering high-quality, safe and responsive care and support to our people and communities. This will be built by the experiences of its stakeholders through direct and indirect contact with the ICS, and how we are portrayed in the media.

A good reputation can be earned by having a clear, locally agreed vision and set of values that is communicated in a clear and positive way. How an organisation behaves also contributes to this and clear communications can help explain why decisions are made. Having a good reputation can help staff morale, and generate local support for change, especially over difficult and contentious issues. It is also an important metric for how NHS bodies and healthcare staff are measured in terms of performance.

The media can influence people's opinions of public services. Many are seen as independent and credible and are influencers nationally and locally. For this reason, good strong relationships with, in particular, the local and regional media, are important. Our local media can be helpful in promoting the work of the ICS and the transformational service changes and improved health and wellbeing outcomes we are seeking to deliver for local people. And helps hold us to account to our local people and communities, increasing our openness and transparency.

How this ICS approach to working with people and communities will support the NHS ICB legal duties on public involvement

The Health and Care Act 2022 created a very different health and care landscape with a particular emphasis on integration and collaboration. It continued the S.14Z45 – Duty of public involvement and consultation, and this document reflects the new statutory guidance around how NHS organisations should work effectively with people and communities. This is laid out in our [Constitution](#).

The approach Norfolk and Waveney takes will:

- ✓ Maximise existing conversations taking place every day with people across the system, starting with the current mapping exercise
- ✓ Involve groups and people we have not been good at listening to before
- ✓ Ensure this information is fed into decision-making structures as they develop
- ✓ Promote the ICB Communications and engagement team as system leaders encouraging trust with ICS partners and local people through the People and Communities Engagement Hub
- ✓ Develop the wider 'system team' of staff in public sector and VCSE organisations who are already working with people and communities and gathering insight

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- ✓ Promote methodologies such as Making Every Contact Count (MECC), What Matters to You and Always Events
- ✓ Promote Co-production & Co-design models as part of a wider spectrum of engagement
- ✓ Promote a support programme to encourage thriving patient engagement around primary care

A spectrum of opportunities will be recognised and encouraged by the ICB when working with people and communities within the ICS. All feedback has value and adds to our understanding of the people and communities in Norfolk and Waveney.



A toolkit has been developed to help CCG staff with planning communications and engagement activity in line with our people and communities' approach, and to ensure due regard is given to all necessary internal and external processes. This includes a communications and engagement template to ensure that due consideration is given to working with people and communities from the earliest possible stages of planning to feeding back at the end.

When ensuring that legal duties to consult and involve are met, all approaches undertaken will be fair, proportionate and will have due regard to equalities as described above, to ensure that no one is excluded, and all relevant groups can take part. They will be mindful of how people live their lives, and where possible delivered in partnership with trusted communicators.

ICBs are now subject to the new 'triple aim' duty in the Health and Care Act 2022. Effective working with people and communities is essential to deliver the triple aim which requires them to have regard to 'all likely effects' of their decisions in relation to three areas:

1. health and wellbeing for people, including its effects in relation to inequalities.
2. quality of health services for all individuals, including the effects of inequalities in relation to the benefits that people can obtain from those services.
3. the sustainable use of NHS resources.

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16/05/2024 16:35:18

Co-production

Co-production refers to a process of shared power to effect change. The term co-production is generally used to mean an end-to-end process where people with lived experience work with those who design services and projects in an equal partnership, sharing power and often involving a significant commitment and where involvement fees or other forms of reciprocity are offered alongside expenses. Think Personal Act Local (TLAP) is held as an exemplar in promoting co-production and they include a comparison of the various definitions on their [website](#).

Examples of co-production do exist in Norfolk and Waveney and work is underway within the system to align existing work and develop a shared approach. A [co-production hub](#) has been developed as part of our people and communities hub to share examples from the system, to promote co-production principles and to signpost to support materials.

- A new Norfolk and Waveney Co-production Network has been established to co-ordinate and promote co-production among the Health and Wellbeing Partnerships at local councils across Norfolk and Waveney
- The ICB is a member of the Adult Social Services Department (ASSD) Engagement and Co-production Group which is promoting [co-production at Norfolk County Council](#)
- The ICB is now represented, alongside Norfolk County Council, on the Norfolk [Making It Real \(MiR\)](#) steering group which promotes co-production particularly for people with lived experience of physical and learning disabilities
- Named Communications and Engagement representatives are working with system partners at Place and Partnership level to promote and support co-production
- Supporting various NHS England funded initiatives to promote co-production
- Co-production as an integral part of [designing research projects](#)
- Exploring ideas around the development of some system-wide shared principles around co-production for Norfolk and Waveney

Rethink Mental Illness Co-production – Norfolk and Waveney has a substantial and unique approach to ensuring that mental health transformation is informed as a system by lived experience. Rethink Mental Illness is a national charity for people severely affected by mental illness. They are facilitating coproduction in a number of Integrated Care Systems across England.

The Norfolk and Waveney Health and Care Partnership commissioned Rethink's co-production team [to bring the views, skills and experience of people living with mental health needs](#) and carers together with those of people whose jobs are to plan and deliver services - so they can work together. Experts by experience have been recruited to various steering and reference groups to work alongside the programme. Paid Experts by Experience are now also sitting on the Norfolk and Waveney Mental Health Partnership Board, working closely with the Mental Health Trust CEO and the Executive Director of Adult Social Services in the delivery of the programme.

Rethink Mental Illness' coproduction team have been supporting Adult Mental Health Transformation in Norfolk and Waveney. They are facilitating the coproduction of [a draft strategy on behalf of NHS Norfolk and Waveney ICB](#) as well as a [Mental Health Co-production Toolkit](#) to enable and support people to use co-production techniques in the development of mental health services.

Better mental health outcomes for the people of Norfolk and Waveney will happen when services meet needs in the most effective ways possible. To do this lived experience of care

and support needs to be valued equally to other expertise in the Integrated Care System. Coproducing mental health care and support in Norfolk and Waveney will help the ICS reach its goals as a system.

Case Study – Coproduction in Norfolk and Waveney

Co-production of the Carers Identity Passport and Carers Awareness Training

During lockdown in 2021 the three acute hospitals in Norfolk and Waveney worked with Carers Voice Norfolk and Waveney and the ICB to hold an online conference for unpaid Carers. Due to visiting restrictions many unpaid Carers were not able to be with their cared for person during conversations about their care, which often made the discharge processes increasingly difficult. Carers wanted to be identified in their caring role and suggested a [Carers Identity Passport](#) so they are recognised, valued and respected. An initial workshop was followed by a Co-production Steering Group.



[Carers Voice Norfolk and Waveney](#) led the co-production project to design and develop the Carers Identity Passport with local Carers, including Parent Carers and Young Carers. The Carers Identity Passport was launched on Carers Rights Day in November 2022. In the first 18 months just under 3000 Passports have been issued. Carer Awareness training was also suggested to promote understanding of the importance of the Carer as a care partner and included information on how to identify unpaid Carers and how to signpost to the Carers Identity Passport. This is delivered across Norfolk and Waveney by [Caring Together](#).

A '[Carers Identity Passport, Education Pack for Young Carers](#)' has also been co-produced and contains information for Young Carers about being recognised and being included in conversations about the person they look after as well as signposting to support available.

More information about the conferences and co-production is available on the [Norfolk and Waveney ICS website](#).



Parker Rachael
16/05/2024 16:35:18

Thriving Patient Engagement Around Primary Care

General Practice - There are 105 GP practices in Norfolk and Waveney. Most of them have patient groups, often referred to as Patient Participation Groups (PPGs). They offer members of the public the opportunity to become more involved in how the practice runs. This could be about the physical building, waiting times, services offered or wider healthcare issues.

We have 17 primary care networks (PCNs) – this is where GP practices work together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices known as PCNs.

We are working with patient representatives, practices and our local Healthwatch's to develop a programme of strategic support to local PPGs and practices so that the voice of people and communities can be reflected more locally. The ICB commissioned Healthwatch Norfolk to engage with local practices and PPGs to find out what support would be most useful.

The ICB is now working to deliver the key recommendations from [the report](#). A [webpage](#) is now in place which features case studies including examples that promote different models of patient engagement. There is also other information and links to resources including a [toolkit](#) produced by Healthwatch Norfolk following the period of engagement which aims to give practices and PPGs a step by step guide.

Care Quality Commission (CQC) – [CQC](#) is the independent regulator of health and adult social care in England. They make sure health and social care services provide people with safe, effective, compassionate, high-quality care and they encourage care services to improve, including General Practice. The ICB talked to CQC about practices being able to try new approaches to involving patients as well as the traditional PPG model so they updated their [mythbuster](#) to encourage and reassure practices.

Other primary care providers – ICBs have taken on more responsibility around other primary care services from April 2023 onwards. Other providers include pharmacies, dentists and optometrists. This can provide an opportunity to explore supporting other primary care providers to work with people & communities in a similar way to that already well developed within general practice.

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Norfolk and Waveney Integrated Care System

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HOME • GET INVOLVED • WORKING WITH PEOPLE & COMMUNITIES • PATIENT PARTICIPATION GROUPS (PPGs)

Patient Participation Groups (PPGs)

There are 105 GP practices across Norfolk and Waveney. Most of them have patient groups, often referred to as [Patient Participation Groups \(PPGs\)](#).

PPGs work in partnership with their GP practice and are vital in ensuring that the patient voice is heard. We are keen to hear about different models for hearing the patient voice in primary care and will be developing this alongside our current patient groups.

PPGs work in different ways, some meet in person, others communicate with their practice online – all are keen to welcome and involve new members.

PPGs provide an opportunity for local people to get involved with their practice and influence the provision of [local health services](#). Members contribute their views, make suggestions and provide feedback on services they may have used. Groups can also get involved with supporting local health initiatives and can engage with a wider range of health and care professionals.

[Norfolk and Waveney ICB](#) is working to develop a programme of support to local PPGs and practices.

We have worked with [Healthwatch Norfolk](#) to conduct an evaluation of Patient Participation Groups across Norfolk and Waveney and gather feedback to develop an understanding of what additional support the ICB can provide to help PPGs and practices be the most successful and develop further.

This has led to the development of [a new PPG Toolkit](#) that aims to help groups establish and run a successful PPG. You can read the report and download the toolkit below.

Resources

- [PPG Toolkit](#)
- [Norfolk and Waveney PPG Evaluation report](#)

New resources will be added soon.

Social Media Managed Service

The ICB Digital team has commissioned a paid for social media service managed by [Redwood Health](#), initially for one year, to help interested practices develop active and positive social media channels. This includes establishing channels where needed and posting positive health improvement messages on behalf of the practices involved. There are currently over forty practices signed up in Norfolk and Waveney.

Having an active account also encourages communications with the practices around a wide variety of topics including promoting their PPGs and hearing feedback on services. The ICB Communications and Engagement team are supporting this initiative by working together with Digital to provide additional social media content over and above the commissioned service. The team are supporting the promotion of this service as a recognition of the future benefits to practices of using social media to work in partnership with their populations.

You can find out more about different PPG activities and projects below.

If you are interested in finding out more about your own PPG, talk to your practice reception team or contact us at melch.bayevousae@nhs.net.

PPG Case Studies

Patient Voice in Aldborough

Aldborough Surgery is situated in a large rural area, 7 miles from the coast of North Norfolk. It serves a population of approximately 3,700 spread out across numerous parishes between Cromer to Aylsham and Edgfield to North Walsham, Aldbor...

[Learn more](#)

Sheringham PPG

Sheringham Patient Participation Group (PPG) was formed in 2008 with membership consisting of patients and some practice staff. The group met monthly in the GP surgery and over the years managed to raise funds for the practice and waiting room equip...

[Learn more](#)

Parker Rachael
16/05/2024 16:35:18

How will we know this work is helping people and communities?

If this work is effective, our people, communities and ICS partners will be able to see that:

- People feel listened to, and empowered
- People can see the difference their views and insight have made
- The voices of our people and communities are looked for early when planning services
- People have shared their story and it has made a difference and been listened to by partners all over the ICS.



Governance structures within the ICB and ICS are now in place, and the need to monitor and evaluate the impact of the people and communities work is acknowledged.

The [Patients and Communities Committee](#) provides NHS Norfolk and Waveney with assurance that it is delivering its functions in a way that meets the needs of our patients and communities across Norfolk and Waveney. That is based on engagement and feedback from local people and groups.

The Committee also specifically focusses on how NHS Norfolk and Waveney and the wider Integrated Care System is actively addressing and reducing health inequalities experienced by individuals and communities. Key to the Patients and Communities Committee will be two Committee members with lived experience, providing vital input, feedback and challenge to support our work as an organisation and the wider ICS. Recruitment for these members is due to start in 2024.

The Committee will also receive insight, make sure it is gathered appropriately, and monitor progress to ensure that change is happening. It will also constantly refer back to the 'so what' question – what this means for our people and communities.

The People and Communities Engagement Hub described above also gives a measurable focal point to engagement activity undertaken by the ICB as part of its legal duties. Specific projects and opportunities for working with people and communities are being advertised, and '[You said, We did/We can't](#)' reports detailing the results of the feedback and any improvements that resulted are being uploaded.

All ICB people and communities activity is being included in [regular systemwide briefings](#) that are widely shared within the ICB and across the ICS. All system partners are also being encouraged to input into the briefing so that it can become a Norfolk and Waveney resource for the promotion of work with people and communities.

We will use all the existing networks of people and stakeholders to regularly monitor our success in working with people and communities.

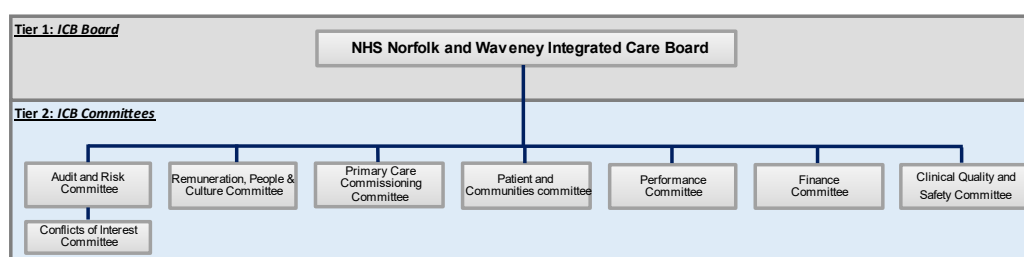
People and communities in ICB Governance

NHS Norfolk and Waveney ICB is committed to embedding the voice of people and communities so that the ICB can listen to and act on the concerns and aspirations of residents. The Patients and Communities Committee will act as a focal point for overseeing how this will happen, led by our Director of Patients and Communities, as laid out in the

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16/05/2024
16/05/2024
16/05/2024

[Terms of Reference](#). The committee is chaired by the chief officer of a local VCSE organisation. [Meeting papers](#) are made available a week in advance and meetings are held in public. Our duty to consult and involve is clearly laid out in our [constitution](#) and in our [Governance Handbook](#).

The ICB Board also includes a programme of [learning from our staff, people and communities](#) at all meetings in public to underline that people are at the centre of strategic decision-making. The programme of stories is being developed as much as possible in partnership with local NHS trusts, local authorities and wider system partners to complement stories they also use at board level and to highlight the stories across the ICS.



The ICB Board receives its assurance via the Committees and Executive Management Team (EMT). Scope of assurance for each Committee is set out in the [ICB Governance Handbook](#)

As described above, communications and engagement activity also happens at [Place](#) and [Health and Wellbeing Partnership](#) levels, to focus on working with people and communities at a much more local level, and to draw on insight from across all ICS partners including trusted communicators in VCSE organisations.

ICB Board
Accountable Board for the new organisation. Chaired by the ICB Chair, and oversees the formally delegated committee structure and engages with the committees through Members as Chairs of those committees, holding the committees and their constituent system partners to collective account. Also links with the Integrated Care Partnership to provide strategic leadership to the Integrated Care System. Some ICB functions will be delegated to formal committees and Member / Participant Directors of the ICB.

ICB Committees
Formal committees of the ICB Board, with committee level formal delegation for matters within the functional remit. Chaired by Members of the ICB Board. Ensuring the functional remit is effectively distributed to relevant Boards (see below) and that Participant and Member Directors are held to account collectively with the wider system for the delivery of the Boards work programme. Committees will receive delegation from the ICB Board.

Boards
Chaired by Member or Participant Directors of the ICB Board, thematic and covering the remit of the coordinating ICB Committees in more detail to divide up the functional remit into manageable remits. Ideally will align to the lead Directors portfolio and delegated responsibilities. Wider membership of the Boards to be drawn from the ICB and partners from across the system. Will take decisions but this will be under the Directors delegated responsibility.

Delivery Groups
Remaining system groups, operational focus on delivery, closely linked with Place and Collaboratives. These groups do not have formal delegation but will deliver the majority of the system's programme as close to the patient as possible. In time, the delivery groups can transition into Place and Provider Collaborative formal structures.

Parker, Michael
16/05/2024 16:35:18

We will continue to build on our good working relationship with Healthwatch Norfolk and Suffolk. The ICB Communications and Engagement Team meets with both Healthwatch organisations regularly, and they are valued members of the Norfolk and Waveney ICS Communications and Engagement Group and the Patients and Communities Committee. Healthwatch also play a key role in the overall assurance and oversight both for the ICB and for the work with people and communities in the wider ICS.

Norfolk and Waveney ICB will also continue the positive and proactive relationship it enjoys with the Norfolk and Waveney Health Overview and Scrutiny Committee (HOSC), through:

- ✓ regular informal meetings with the Chair and Vice-Chair
- ✓ including proactive information about changes to services and working with people and communities in the members briefings
- ✓ supporting and attending meetings held in public

Equality Impact Assessments (EIAs) have been embedded within the ICB to ensure the voice of underserved communities is given due regard in planning services and in any transformational work. It also highlights areas where more work with particular people and communities would be beneficial to understanding their needs, and links can then made with the communications and engagement team.

The future

The aspirations and ambitions in this document clearly demonstrate a journey to improve communications and engagement with people and communities across Norfolk and Waveney by building on existing structures and processes where possible. Whilst a lot of work has taken place since July 2022 to work together much more closely, it is vital this work continues, at pace, to ensure that all partners across the system work together to share resource, intelligence, insight and feedback.

Our collective focus will be to always ensure that the voice, views and feedback of people and communities across Norfolk and Waveney is heard at every opportunity.

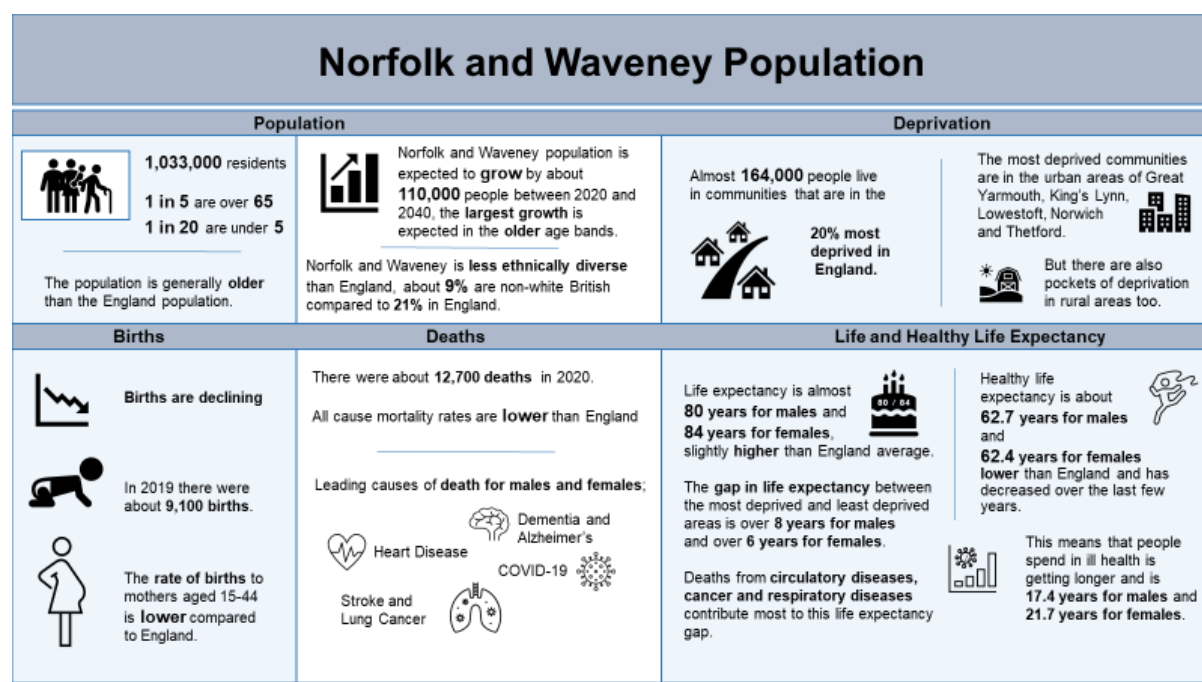
The transformation journey ahead will be evaluated at every possible point.

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16/05/2024 16:35:18

Appendix 1

An overview of the people and communities in Norfolk & Waveney ICS

The [Joint Strategic Needs Assessments](#) (JSNAs) available for Norfolk and Waveney have a wealth of information about the local area. Norfolk and Waveney is a large rural area made up of many villages and rural hamlets, market towns and urban areas in Norwich, Kings Lynn, Great Yarmouth, Lowestoft and Thetford. Numerous people move to the area to retire and there are many second and holiday homes. Norfolk and Waveney has many affluent areas that often sit alongside pockets of deprivation, especially in the rural areas.



Age - Norfolk and Waveney has one of the oldest populations in England. About 1 in 4 of the population (25%) is aged 65 and over and about 1 in 30 is aged 85 and over. This makes it the 4th oldest ICS area in the country. The proportion is likely to rise to 28% by 2029. Norwich is the youngest population and North Norfolk the oldest. This has remained the case over the last 10 years.

In 2020 the estimated population was as follows:

- **0–4 years** - 49,700 = **4.8%** of the total population.
- **5-11 years** - 80,200 = **7.8%** of the total population.
- **12-15 years** - 44,300 = **4.3%** of the total population.
- **16-64 years** - 600,600 = **58.2%** of the total population.
- **65+ years** - 257,900 = **25%** of the total population.

More than half of people under 50 live in the areas of Norfolk and Waveney classified as urban city and town, whereas people aged over 50 are more likely to live in more rural areas.

Between 2020 and 2040 there will be a projected increase of almost 110,000 people living in Norfolk and Waveney. The population is projected to increase by approximately 6.7% between 2019 and 2029, which equates to approximately 68,880 spread over the next ten years. 48,100 of this increase is in the population over 65.

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Total live births in Norfolk and Waveney have been just below 70,000 between 2013 and 2019, decreasing from just over 10,000 to just over 9,000 births per year over that period. The most live births have been in Norwich, and the fewest in North Norfolk.

The general fertility rate is the number of live births per 1,000 women aged 15-44 years old. In Norfolk and Waveney this has declined from just over 61 births per 1,000 to just over 54 births per 1,000 from 2013-2019. Rates in Norfolk and Waveney have been lower than the England rates since 2013

Ethnicity - The Norfolk and Waveney population are less ethnically diverse than average in England. Norfolk & Waveney's ethnic make-up was characterised by a predominantly White, 940,607 people (96.7%). The proportion of people with an ethnic group other than White was 3.3%. The most diverse areas across Norfolk and Waveney are Norwich, Great Yarmouth and Breckland. There are around 160 languages spoken in Norfolk & Waveney. English is not the first language of around 12,400 school children in the county.

INTRAN is the non-profit-making partnership that commissions and manages interpreting and translation services on behalf of public-facing organisations throughout the East of England. According to INTRAN the top 10 languages requested are:

- Swahili (Kiswahili)
- Slovakian (Slovensky)
- Romanian (Română)
- Lithuanian (Lietuvis)
- Portuguese (Português)
- Latvian (Latvietis)
- Kurdish Sorani (Kurdî)
- Farsi Persian (فارسی)
- Chinese 普通话 ; 國語
- Russian (русский)

During the COVID-19 pandemic the following languages were also frequently requested:

- Turkish (Türkçe)
- Spanish (Español)
- Polish (Język Polski)
- Arabic (Al Arabiya) العربية
- Bulgarian (български)
- Czech (čeština / český jazyk)

Information in Ukrainian (український) was also included to support those relocated during the conflict between Ukraine and Russia.

Disability - Based on the NHS population and person insight dashboard about 1.2% of the registered population has a disability. This is about 13,200 people and includes people with a physical disability, a learning disability and autism. The information might be an underestimate as it is based mainly on national NHS data returns.

Informal Unpaid Carers – are described by [NHS England](#) as 'anyone, including children and adults who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid.' They are also known as Family Carers, Companion Carers, Primary Unpaid Carers or Support Companions.

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16/05/2024 16:35:18

The 2011 UK census reported there are 5712 carers aged between 0 and 24, providing unpaid care in Norfolk. Of these 1,752 were aged 15 or under. The total number of carers reported in Norfolk was over 94,000 and more than 13,000 in Waveney. Both these figures had risen by more than 10% since the 2001 census.

As of February 2022, Carers Matter Norfolk (CMN) have approximately 7,000 adult carers registered with the service, showing there are many unpaid informal carers who do not come forward for help or do not recognise themselves as carers.

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16/05/2024 16:35:18

Appendix 2

Glossary of acronyms and phrases

Acronym	Full Title	Meaning / Definition
ICS	Integrated Care Systems	New partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.
ICB	Integrated Care Board	Each Integrated Care System (ICS) will have an Integrated Care Board (ICB), a statutory organisation bringing the NHS together locally to improve population health and establish shared strategic priorities within the NHS.
ICP	Integrated care partnerships	(ICPs) are alliances of NHS providers that work together to deliver care by agreeing to collaborate rather than compete. These providers include hospitals, community services, mental health services and GPs.
VCSE	Voluntary Community and Social Enterprise	Any organisation working with social purpose that is independent of government and are constitutionally self-governing. They exist for the good of the community, to promote social, economic, environmental or cultural objectives to benefit society as a whole, or particular groups within it. Ranging from small community-based groups/schemes to larger registered Charities.
	Primary care	Primary care is the first point of contact for healthcare for most people. It is mainly provided by GPs (general practitioners), but community pharmacists, opticians, dentists and other community services are also primary healthcare providers.
PCN	Primary care networks	GP practices are working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices known as primary care networks (PCNs) to meet the needs of the local populations.
	Population health	The collection of patient data across multiple health information technology systems. This data is then analysed into a single, actionable patient record. Care providers can improve both clinical and financial outcomes using this data.
PHM	Population Health Management	Our health and care needs are changing: our lifestyles are increasing our risk of preventable disease and are affecting our wellbeing, we are living longer with more multiple long-term conditions like asthma, diabetes and heart disease – and the health inequality gap is increasing.
CEO	Chief Executive Officer	The chief executive officer (CEO) is the highest-ranking person in an organisation.
HWP	Health & Wellbeing Partnerships	HWPs are Local health and wellbeing partnerships work on addressing the wider determinants of health, reducing health inequalities and aligning NHS and local government services and commissioning.
LTP	NHS Long Term Plan	The NHS LTP was published in 2019 setting out key ambitions for the service over the next 10 years.
	Local Authority	Generally, this is just another word for a local council, but it can refer to any administrative organisation in local government.
LGA	Local Government Association	The Local Government Association is the national membership body for local authorities. Its core membership is made up of 339 English councils and the 22 Welsh councils through the Welsh Local Government Association. The LGA is politically-led and cross-party.
	Provider collaboratives	Provider collaboratives bring NHS providers together across one or more ICSs, working with clinical networks, alliances and other partners, to benefit from working at scale.

	Place-based partnerships	Place-based partnerships will bring together the NHS, local councils and voluntary organisations, residents, people who access services, carers and families. These partnerships will lead design and delivery of integrated services in their local area.
	Health and wellbeing partnerships	Health and wellbeing partnerships will bring together colleagues from county and district councils, health services, wider voluntary, community and social enterprise sector organisations and other partners. They will focus on the local population's health and wellbeing by addressing the wider determinants of health to avoid health crises.
DHSC	Department of Health and Social Care	Support ministers in leading the nation's health and social care to help people live more independent, healthier lives for longer.
	Acute care	Acute care providers are emergency services and general medical and surgical treatment for acute disorders rather than long-term residential care for chronic illness
	Commissioning	Identifying health needs of local people, planning and purchasing health services which respond to their needs. CCGs are responsible for deciding what services their local residents need from the NHS and buy these services with public money from the most appropriate providers.
	Care Pathway	The care and treatment a patient receives from start to finish for a particular illness or condition. This usually includes several parts of the health service and social care. For example, a care pathway can involve support from a GP, a specialist doctor, home care and a district nurse.
	CQC	Independent regulator of health and social care in England – including hospitals, care homes and other provider organisations.
	FOI	The Freedom of Information Act 2000 provides public access to information held by public authorities.
	Place	The geographical level below an Integrated Care System (ICS) at which most of the work to join up budgets, planning and service delivery for routine health and care services (particularly community-based services) will happen. The Norfolk and Waveney ICS will comprise five places.
	Place-based Working	This is the new way of working set out as part of integrated care systems. It involves bringing together all the health and care organisations that sit within that place area, such as the hospitals, councils, care providers and voluntary groups, to work together as local partners. Their knowledge of the local people's needs means all of these organisations can work together to make sure health and care services meet the needs of the people who live there.
	Neighbourhood	Within each 'place' there are several neighbourhoods, which cover a smaller population size of roughly 30,000 to 50,000 people. They often focus on integrating primary, community and social care through multidisciplinary teams and joint working arrangements. Neighbourhoods are therefore key to the NHS's commitment to deliver more care as close to home as possible.
	System	In relation to integrated care systems (ICS), this refers to the level of the ICS. Key functions at the system level include setting and leading overall strategy, managing collective resources and performance, identifying and sharing best practice to reduce unwarranted variations in care, and leading changes that benefit from working at a larger scale such as digital, estates and workforce transformation.
	Place Boards	A forum that brings together colleagues from health and care to integrate services and focus on effective operational delivery and improving people's care.
JFP	Joint Forward Plan	This is our plan for the next five years setting out how we are going to improve health and care services for our local population, their families and carers.

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16/05/2024 11:35:18

Appendix 3

Norfolk and Waveney ICS – People and Communities
Easy Read version can be found on our website:

<https://improvinglivesnw.org.uk/~documents/documents/edi-resource-hub/easy-read/norfolk-and-waveney-ics-people-and-communities-easy-read-summary-060622>



Parker Rachael
16/05/2024 16:35:18

Agenda item: 9

Subject:	North Norfolk Place Board
Presented by:	James Gair – Chair North Norfolk Place Board Heather Farley – Acting Associate Director North – N&WICB
Prepared by:	Philippa Gregory, Acting Senior Integration and Partnerships Manager – N&W ICB
Submitted to:	N&W ICB Patients and Communities Committee
Date:	20 May 2024

Purpose of paper:

To update the Patient and Communities Committee regarding activities being led by the North Norfolk Place Board and to seek input about further developments at Place in North Norfolk.

Executive Summary:

This report provides a summary of the following:

- Background information surrounding the challenges facing North Norfolk and the development and role of the North Norfolk Place Board.
- North Norfolk Place Board Priorities.
- Spotlight on key work areas sitting under the North Norfolk Place Board, including past and present Community Transformation Funded projects/programmes of work.
- Future development and opportunities.

Slides will be presented at the meeting to highlight key points for the Committee's information and consideration.

Report

1.0 Background

North Norfolk Place Board is one of five Place Boards operating across Norfolk & Waveney. Established in July 2022, the Place Boards share the same terms of reference with the following aim:

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

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16/05/2024 15:18

As a Place Board, we look to collectively agree and deliver on our Place based priorities, through the lens of '*what is within our remit*'. Whilst maximising our enablers, we aim to overcome our challenges through innovation and transformation, thereby developing how we, as a Place Board, work together. We intend to achieve this through:

- **Being partner led** → sharing decision making and priorities to promote shared responsibility/ownership.
- **Collaborative working** → Both amongst ourselves and developing an interface with key boards, e.g. *Health & Wellbeing Partnerships, CSORT*.
- **Being transformational** → appetite for innovation and new ways of working
- **Being quality led** → driven by evidence, outcomes and evaluation.
- **Being asset-based** → maximising our strengths and working within our means
- **Taking a whole place approach** → focussed on needs of North Norfolk communities and individuals.

The North Place Board has been chaired since its establishment by the North Place Clinical Advisor, with the Acting Associate Director of the North Locality (Norfolk and Waveney ICB) taking on the role of Vice Chair. The wider Board is made up of members from *Local Authorities, General Practice, Community Healthcare, Norfolk & Suffolk Foundation Trust and the Voluntary, Community and Social Enterprise Sector*. Furthermore, the Board works closely with the two *Health & Wellbeing Partnerships* operating within the Place footprint (North Norfolk and Broadland), with a representative from each Partnership attending the Place Board. Reciprocal arrangements are also in place for the Place Board at *Health and Wellbeing Partnership* meetings. The meeting is administered by the Norfolk and Waveney ICB North Locality team, as well as programme oversight and project management.

1.1 Challenges in North Place

It is well accepted that North Norfolk faces some unique challenges which can be overlooked as they often don't fit with some of the national or even Norfolk and Waveney system challenges. For example, as per the Core20Plus5 framework¹ (NHS England, 2024), North Norfolk has only 2,800 residents which form part of the Core20 population and this population is spread out across a large geographic area, meaning there are no obvious pockets of deprivation. Furthermore, any existing deprivation can be hidden leading to poorer health outcomes. Further key characteristics include:

- 1 in 3 residents are over the age of 65. The Chief Medical Officer's Annual Report (2023)² highlights that North Norfolk has the second highest old age dependency rate in the country.
 - The population in the North Place area is also expected to grow by approximately 20,000 people between 2020 and 2040; the largest growth is expected in the older age bands.³

¹ NHS England, (2024), '*Core 20 Plus 5, (adults) – an approach to tackling healthcare inequalities*', <https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/>, (Accessed: 08 May, 2024)

² Prof Witty, C. (2023), '*Chief Medical Officer's Annual Report 2023, Health in an Ageing Society*', <https://assets.publishing.service.gov.uk/media/65562ff2d03a8d000d07faa6/chief-medical-officers-annual-report-2023-web-accessible.pdf>, (Accessed: 08 May 2024)

³ Insight and Analytics, Norfolk County Council (2023), '*North Norfolk Place Board Population Overview*', https://www.norfolkinsight.org.uk/wp-content/uploads/2023/11/NN_Place.html (Accessed: 07 May 2024)

- Dementia is noted as featuring in the top 4 leading causes of death.⁴
- North Norfolk is primarily of a rural geography with limited public transport options.
 - Access to services can be inequitable as providers often do not have a base or hub in North Norfolk meaning patients/residents have to travel into larger towns or cities for care/support.
 - Furthermore, there are no obvious locations for service hubs due to the rural nature of North Place.
 - This can increase the reliance upon community level support which is often informal or based on local networks.
 - The Chief Medical Officer's Annual Report (2023)⁵ notes that we should expect to see an increase in need in our more rural areas which will only enhance the existing challenges experienced.

1.2 What does North Place look like?

As noted above, the Place Board and relevant Health and Wellbeing Partnerships co-exist within the Integrated Care System (ICS) and work in parallel to one another to address both health and social care outcomes for our population. The Health and Wellbeing Partnership's priorities are:

Broadland Health and Wellbeing Partnership:

- Mental Health & Wellbeing
- Resilient & Healthy Communities
- Access & Prevention

North Norfolk Health and Wellbeing Partnership:

- Mental Health
- Older People
- Health Inequalities

As we develop out Place based working arrangements, the relationships between Health and Wellbeing Partnerships and the Place Board will evolve as well. There will be opportunities to collaborate or align our work, as well as developing shared priorities.

1.3 Communication and Engagement: As we continue to develop as a Place, how we engage with our partners, share information and highlight best practice will become ever more important. We have developed a quarterly briefing which highlights progress at both a Place Board and Health & Wellbeing Partnership level. It provides an opportunity to promote local initiatives as well as system/strategic updates. This will remain an evolving space for North Place. You can view the latest issue here:



NN Briefing Feb 24

⁴ Insight and Analytics, Norfolk County Council (2023), 'North Norfolk Place Board Population Overview', https://www.norfolkinsight.org.uk/wp-content/uploads/2023/11/NN_Place.html (Accessed: 07 May 2024)

⁵ Prof Witty, C. (2023), 'Chief Medical Officer's Annual Report 2023, Health in an Ageing Society', <https://assets.publishing.service.gov.uk/media/65562ff2d03a8d000d07faa6/chief-medical-officers-annual-report-2023-web-accessible.pdf> , (Accessed: 08 May 2024)

2.0 Place Board Priorities

The North Place Board has developed its priorities within the context of the wider ICS, including the Joint Forward Plan⁶, and the ICB's 2 Place Priorities: *Urgent and Emergency Care* and *Care Closer to Home*. In September 2023, the Board agreed on key outcomes aligned to the following priority workstream areas:

2.1 Dementia: As noted in section 1.1, Dementia is noted as being one of the main causes of death in North Norfolk⁷. It is expected that there will be an increase in prevalence of 26.4% in North Norfolk between the years of 2019 and 2023, and 29.7% in Broadland⁸. With this in mind, the North Norfolk Dementia Working Group 2023 – 24 objectives included:

- *To increase the number of patients with dementia receiving a diagnosis.*
- *Linking together existing group with warm spaces.*
- *Mapping groups.*
- *Promote groups via social prescribing.*
- *Identifying any gaps in provision.*
- *Provide a support element for carers.*
- *Transport and information to support people attending groups.*
- *Maximise further information available to patient's attending groups.*

See section 3.1 for more details.

2.2 Integrated Neighbourhood Teams: Integrated Neighbourhood Teams, as per the Fuller Stocktake⁹ (2022), were identified by the North Place Board in September 2023 as not only a priority for the Board, but also a long-term commitment. The INT objectives included:

- *Integrated Neighbourhood Teams developed.*
- *The Fuller Stocktake recommendations implemented.*

Whilst these objectives are very broad, a more detailed workplan has been developed (see section 5.0 for more details).

2.3 Palliative Care (Task and Finish Group): This area of work was identified by Board members as a topic of great interest, and initial outcomes were set:

- *Care homes to have access to a multi-disciplinary meeting.*
- *Multi-disciplinary team/Integrated Neighbourhood Teams established.*

⁶ Norfolk and Waveney Integrated Care System (2024), 'Norfolk and Waveney 5-year Joint Forward Plan', <https://improvinglivesnw.org.uk/norfolk-and-waveney-5-year-joint-forward-plan/> (Accessed: 07 May 2024)

⁷ Insight and Analytics, Norfolk County Council (2023), 'North Norfolk Place Board Population Overview', https://www.norfolkinsight.org.uk/wp-content/uploads/2023/11/NN_Place.html (Accessed: 07 May 2024)

⁸ Wilson, C Norfolk County Council (2021), 'Norfolk JSNA Briefing Document', https://www.norfolkinsight.org.uk/wp-content/uploads/2021/12/Briefing_paper_Dementia_v2accessible.pdf-correctedByPAVE.pdf, (Accessed: 09 May 2024)

⁹ Dr Fuller, C (2022), *Next Steps for Integrating Primary Care: Fuller Stocktake Report*, <https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/> (Access 07 May 2024)

- *Increased numbers of completed, good quality, ReSPECT forms.*

However, it has become clear that with wider system strategic developments in this space, the Board may wish to wait for further strategic steer before we engage in any Placed based projects.

2.4 Sharing Best Practice: Following Winter 2022-23, it was felt that there was an opportunity to explore how we evaluation our projects, and how we share best practice and good examples of models across the system. The following outcomes were agreed:

- *A shared evaluation framework across Norfolk and Waveney has been collaboratively developed.*
- *A mechanism for the sharing of best practice across North Place, including collating/mapping existing pieces of work has been identified and developed.*
- *Appropriate system leadership has been identified to deliver this work across Places and the Norfolk and Waveney System.*

Although important to the North Board, it was agreed that this area of work is best sat at a system level, therefore appropriate leadership will be identified in due course.

2.5 Winter: As with all winter planning, it is usually an all-year exercise and the earlier the Board can prepare the better. The following outcomes were agreed:

- *A comprehensive Winter Plan for North Place has been collaboratively developed with the North Place Board.*
- *The Board are informed and engaged in winter planning and delivery.*
- *Maximum opportunity has been made for winter projects which will support North residents and have a positive impact.*

The outcomes above set out above will be reviewed in due course and updated as required.

3.0 Example of Best Practice

3.1 Dementia Working Group: As noted in the Place Board priorities, Dementia has been of great focus and an active workstream since February 2023. As highlighted in the terms of reference, the workstream is about: *Bringing together dementia support advocates from across North Norfolk with a focus on identifying, mapping, promoting and maximising effective, equitable and sustainable dementia support services; for those living with dementia and those that care for them.*

With this approach in mind, the membership is made up of representatives from the NHS, Voluntary, Community and Social Enterprise Sector, District Councils and local Councillors, Primary Care, Community Healthcare, Norfolk County Council, Alzheimer's Society, local Dementia groups and, most importantly, those with lived experience.

This focus upon lived experience has shaped the working group and its activity. The work to date has been community driven with a focus upon sustainable transformation, maximizing existing assets and ensuring the best outcomes for our communities. Some of the key outputs of the group are:

Parker Rachael
16/05/2024 16:35:18

- Recruited a **Dementia Fellow** - Dr Amer Sana
- Delivered a two-hour dementia **awareness training** session to 100 delegates including social prescribers, community connectors and health coaches. (Trainer- Dr Zena Aldridge)
- Developed the North Norfolk Dementia **Leaflet**
- Developed the North Norfolk **Infographic**
- Reinstated the **GP referral form** to enable one referral form to be shared with both NSFT and Alzheimer's Society.
- Supported the **Education and Upskilling Workstream**, newly established in the Integrated Care System
- Commenced the **Protect Now Pro-active dementia support** project.



NN Dementia
Leaflet



NN Infographic

With the success of the group, the working group proposed new priorities for 2024-25 which were fully endorsed by North Board members in April 2024:

- To engage with the SPLENDID project, identifying and supporting a North Norfolk Practice as a research site
- Support development of a dementia information area/s on Knowledge Now which can be updated and links with partner websites.
- To seek GP Practice agreement for patients and carers to be given North Norfolk Dementia Leaflet and Infographic at the point of NSFT referral
- [ICS Dementia Charter](#) To develop a "North Norfolk Place Dementia Charter" based on pro-active support for those living with dementia and those supporting them (paid and unpaid).
- To complete the Protect Now project and publish an evaluation report (August 2024).
- To link with the Community Voice Insights Bank to ensure all feedback is recorded.
- Further consider the role of a "Dementia Co-Ordinator" or potential for a single point of access. Step up/step down approach, fully utilising available resources.
- Ensure links with ICS Ageing Well and Age Friendly North Norfolk
- Produce local professional contact list and keep up to date

The momentum behind this group is greater than ever and their work is a wonderful example of what can be achieved when we work in partnership with our communities. This work will soon be presented to the Integrated Care Board meeting in recognition of its success. It is hoped we can take the learning from this approach and apply it elsewhere in the system.

4.0 Community Transformation Funding.

The Norfolk and Waveney system was allocated Community Transformation Fund (CTF) funding to support transformation and promote collaborative working between providers within the community. The funding was set out across three years starting in 2021 (spread across 4 years) as follows:

- 2021/2022 - **£88,500** - reduced to **£59,041**
- 2022/2023 - **£177,000**
- 2023/2024 **£177,000** - reduced to **£168,000**
- 2024/2025 – Reduced to **£40,315**

Parker Rachael
16/05/2024 16:35:18

The key aims of this funding are:

- Parity in community services
- Primary Care Network development
- Community Transformation - Delivery of 2-hour Urgent Community Response, Delivery of Reablement 2 Day response, Anticipatory Care, Enhanced Health in Care homes (EHCH)
- Implementation of Hospital Discharge Policy (D2A).

4.1 2022 – 23

In 2022, the North Norfolk Local Delivery Group (pre-dating the North Place Board) agreed to fund five projects:

1. Waiting Well (Broadland District Council)
2. Waiting Well (North Norfolk District Council)
3. FCP Physio Prehab Pilot
4. Community and Primary Care Collaboration Project – Leg Ulcer Clinics and Discharge
5. Mundesley End of Life Project

4.1.1 Waiting Well - Broadland District Council: In the Spring of 2022, patients awaiting a hip and/or knee replacement with the Norfolk and Norwich University Hospital were contacted by South Norfolk and Broadland District Councils. The purpose was to offer a holistic assessment to each individual to determine whether they required any form of support whilst they await their surgery, given the backlog being experienced post-covid. Support options included:

- Access to internal District Council services (e.g. low level housing adaptations, financial services, housing)
- Voluntary and community-based services
- Wellbeing support
- Occupational therapies and physio

During the two-month period of the project, 797 patients were contacted with 104 (13%) of people requiring some form of support or referral. The age of this cohort was primarily between 62 and 78 years, with welfare rights being the primary destination for referrals. In close second was the District Council's Community Connector team – with mental health and wellbeing being the main reason for referral.

Next Steps: This project was evaluated by Norfolk Healthwatch which helped inform the development of a similar initiative led by North Norfolk District Council

4.1.2 Waiting Well – North Norfolk District Council: The Waiting Well Project was delivered by North Norfolk District Council between November 2022 and October 2023. During this time over 350 patients on orthopaedic waiting list for either hip and knee surgery at Norfolk and Norwich University Hospitals were contacted to offer advice and support to help them live as safely and independently as possible while waiting for surgery.

This project was able to utilize the learnings from the Broadland model to help inform their approach. For example, North Norfolk District Council opted to sending patients a letter first before following up with a phone call, so patients had the opportunity to decline the call or

prepare for the conversation. Furthermore, the North Norfolk model had access to updated patient list data following an improved data sharing agreement.

As a result of the project:

- 72 patients were supported to obtain disability living aids or free-standing equipment, including 43 patients referred for occupational therapy assessments.
- 32 patients received advice about adapting their home due to their disability, including 11 patients who were supported to apply for [Disabled Facilities Grants](#).
- 165 patients were signposted to [accessible exercise classes](#) in their local area, including 61 patients who were referred to specialist hip and knee exercise courses.
- 25 patients were referred to [Carers Matters Norfolk](#) for carers assessments.
- 37 patients were referred to [Financial Inclusion](#) for advice about claiming benefits.
- 29 patients were supported with [Blue Badges](#) applications.
- 21 patients were signposted to [North Norfolk Community Transport](#) services.

This approach was unique in its case management approach – opting to provide ongoing support where appropriate and 3/6 month check-ins for those who agreed. This has enabled North Norfolk District Council to develop case studies demonstrating the benefit that small interventions can have on an individual.

Next Steps: The benefits of such an approach have been fed into the development of current projects (2023-24 and 2024-25).

4.1.3 FCP Physio Prehab Pilot: Much like the two models outlined above, delays on Orthopaedic Secondary Care waiting lists increased significantly following the pandemic, meaning that patients were waiting much longer for total hip and knee replacement surgery. This posed a significant risk for patients, who may deteriorate, physically, ahead of their surgery. Along with the risk associated with social isolation and mental wellbeing, there was also the risk that patients may have to access Primary Care services during this waiting period, thereby increasing pressure on frontline services.

The aim of this project was to improve or prevent deterioration of function, pain, and confidence to optimize preparation for surgery of patients on orthopaedic waiting list through things such as:

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

This pilot was able to show the positive impact of physical and lifestyle interventions in patients awaiting hip and knee replacement and indicates the need for early intervention where possible.

Next Steps: Overall, a great deal of learning can be taken from these three projects – not only have they complemented one another and provided a well-rounded offer of support to patients awaiting surgery, but they have demonstrated the value of early intervention and a patient-centred approach to support. The North Place Board was keen to take these learnings and apply them to the wider work programme.

4.1.4 Mundesley End of Life Project: Patients' families / friends / carers can find the process surrounding the death of a loved one quite unfamiliar and oftentimes difficult to

Parker Rachael
16/05/2024 14:35:18

navigate. This can be due to an uncertainty around processes, both amongst relatives and staff in primary and community care.

The focus of this project is to utilize existing resources and information and apply them to a local level, to help patients and their families understand what will happen in their own personal context leading up to, and after their loved one has passed away. It was agreed that the focus of the project would be:

- Inheriting the Daffodil Standards. The focus would be on the following standards :
 - Professional and competent staff
 - Carer Support – before and after death
 - Seamless, planned, coordinated care
- Improving the delivery of care to patients who are diagnosed with severe long-term conditions (Gold Standards Framework)
- Improving the way that information is recorded and handled by the reception team and GPs.
- Researching organisations and their services surrounding end of life/ death

Since completing this project, the practices' procedures are now clear and streamlined to ensure that all needs are met and no distress is caused. The staff at Mundesley Medical Centre are also more confident in dealing with these difficult situations. The practice aims to continue to develop the way in which they manage end of life care, with the aim to make real change within the practice and much wider.

Next Steps: Much like the Waiting Well Models, this piece of work has established some best practice which is being further developed in the Board's 2024-25 work programme.

5.0 Integrated Neighbourhood Teams Workstream

As the Place Board's priority focus area, a programme of work has been established, focussing on four key areas:

1. Multi-Disciplinary Meeting Reviews
2. Self-Neglect and Hoarding
3. Nursing Activity Review
4. Frailty

5.1 Multi-Disciplinary Meeting Reviews: The aim of this working group is to analyse existing multidisciplinary team meetings (MDM's) to find best practice and ways to support and improve meetings to ensure a high level of discussion is taking place across North Norfolk. It will act as a strong foundation for other work including the Frailty project as patients will be easily identified and brought to the meetings for partner discussions on how to support as one team. To date, all 19 practice MDM's have been observed at least once and a summary report is being developed. A follow up IT survey is live, as well as a stakeholder survey gathering examples of best practice. The next step is to analyse the feedback from the surveys and develop some 'top tips' for MDM's. The group will also look to identify support for MDM Chairs to increase skills and confidence, as well as supporting partners to engage to ensure maximum engagement and a holistic approach.

5.2 Self-Neglect and Hoarding: Self-neglect and/or hoarding are factors that frequently complicate the cases of some of the patients brought to MDMs. Such patients are often difficult to support due to the lack of specific services available. Work is slowly beginning to

develop a framework for micro providers to register with so that cleaning/decluttering teams going into a patient's home have been through the proper checks. The next steps are to develop a work plan for 2024 – 25 and to strengthen the links with work taking place in Central Norfolk.

5.3 Nursing Activity Review: To look at the nursing needs (community and practice) of a population and identify how we can better meet the demand. This project also hopes to build stronger working relationships between NCH&C and practice staff. A PCN level geography has been identified as a potential footprint to focus on initially; there is a high level plan in development to get nurses back in practices and to look at activity coming in and how this can be managed, along with quality of referrals. The next steps are to gain final agreement to proceed and to set a workplan and goals for 2024-25.

5.4 Frailty: By identifying patients tipping into frailty and providing proactive support we hope to delay or reduce the risk of frailty developing. Patients over 50 years of age who attend A&E for a fall related injury, but are not admitted, will be called by the relevant District Council. The District Council will then offer support and use the Dialog+ evaluation tool to support the patient who may also be discussed at an MDM if appropriate. Data sharing agreements and other relevant information governance documents are awaiting sign off which will allow the data to flow from the hospital to the District Councils. In the meantime, staff are being trained and prepared for a soft launch in May.

This piece of work has been greatly informed by the three Waiting Well models outlined earlier in this paper and is an exemplar of how the Board has progressed over time; the group has been able to take the learning to help build the foundations of this project. Some of the key aspects included:

- Taking a population health management approach to identifying cohorts
- Developing a strong workforce training offer through pump priming to support long term sustainability of this approach
- Ongoing sharing of learning
- A patient-centred approach to support i.e. tailored to an individual's needs
- Furthermore, the Chief Medical Officer's Annual Report (2023) highlights that ill health and older age does not go hand in hand, so we have the perfect opportunity to focus upon quality of life and enabling our populations to live independent and healthy lives.

Most importantly, this work has been underpinned by a strong sense of collaboration – each and every partner have a shared interest in proactively supporting this population.

This piece of work is also being supported by CTF monies, emphasising the commitment to INT's in North Norfolk. As set out in a paper to the North Place Board in November 2023, some clear principles of collaboration were established. The proposals as agreed by the North Place Board are:

1. *Transformational and sustainable.*
2. *Produced in collaboration with the North Norfolk INT Transformation Group.*
3. *Supporting INT development.*
4. *Furthering our ambition for cross sector integration.*
5. *Creating a solid foundation on which to build future initiatives.*
6. *Preparing us for place-based working and joint decision-making within an Integrated Care System*

Parker Rachael
16/05/2024 16:35:18

The intention is that these principles will form the foundation of all future INT work in North Norfolk.

6.0 Looking Ahead: Community Transformation Funded Projects 2024-25

As our current work programme and projects progress in their delivery, two new areas have been identified as a focus.

6.1 Daffodil Standards (Aligned with Palliative and End of Life Care Workstream):

Based on the work initially led by Mundesley Medical Practice, the North Board will be looking to support practices across North Place to undertake the work by Curie/GPC that leads to accreditation for End-of-Life Care (the ‘Daffodil Standards’). The aim is to increase awareness, skills and confidence in staff when supporting patients who are end-of-life and their families/carers. Mundesley Medical Practice have laid some great foundations and we will be looking to draw upon their experiences to support the delivery of this project. This project will be supported by some CTF monies which will enable Practices to dedicate time to engagement with this project.

6.2 VCSE Capacity and Volunteering (Aligned with INT Workstream): The intention is to scope local VCSE provision and capacity in the more rural and deprived communities across North Place, to identify opportunities to boost or transform the services. The Board hopes to strengthen community level resilience and support our VCSE colleagues in their local agendas, which will in turn, help to reduce health inequalities and improve the health and wellbeing of our communities.

Recommendation to the Committee:

The Committee is asked to note the report and consider any opportunities for joint working with the North Norfolk Place Board.

Key Risks	
Clinical and Quality:	Clinicians are present on the Board and ensure clinical risk are considered, where there is more detailed input required this is sought from the developmental stage through to evaluation.
Finance and Performance:	No finance risks as the small budgets are closely monitored. There is a previously agreed performance monitoring process for all projects which is appropriate to the complexity and finance allocated for the project.
Impact Assessment (environmental and equalities):	No environmental risks, equality of access for projects is considered although further work will be considered in this area.
Reputation:	Successful delivery of partnership projects aids reputation of the individual organisations and the Board. However, it is understood that not all projects will succeed, and this is part of the ‘sharing best practice’ model that we are aiming for.
Legal:	None identified

Information Governance:	Cross organisational working results in complex information governance issues to overcome. This continues to be a challenge for all projects.
Resource Required:	Community Transformation Fund has been a key lever to support delivery of work, Reductions in this sum have resulted in considerable rethinking of projects to be completed by the Board.
Reference document(s):	NHS England, (2024), 'Core 20 Plus 5, (adults) – an approach to tackling healthcare inequalities', https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/, (Accessed: 08 May, 2024) Prof Witty, C. (2023), 'Chief Medical Officer's Annual Report 2023, Health in an Ageing Society', https://assets.publishing.service.gov.uk/media/65562ff2d03a8d000d07faa6/chief-medical-officers-annual-report-2023-web-accessible.pdf , (Accessed: 08 May 2024) Insight and Analytics, Norfolk County Council (2023), 'North Norfolk Place Board Population Overview', https://www.norfolkinsight.org.uk/wp-content/uploads/2023/11/NN_Place.html (Accessed: 07 May 2024) Norfolk and Waveney Integrated Care System (2024), 'Norfolk and Waveney 5-year Joint Forward Plan ', https://improvinglivesnw.org.uk/norfolk-and-waveney-5-year-joint-forward-plan/ (Accessed: 07 May 2024) Wilson, C Norfolk County Council (2021), 'Norfolk JSNA Briefing Document', https://www.norfolkinsight.org.uk/wp-content/uploads/2021/12/Briefing_paper_Dementia_v2accessible.pdf-correctedByPAVE.pdf , (Accessed: 09 May 2024) ¹Dr Fuller, C (2022), <i>Next Steps for Integrating Primary Care: Fuller Stocktake Report</i>, https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/ (Access 07 May 2024)
NHS Constitution:	1. The NHS provides a comprehensive service, available to all 3. The NHS aspires to the highest standards of excellence and professionalism 4. The patient will be at the heart of everything the NHS does 5. The NHS works across organisational boundaries 6. The NHS is committed to providing best value for taxpayers' money 7. The NHS is accountable to the public, communities and patients that it serves
Conflicts of Interest:	None identified
Reference to relevant risk on the Board Assurance Framework	BAF02 System and Emergency Care Pressures BAF06 Health Inequalities and Population Management BAF08 Elective Recovery

Governance

Process/Committee approval with date(s) (as appropriate)	
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16/05/2024 16:35:18



Improving lives **together**

Norfolk and Waveney Integrated Care System

North Norfolk Place Board: An Overview (May 2024)

James Gair – Chair North Norfolk Place Board

Heather Farley – Acting Associate Director North – N&W ICB

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16/05/2024 16:35:18

Prepared by - Philippa Gregory

Acting Senior Integration and Partnership Manager, North Locality ICB

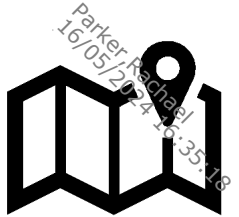
Background – What are the challenges in North Place?

Population

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

Deprivation

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



Rural geography



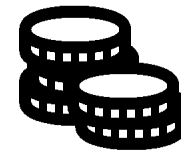
Limited transport
options



Inequitable access
to services



Ageing population



Hidden deprivation



Reliance upon
community level
support

Background – What does North Place Look Like?

3 Priority Areas: Older People, Mental Health, Inequalities

3 Workstreams: Mental Health & Wellbeing, Access & Prevention, Resilient & Healthy Communities

5 Priority Workstreams: Dementia, Integrated Neighbourhood Teams, Palliative and End of Life Care, Sharing Best Practice, Winter

North Norfolk
**Health &
Wellbeing
Partnership**

Broadland
**Health &
Wellbeing
Partnership**

North Norfolk
Place Board

North Place

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16/05/2024 16:35:18

North Norfolk Place Board

NNUH

NSFT

NCHC

NCC

District
Councils

(VCSE Place
Lead)

General
Practice

GP Provider
Organisation

ICB

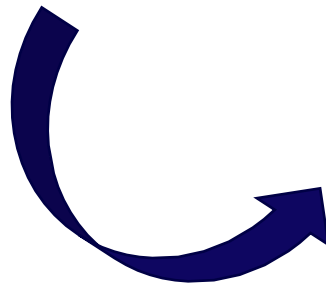
As a Place Board, our focus is on:

- Collectively agree and delivering on our Place based priorities, through the lens of *'what is within our remit'*
- Maximising our enablers
- Overcoming our challenges through innovation and transformation
- Developing how we, as a Place Board, work together

We intend to achieve this through:

- **Being partner led** → shared decision making and shared priorities = shared responsibility/ownership
- **Collaborative working** → Both amongst ourselves, and developing an interface with key boards, e.g. *Health & Wellbeing Partnerships, CSORT*
- **Being transformational** → appetite for innovation and new ways of working
- **Being quality led** → driven by evidence, outcomes and evaluation
- **Being asset-based** → maximising our strengths and working within our means
- **Taking a whole place approach** → focussed on needs of North Norfolk communities and individuals

Parker Rachael
16/05/2024 16:35:18



Current North Place Board Priorities

System	Integrated Care System (ICS) Mission: To help the people of Norfolk and Waveney to live longer, healthier and happier lives.				
	Joint Forward Plan 8 Priorities: Mental Health Transformation; UEC Transformation, Elective Recovery & Improvement; Primary Care Resilience & Transformation; Integrated Neighbourhood Teams; Improving Productivity & Efficiency; PHM, Reducing Health Inequalities and Supporting Prevention; Babies, CYP & Maternity; Older People				
Place	ICB Place Priority 1: Urgent and Emergency Care		ICB Place Priority 2: Care closer to home		
North Board Priorities (2023 – 24)	Dementia - Increased diagnosis - Existing groups linked with warm spaces - Groups mapped and gaps in provision identified - Groups promoted via social prescribing - A support element provided for carers - Options on transport to attend groups has been shared (Complete) - Information on groups has been made available (linked with 3)	Integrated Neighbourhood Teams - Integrated Neighbourhood Teams developed - The Fuller Stocktake recommendation s implemented	Palliative Care (T&F Group) - Care Homes to have access to an MDT - MDT/Integrated Neighbourhood Teams established - Increased numbers of completed good quality ReSPECT forms	Sharing Best Practice - A shared evaluation framework across Norfolk and Waveney has been collaboratively developed. - A mechanism for the sharing of best practice across North Place, including collating/mapping existing pieces of work has been identified and developed. - Appropriate system leadership has been identified to deliver this work across places and the Norfolk and Waveney system	Winter - A comprehensive Winter Plan for North Place has been collaboratively developed with the North Place Board. - The Board are informed and engaged in winter planning and delivery. - Maximum opportunity has been made for winter projects which will support North residents and have a positive impact.

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16/05/2024 16:35:18

Spotlight On: Dementia Working Group

- Recruited **Dementia Fellow** Dr Amer Sana
- Delivered a two-hour dementia **awareness training** session to 100 delegates including social prescribers, community connectors and health coaches. (Trainer- Dr Zena Aldridge)
- Developed the North Norfolk Dementia **Leaflet**
- Developed the North Norfolk **Infographic**
- Reinstated the **GP referral form** to enable one referral form to be shared with both NSFT and Alzheimers Society.
- Supported the **Education and Upskilling Workstream**, newly established in the Integrated Care System
- Commenced the **Protect Now Pro-active dementia support** project. To date 753 have received contact with 152 requests for support. Total Budget £3000



NN Dementia Leaflet



NN Infographic



Updated Dementia Objectives 2024 - 25

- To engage with the SPENDID project, identifying and supporting a North Norfolk Practice as a research site
- Support development of a dementia information area/s on Knowledge Now which can be updated and links with partner websites.
- To seek GP Practice agreement for patients and carers to be given NN Dementia Leaflet and Infographic at the point of NSFT referral
- **ICS Dementia Charter** To develop a “North Norfolk Place Dementia Charter” based on pro-active support for those living with dementia and those supporting them (paid and unpaid).
- To complete the Protect Now project and publish an evaluation report (August 2024).
- To link with the Community Voice Insights Bank to ensure all feedback is recorded.
- Further consider the role of a “Dementia Co-Ordinator” or potential for a single point of access. Step up/step down approach, fully utilising available resources.
- Ensure links with ICS Ageing Well and Age Friendly North Norfolk
- Produce local professional contact list and keep up to date

Bringing together dementia support advocates from across North Norfolk with a focus on identifying, mapping, promoting and maximising effective, equitable and sustainable dementia support services; for those living with dementia and those that care for them.

Terms of Reference



Spotlight On: Waiting Well Models

2022/23 Community
Transformation Projects

Waiting Well – North Norfolk and Broadland District Councils



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

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

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

Learnings

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

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

→ *This has fed into how we approach our CTF projects for 2023-24 and 2024 - 24*



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



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

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

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

Spotlight on Mundesley

2022/23 Community
Transformation Project

End of Life Project



Aims:

- To enhance the patient-centred approach when dealing with the end stages of life/death, using the Daffodil Standards.
- To have close communication with patient's relatives and carers, offering a network of support
- To improve contact with other organisations that are involved at the end stages of life
- Create a seamless process to ensure that these difficult times are dealt with efficiently and effectively

Outcomes:

- They key areas of focus have been:
 - Inherit the Daffodil Standards
 - Improve the delivery of care to patients who are diagnosed with severe long-term conditions (Gold Standards Framework)
 - Improve the way that information is recorded and handled by the reception team and GPs
 - Research organisations and their services surrounding end of life/ death
- Mundesley have also worked through and adopted the following from the Daffodil Standards:
 - Professional and competent staff
 - Carer Support – before and after death
 - Seamless, planned, coordinated care

→ This work is ongoing and will feed into the Community Transformation projects in 2024 – 25.

Spotlight On: Integrated Neighbourhood Teams



Multi-Disciplinary Meeting Reviews

- Analysing existing multidisciplinary team meetings to find best practice and ways to support and improve meetings to ensure a high level of discussion is taking place across North Norfolk.
- Will act as a strong foundation for other work including the frailty project as patients will be easily identified and brought to the meetings for partner discussions on how to support as one team.
- Carried out reviews of all 19 practice based MDM's



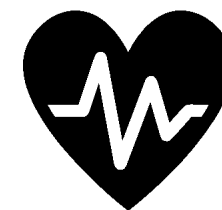
Self-Neglect and Hoarding

- Self-neglect and/or hoarding are factors that frequently complicate the cases of some of the patients brought to MDMs.
- Such patients are often difficult to support due to the lack of specific services available.
- Work is about to begin to explore how patients in North Place can be supported.



Nursing Activity Reviews

- To look at the nursing needs (community and practice) of a population and identify how we can better meet the demand.
- This project also hopes to build stronger working relationships between NCH&C and practice staff.
- Work to begin shortly.



Frailty

- By identify patients tipping into frailty, and providing proactive support we hope to delay or reduce the risk of frailty developing.
- Patients over 50 years of age who attend A&E for a fall related injury, but are not admitted, will be called by the relevant district council. The DC will then offer support and use the Dialog+ tool to help the patient.
- Patient may be discussed at an MDM.
- This project is being supported by CTF monies 2023-24.**

CTF Money

Although some aspects of the North Place Board programme are being support by CTF, the focus remains on collaborative working and transformational projects which may or may not receive funding.



Palliative and End of Life Care: Daffodil Standards in GP Practices

- To support practices in North Norfolk to undertake the work by Marie Curie/GPC that leads to accreditation for End-of-Life Care (the “Daffodil Standards”).
 - Aim is to increase awareness, skills and confidence in staff when supporting patients who are EoL and their families/carers.



Integrated Neighbourhood Teams: VCSE Capacity and Volunteering

- To scope local VCSE provision and capacity in these more rural and deprived communities, to identify opportunities to boost or transform the services.
- The aim of this work is to strengthen community level resilience and support our VCSE colleagues in their local agendas, which will in turn, help to reduce health inequalities and improve the health and wellbeing of our communities.

Communication & Engagement



- Quarterly briefing to highlight progress at both a Place Board and Health & Wellbeing Partnership level.
- Opportunity to provide wider ICS updates.
- Opportunity to put a spotlight on Place Based working.
- An evolving space for North Place.
- You can view the latest issue here:



NN Briefing Feb
24



References

- **North Place Data** - https://www.norfolkinsight.org.uk/wp-content/uploads/2023/11/NN_Place.html
- **Broadland Health & Wellbeing Partnership** - <https://www.southnorfolkandbroadland.gov.uk/communities/health-wellbeing-partnership/1>
- **North Norfolk Health & Wellbeing Partnership** - <https://www.north-norfolk.gov.uk/tasks/health-and-wellbeing/north-norfolk-health-and-wellbeing-partnership/>

Parker Rachael
16/05/2024 16:35:18

Parker Rachael
16/05/2024 16:35:18

Agenda item: 10

Subject:	Population Health & Inequalities (PH&I) Board – 16/04/2024 – Assurance & Escalation Report
Presented by:	Dr Frankie Swords, Executive Medical Director
Prepared by:	Dr Frankie Swords, Executive Medical Director
Submitted to:	N&W ICB Patients and Communities Committee
Date:	20 May 2024

Purpose of paper:

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

Executive Summary:

The Population Health & Inequalities Board (PH&I) Board meets bi monthly and was last held on Tuesday 16 April 2024. The report details points of assurance and escalation as well as a high level risk overview summary.

Report

Please find attached document.

Recommendation to the Committee:

To review points for assurance.

Key Risks

Clinical and Quality:

Health inequalities are avoidable, unfair and systematic differences in health between different groups of people, which impact on longer term health outcomes and a person's ability to access healthcare. Population Health Management is a systematic way of working to understand the health and care needs of our population and put in place new models of care to deliver improvements in health and well-being. This work is fundamental to the delivery of our ambitions in relation to Prevention and addressing Health Inequalities. There is a risk we do not achieve the impact we seek if we do

Parker Rachael
16/05/2024 16:35:18

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

Governance

Process/Committee approval with date(s) (as appropriate)	
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Parker Rachael
16/05/2024 16:35:18

Population Health & Inequalities (PH&I) Board - Points of Assurance / Escalation [16/04/2024]



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

Item No.	Meeting Name	Date of meeting where item was first raised	Details of Item for Escalation	Requested Outcome/Support	Financial Implication (if any)	Is item recorded on Risk Register	"EXAMPLE" Board Decision	Fed back to Meeting Group Date
10.	PH&I Board	10/10/2023	ICS PHM Strategy & HI Framework for Action	Update : PHM Strategy now published and communication and implementation plan being developed. HI Strategic Framework for Action recommended for approval by ICP to be published after election period.	N/A	N/A	For assurance	
19.	PH&I Board	20/02/2024	PHM software procurement	Update: Expected to go live May 2024	N/A	No	For assurance	
23.	PH&I Board	16/04/2024	Community Voices programme	To note excellent work by CVP to "listen, capture, respond and enable" people, focusing on those in Core20 communities. Examples shared of work to improve health literacy with a view to improving uptake of vaccination and screening as well as other interventions. Need to track impact noted and to use this intelligence to inform service planning.	Yes	In progress	For assurance	
24.	PH&I Board	16/04/2024	Protect NoW – VST Team – Project Support	Valuable, varied and extensive work performed by the VST team noted, including work done to increase uptake of Active NoW in West Norfolk following the targeted calls from this team	No	N/A	For assurance	
25.	PH&I Board	16/04/2024	EIA Process Update	Work on track to formalise the start of new process with support from across the ICB and ICS by June 2024. Current EIA form to continue to be used until new process is finalised.	No	Yes HI06	For assurance	
26.	PH&I Board	16/04/2024	PH and Inequalities Dashboard	Interactive dashboard now live to enable teams to access data about their own population, to identify priority areas of work and track impacts. Communication plan in place to share widely	No	N/A	For assurance	

Parker Rachael
16/05/2024 16:35:18

Programme Risks as of 16/04/2024 – PH&I Board

The PHM and HI March 2024 versions of risk registers were reviewed at this meeting.

The overarching BAF06 PHM &HI risk continued to score at 12. This will be further reviewed and updated by the PHM and HI team which may impact the risk scoring.

The PHM team reported 4 risks, no new risks were added, no risks scored above 15 and all risk scores remained the same as the previous reporting period.

‘PHMI02 Practice DPIA Sharing’, remains at a risk score of 4. It was agreed for this to be archived at the next risk register review.

‘PHMI09 Procurement of PHM System – Lack of ICB Resource’ remains at a risk score of 9, this will be reviewed and reduced at the next risk register review.

The HI team reported 7 risks, no new risks were added, 1 risk scored above 15 and all risk scores remained the same as the previous reporting period.

‘HI06 No PMO process for Equality Impact Assessments (EIAs)’ remains at a risk score of 9. Paper previously provided to the 19/12/2023 PH&I Board. Further update provided to the PH&I Board 16/04/2024 (see item 25 of the assurance report). Risk detail to be updated accordingly.

‘HI05 No HI ring fencing of NHSE funding allocations’ remains at a risk score of 16. This was previously escalated to the Patient & Communities Committee (see item 19 of the assurance report) and continues to be an escalation.

‘HI01 Not completing HI Strategy as per JFP ambition / objective’ remains at a risk score of 6. This will be reviewed and reduced at the next risk register review.

Risk surrounding long term funding for CVP programme to be considered by HIOG.

Parker Rachael
16/05/2024 16:35:18

NHS Norfolk and Waveney ICB –PHMI Programme Risk Register (2024-2025)

NHS Norfolk and Waveney ICB – PHM Programme Risk Register (2024-2025)

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

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

Ref	Risk description	Month risk rating 2024-25											
		1	2	3	4	5	6	7	8	9	10	11	12
BAF06	Health Inequalities and Population Health Management	12											

Open PHM Risks

Ref	Risk description	Month risk rating 2024-25											
		1	2	3	4	5	6	7	8	9	10	11	12
PHMI02	Practice DPIA Sharing	4											
PHMI09	Procurement of PHM System - Lack of ICB Resource	6											
PHMI14	ICB BI capacity	4											
PHMI18	Lack of allocated PHM Budget. Impacting PHM projects and Protect NoW VST team	10											

Parker Rachael
16/05/2024 16:35:18

BAF06

Risk Title		Health inequalities (HI) and Population Health Management (PHM)										
Risk Description		There is a risk that the ICB will not meet its statutory requirements to reduce HI or use PHM techniques to their full potential in line with the PHM strategy and HI strategic framework for action. If this happens, specific groups of people will experience poor outcomes which could have been prevented.										
Risk Owner		Responsible Committee			Operational Lead		Date Risk Identified		Target Delivery Date			
Mark Burgis / Dr Frankie Swords		Patients and Communities			S Meredith		01/07/2022		31/05/2025			
Risk Scores												
Unmitigated			Mitigated			Tolerated (Target in 12 months)						
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total	
4	4	16	3	4	12	1	4	4				
Controls						Assurances on controls						
- The HI Strategic Framework for action and the PHM strategy have been developed. Implementation plans will be developed in 2024/25. Specialty advisors are leading on HI, PHM and the Core20Plus5 clinical areas. - The NCC deputy DPH is leading the PHM team reporting to the ICB Medical Director working closely with the HI Clinical Lead and SRO. - The Health Improvement Transformation Group (HITG) is established and focusses on Primary Prevention, reporting to the ICP. Key priorities: smoking, physical activity and Healthy weight. - Community Voices gathering insights into HI and connecting with local communities. - ICS groups set up for Inclusion health groups, vaccines inequalities, Core20plus5 programme group, NHS Anchors group, access and support programme group, reporting to HIOG - Datahub Population Health dashboards in place to support reporting and health oversight. - Health and wellbeing partnerships and place boards overseeing local work programmes. - External factors that impact on "Plus groups" (such as the moving of hotels for asylum seekers which impacts on the services they receive) are raised by the HI team to be managed across the ICP.						Internal: PHM and addressing HI has been identified as a priority in our JFP. Progress against key national delivery timelines reported and led by appropriate governance structures: Health Inequalities Oversight Group (HIOG), PHM Oversight Group (PHMOG) and PH and Inequalities Board with assurance reporting to Patients and Communities Committee. NHSE reporting of NHS Inequalities Improvement Frameworks and annual reporting against NHS statement on Information for health Inequalities. Elective Recovery Board receive monthly report on waiting lists per decile of deprivation index External: Integrated Care Partnership Board						
Gaps in controls or assurances												
- Embedding resources at Place level to co-ordinate the mechanisms needed to address HI and deliver PHM - Further work required to develop the data hub and dashboards. - NHSE HI funding not ring-fenced to support emerging work programmes and respond to system priorities. - Agreed governance for Equality health impact assessments but uniform process not yet established												
Updates on actions and progress												
Date opened	Action / update							BRAG		Target completion		
05/04/24	The PHM strategy has been published. The HI Framework for action has been endorsed by the Patient and Communities committee and will be published on 15 th May. Implementation plans are being developed for both. The new ICB structure includes a small HI team to lead these HI actions, co-ordinating and working with multi-partner agencies.									15/5/24 (to accommodate purdah restrictions)		
	A co-ordinating multi-partner health inequalities group is arranged for April that will prepare terms of reference and implementation plan to go to the ICP June meeting and other governance structures.											
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12											
Change	→											

PHMI02								
Risk Title	Practice DPIA Sharing							
Risk Description	There is a risk that patients registered under practices which have not signed an appropriate data protection impact assessment agreement can not be included in the PHM programmes run through the Protect NoW team as this uses the Eclipse system. This may result in inequalities and potentially avoidable poorer health outcomes for people living in some areas of Norfolk &Waveney.							
Risk Owner	Responsible Committee		Operational Lead		Date Risk Identified		Target Delivery Date	
Dr Frankie Swords	Patients and Communities		Shawn Haney / Samantha Weston		12/07/2022			
Risk Scores								
Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	5	20	2	2	4			
Controls				Assurances on controls				
- Comms sent to Practices. - PHMI team attending South GP lunch session. - Agreed a targeted approach - project specific as a reminder to practices. - Email comms being sent from Clinical Leads, followed by phone calls for those that do not respond to initial email.				PHMOG which reports into the PH&I Board meeting/reporting governance structure in place.				
Gaps in controls or assurances								
ICS data sharing strategy must be implemented, and progress tracked on this.								
Updates on actions and progress								
Date opened	Action / update					BRAG	Target completion	
14/12/2022	Sign up status as of 14/12/2022:70 practices have now signed up. 3 have specifically indicated that they have no wish to share data. Outstanding practices are being followed up by Clinical Leads.					N/A	N/A	
15/11/2022	Population Health & Care Steering Group Discussion (15/11/2022, 29/11/2022, 13/12/2022). Agreed that the PHMI team would draft an email to outstanding practices. This will then be sent by the PHMI Clinical Leads to applicable practices. If a response is not received, then the Clinical Leads will phone practices. 25/01/2023: Emails comms drafted and agreed. Clinical Leads emailing outstanding practices w/c 23/01 and 30/01. 01/03/2023: PHM Clinical Leads emailed outstanding practices w/c 13/02/2023 with a deadline of 28/02/2023 and advised that they would phone the practice if no response had been received by this date. PHMI programme team to liaise with PHM Clinical Leads and also agree further escalation steps – as we remain at only 70 practices that have signed the DPIA. 28/03/2023: PHMI team to review list of current outstanding practices. Escalation/next steps to then be agreed at PHM Clinical Steering Group.						07/02/2023	
25/01/2023	70 practices have signed the DPIA					N/A	N/A	
01/03/2023	The first PHMOG is scheduled for 13/04/2023 and the first PH&I Board for 18/04/2023. Invites sent for 2023-24 to known members (representative membership still to be confirmed)					N/A	N/A	
28/03/2023	72 practices have signed the DPIA. We expect this to increase as new PHMI projects are implemented. Some of the representative membership has now been confirmed for the PH&I Board and PHMOG– we are continuing to follow up where applicable.					N/A	N/A	
25/04/2023	The first PHMOG took place on 13/04/2023 and the first PH&I Board on 18/04/2023. Meeting dates for these meetings have been scheduled – remaining membership will continue to be confirmed as per BAU. Practice sign up of DPIA remains at 72. GYW locality colleagues have offered support to encourage remaining practice sign up in their locality - in relation to a potential SMI and smoking project					N/A	N/A	

Parker Rachael
16/05/2024 16:35:11

23/05/2023	Practice sign up of DPIA has increased to 75, the additional 3 are from the GYW as a result of support in contacting practices via GYW locality colleagues.	N/A	N/A
27/06/2023	Practice sign up of DPIA has increased to 77, the additional 2 are as a result of support in contacting practices via GYW locality colleagues. GYW locality colleagues has finished contacting all GY&W practices and is now beginning to encourage remaining practice from other localities.	N/A	N/A
25/07/2023	Practice sign up of DPIA had increased to 79.	N/A	N/A
31/08/2023	Practice sign up remains at 79.	N/A	N/A
25/09/2023	Practice sign up remains at 79. As we towards fully utilising the data hub this contract will become redundant.	N/A	N/A
26/10/2023	It was discussed at the PHMOG on 12/10/2023 to expand this risk to include a wider uptake for the main data sharing agreement with the CSU (currently at 96). After further consideration it was agreed for a new risk to be created to capture this. Protect NoW DSA sign up remains at 79.	N/A	N/A
29/11/2023	Sign up Remains at 79. After further discussions, it was agreed to not add the new risk as mentioned above as it was felt that data hub DSA's sign up should be captured within the data hub risk register. This was feedback to Pete Best.	N/A	N/A
02/01/2024	Sign up increased to 81.	N/A	N/A
23/01/2024	Sign up increased to 86. Risk score reduced to 4. Practices seem willing to share once there is a project that they benefit from.	N/A	N/A
27/02/2024	Sign up increased to 87. PHM team will be contacting ICB PCN teams to provide an overview of outstanding practices to sign up for them to follow up on.	N/A	N/A
26/03/2024	Emails to PCN teams sent by PHM team. Sign up increased to 89.	N/A	N/A
02/05/2024	Sign up increased to 91. Agreed at PH&I Board on 16/04/2024 to close this risk- will be removed going forwards.	N/A	N/A

Visual Risk Score Tracker – 2022/23												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				15			15		10	10	10	8
change				NEW			→		↓	→	→	↓

Visual Risk Score Tracker – 2023/24												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	8	6	6	6	6	6	6	6	6	4	4	4
change	→	↓	→	→	→	→	→	→	→	↓	→	→

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

Parker Rachael
16/05/2024 16:35:18

PHMI09								
Risk Title		Procurement of PHM System - Lack of ICB Resource/Funding						
Risk Description		If dedicated ICB resource/funding is not allocated to facilitate the procurement exercise, then either this will not be taken forward or other work commitments within the ICB PHMI team will need to cease.						
Risk Owner		Responsible Committee		Operational Lead		Date Risk Identified		Target Delivery Date
Dr Frankie Swords		Patients and Communities		Shawn Haney / Samantha Weston		12/07/2022		
Risk Scores								
Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	3	12	3	2	6			
Controls				Assurances on controls				
A paper has been presented to EMT outlining the risk and requirements to mitigate this.				- PHMOG which reports into the PH&I Board meeting/reporting governance structure in place. - Current contract ends 31/04/2024.				
Gaps in controls or assurances								
Updates on actions and progress								
Date opened	Action / update					BRAG	Target completion	
09/2022	Paper SH/SW wrote paper and HM submitted paper to EMT Paper to be submitted to PHM Board						TBA	
	SH had a meeting with the new Director of Digital and raised this capacity issue.						N/A	
25/01/2023	PHMI programme team are creating a draft PHM specification and will share this with the new Director of Digital. 01/03/2023: PHMI Specification progressed by PHMI programme team. Update being provided at PHMI Clinical Steering Group on 07/03/2023. PHMI programme team meeting with SM on 30/03/2023.						28/02/2023 (Amended to April 2023 following new actions)	
01/03/2023	The first PHMOG is scheduled for 13/04/2023 and the first PH&I Board for 18/04/2023. Invites sent for 2023-24 to known members (representative membership still to be confirmed).					N/A	N/A	
28/03/2023	Some of the representative membership has now been confirmed for the PH&I Board and PHMOG– we are continuing to follow up where applicable. SM has contacted Ann Heath- awaiting response.					N/A	N/A	
25/04/2023	SM has confirmed the majority of the membership for a PHM Procurement Steering Group. Initial meeting in the process of being scheduled. The first PHMOG took place on 13/04/2023 and the first PH&I Board on 18/04/2023. Meeting dates for these meetings have been scheduled – remaining membership will continue to be confirmed as per BAU.					N/A	N/A	
23/05/2023	Initial PHM procurement steering took place on 11/05/2023. Follow up meeting scheduled for 25/05/2023.					N/A	N/A	
27/06/2023	Follow up meetings have continued with fast paced actions. Pre procurement discovery day is being organised for the 13 th July. Ongoing discussions with finance have yet to confirm the financial envelop for the PHM procurement					N/A	N/A	
25/07/2023	Pre Procurement discovery day on 13/07/2023 cancelled as a result of the number of suppliers interested to attend and the logistics of this taking place in one day as a face to face event. The Steering Group met on 13/07/2023 and process of a questionnaire and pre recorded demonstrations being sent to the group for review was agreed.					N/A	N/A	

Parker Rachael
16/05/2024 16:35:18

31/08/2023	Questionnaires and pre recorded demonstrations from suppliers are currently being reviewed by Steering Group Members. Next steering group for further review and discussion of these scheduled for 13 September 2023.	N/A	N/A
25/09/2023	Steering Group took place on 13 September 2023. Suzanne Meredith leading on completing an options paper (which will also confirm funding) which will then steering this procurement exercise.	N/A	N/A
26/10/2023	It was agreed at the PHMOG on 12/10/2023, that this risk required further focus on the clarification of funding to procure the system. Options paper provided to Dr Frankie Swords.	N/A	N/A
29/11/2023	FS and SM continuing to liaise with Executive colleagues to agree funding and next steps. SM liaising with Roy Weston re additional procurement support from the regional procurement hub due to the CSU conflict of interest.	N/A	N/A
02/01/2024	No updates.	N/A	N/A
24/01/2024	The funding for the procurement has been approved and the support of the Regional Procurement hub has been approved. Meetings held with the Regional procurement Hub and the Associate Director for Contracting to confirm timescales and responsibilities.	N/A	N/A
27/02/2024	Further meeting took place with Regional Procurement Hub. PHM team progressing documentation (ITT – invitation to tender and SSQ standard selection questions) to enable advert publication. Advert expected to go live March 2024. Contracting team will progress current provider contract extension by 2 months with a rolling 1 month (to cover procurement period). Follow up meeting scheduled for 05/03/2024.	N/A	N/A
26/03/2024	On track for ITT to be published and the scoring matrix has been completed. Regular meetings taking place to ensure sufficient oversight and timescales being met. The PSL contract has been extended to 31 July 2024.	N/A	N/A
02/05/2024	Agreed at PH&I Board on 16/04/2024 to reduce risk and potentially close as finances agreed and support from Regional Procurement Hub in place. Risk reduced to 6, will close when ITT advert is published.	N/A	N/A

Visual Risk Score Tracker – 2022/23

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

Visual Risk Score Tracker – 2023/24

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

Visual Risk Score Tracker – 2024/25

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

Parker Rachael
16/05/2024 16:35:18

PHMI14								
Risk Title	ICB BI capacity							
Risk Description	The ICB business intelligence team has insufficient capacity to manage the volume of data requests from PHM as well as the large volume from other sources. This limits the availability of the BI team to engage with and support the PHMI programmes, resulting in significant delays and lack of development of some programmes, and impacting on the ability of the PHMI programme team to deliver projects to improve population health.							
Risk Owner	Responsible Committee			Operational Lead	Date Risk Identified	Target Delivery Date		
Andrew Palmer	Audit and Risk			Shawn Haney / Samantha Weston	13/09/2022			
Risk Scores								
Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	2	2	4			
Controls				Assurances on controls				
- Regular meetings & prioritisation between BI/PHM teams. - PSL & Protect NoW team, has taken up the BI function for the PHM team				- PHMOG which reports into the PH&I Board meeting/reporting governance structure in place. - New director of digital in place, chairing Digital board.				
Gaps in controls or assurances								
BI team continues to have staffing and capacity challenges.								
Updates on actions and progress								
Date opened	Action / update					BRAG	Target completion	
01/11/2022	PHMI Programme team liaised with BI Team leads to understand their delivery plans when the PHMI dedicated resource leaves as of January 2023.					N/A	N/A	
	SW provided with query access to the PHMI database (although this results in a further capacity issue within PHMI programme team if SW completed this work)					N/A	N/A	
25/01/2023	Recruitment has taken place for Insights & Analytical role. Recruitment outstanding for 8b role. 28/03/2023: This role has been appointed to and the postholder is commencing in post mid- April 2023.					N/A	N/A	
01/03/2023	The first PHMOG is scheduled for 13/04/2023 and the first PH&I Board for 18/04/2023. Invites sent for 2023-24 to known members (representative membership still to be confirmed).					N/A	N/A	
28/03/2023	Some of the representative membership has now been confirmed for the PH&I Board and PHMOG– we are continuing to follow up where applicable.					N/A	N/A	
25/04/2023	Insights & Analytical role 8b – now in post. No support or updates have been received in relation to BI support for the PHM team. The first PHMOG took place on 13/04/2023 and the first PH&I Board on 18/04/2023. Meeting dates for these meetings have been scheduled – remaining membership will continue to be confirmed as per BAU.					N/A	N/A	
23/05/2023	No further updates.					N/A	N/A	
27/06/2023	The following update has been provided via Jon Fox in relation to BI support for one of our PHM projects, 'The team is currently in the middle of an enormous logistical exercise of migrating from the DME into the Data Hub (previously known as the HCDA) and has been testing all of the various data assets that have landed in there. This is priority one for the team over the next few weeks and Pete					N/A	N/A	

	has been in touch with leads in the organisation to let them know about this and the impact this will have on all other work that isn't of the highest priority.'											
25/07/2023	No further updates.							N/A	N/A			
31/08/2023	No further updates.							N/A	N/A			
03/10/2023	Pete Best has proposed setting up a working committee to facilitate collaborative working to develop a PHM/BI database. Propose to remove from October 2023 risk register.							N/A	N/A			
26/10/2023	It was agreed at the PHMOG on 12/10/2023 for this risk to remain but for the risk scoring to be reduced as steps have been taken to increase BI support. This new support has still not been integrated into business as usual.							N/A	N/A			
29/11/2023	SM meeting with PB and team to discuss data hub requirements.							N/A	N/A			
02/01/2024	PHM team met with BI team to discuss requirements of PHM database. This is being progressed by Jamie Davies – first draft expected end of Jan 24. First reporting drafts expected by end of Feb 24.							N/A	N/A			
23/01/2024	The PHM team continues to meet with the BI team and progress is being made.							N/A	N/A			
27/02/2024	No further updates – work continuing to progress between the PHM and BI team. Following publication of ICB staffing structure – new analytical posts have been confirmed which will enable the development and support of the PHM programme.							N/A	N/A			
26/03/2024	The BI and PHM team are continuing to progress the PHM insights reporting tool. Plans for the wider communication of this including presenting at ICB weekly staff briefing and presentations at Place Boards are currently underway.							N/A	N/A			
02/05/2024	Agreed to close risk, as first iteration of dashboard has been published, improvements scheduled and continued aligned working between PHM and BI team is taking place.							N/A	N/A			
Visual Risk Score Tracker – 2022/23												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score						8	8		8	8	8	8
change						NEW	➔		➔	➔	➔	➔

Visual Risk Score Tracker – 2023/24												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	8	8	12	12	12	12	8	8	8	6	6	6
change	→	→	↑	→	→	→	↓	→	→	↓	→	→

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

Parker Rachael
16/05/2024 16:35:18

PHMI18												
Risk Title		Lack of allocated PHM Budget. Impacting PHM projects and Protect NoW VST team										
Risk Description		A lack of an allocated budget negatively impacts on the implementation of PHM programmes. Lack of implementation of projects could result in the VST team (5 staff members) not having enough patient contacts.										
Risk Owner		Responsible Committee		Operational Lead		Date Risk Identified		Target Delivery Date				
Dr Frankie Swords		PH&I Board		Suzanne Meredith		11/2023						
Risk Scores												
Unmitigated			Mitigated			Tolerated						
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total				
5	3	15	5	2	10							
Controls				Assurances on controls								
- PHM programme team advise Project Leads that in order for a project to be supported by the Protect NoW team that they need to provide the finances (included within PHM governance pack) - Monitoring of VST workload within the PHM programme team - EIA to be completed to enable SMS to be used rather than letters (project and cohort dependant)				- Project Meetings - Governance structure in place to escalate issues (PHMOG – PH&I Board)								
Gaps in controls or assurances												
Some projects have not progressed due to funding												
Updates on actions and progress												
Date opened	Action / update						BRAG	Target completion				
29/11/2023	Underspend from the PPR project has been assigned, but this is limited to IAPT and Active NoW and not a re-occurring fund						N/A	N/A				
02/01/2024	No updates						N/A	N/A				
23/01/2024	No updates						N/A	N/A				
27/02/2024	SM summarised this risk at the PH&I Board on 20/02/2024. Risk to be escalated if the lack of finances for patient communication delays any projects. The PHM team, as part of the PHM strategy, will be forward planning future project ideas.						N/A	N/A				
26/03/2024	No further updates.						N/A	N/A				
02/05/2024	Future communications method options appraisal being considered by the PHM team, to be discussed at a future PHM Clinical Steering Group & paper to then be presented to a future PH&I Board.						N/A	N/A				
Visual Risk Score Tracker – 2023/24												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score								10	10	10	10	10
change								NEW	➔	➔	➔	➔
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	10											
change	➔											

NHS Norfolk and Waveney ICB – HI Programme Risk Register (2024-2025)

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

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

Summary of risks relevant to HI

Ref	Risk description	Month risk rating											
		1	2	3	4	5	6	7	8	9	10	11	12
HI01	Not completing HI Strategy as per JFP ambition/objective	1	1										
HI02	Incomplete data picture for health inequalities	6	6										
HI03	Lack of coordination of HI workstreams	12	12										
HI04	Risk of not delivering against NHSE directives e.g Core20plus5 health inequalities improvement framework for adults and CYP, anchor institutions	9	9										
HI05	No HI ring fencing of NHSE funding allocations	16	16										
HI06	No PMO process for EIAs	6	6										
HI07	Lack of Place resources to support HI strategy development & implementation	12	12										

Parker Rachael
16/05/2024 16:35:18

HI 01								
Risk Title		Not completing HI Strategy as per JFP ambition/objective						
Risk Description		A commitment to develop our health inequalities strategy has been outlined in our Joint Forward Plan, with a due date of 1 st April 2024.						
		It is critical that we co-develop our strategy with internal colleagues and external system partners to ensure we add value, leverage our system resources, and collaborate as appropriate to effect change. Lack of dedicated HI capacity and resource is the fundamental contributor to this risk.						
		The impact of COVID, cost of living crisis and acute system pressures further contribute to this risk. Failure to develop a HI strategy and align our system resources appropriately may result in further exacerbations of poorer health outcomes for our Core20plus groups.						
Risk Owner		Responsible Committee		Operational Lead		Date Risk Identified		Target Delivery Date
Mark Burgis		PH&I Board/ HIOG		TBC		1/04/23		1.4.24
Risk Scores								
Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	1	1	1	1	1	1
Controls					Assurances on controls			
- 0.4FTE temporary capacity identified by EMT to support delivery of agreed HI priorities pending formal position. - Clinical Lead for Health Inequalities & Inclusion Health - Inclusion Health Lead, VCSE Partnering Lead & Community Voices programme leads supporting development (fixed term contracts). - NHSE stocktake will include maturity matrix and system baselining that will support strategy development - Consideration for dedicated HI capacity and resource in organisational restructure - HIOG established and responsible for driving development of strategy, PH&I Board responsible for oversight - Health Improvement Transformation Group (HITG) focussing on Primary Prevention reporting to the ICP, established with key priorities including smoking and physical activity. - Clinical care and professional lead identified for health inequalities					Internal: - Progress against key national delivery timelines reported and led by appropriate governance structures: Health Inequalities Oversight Group (HIOG), PHM oversight group and PH and Inequalities board. - Quarterly NHSE reporting of NHS Inequalities stocktake - Health Improvement Transformation Group (HITG), Inclusion Health Group, Integration & Partnership team linked to Place, - PHM team External: - ICP/HWBB, Health & Wellbeing Partnerships, Place Boards, Clinical & Operational Steeering Groups			
Gaps in controls or assurances								
- Governance established, but substantive capacity & resource to coordinate co-development of strategy and lead implementation is not in place. - Engagement plan to support co-development of strategy and ensure it aligns with existing system commitments & strategies - NHSE HI funding not ring-fenced to support emerging work programmes and respond to system priorities - Understanding of best practice to inform future HI structure - Lack of data, particularly relating to Core20Plus5 monitoring - HI structure decisions made ahead of strategy development – form before function - Links to Place Boards and HWPs to be formally established – risk of duplication of effort, energy and resources at Place and system level – lack of coordination of all mechanisms to address inequalities, further alignment required with partners and ICS governance structures								
Updates on actions and progress								

Parker Rachael
16/05/2024 16:35:18

Date opened	Action / update								BRAG	Target completion		
15/05/23	The first HIOG is scheduled for 30/5/23 and the first PH&I Board took place on 18/04/2023. Invites sent for 2023-24 to known members (representative membership still to be confirmed)								N/A	N/A		
15/5/23	Some of the representative membership has now been confirmed for the PH&I Board and HIOG – we are continuing to follow up where applicable.								N/A	N/A		
19/06/23	0.4FTE temporary internal capacity identified and deployed to support development of strategy engagement plan								N/A	Sept 2023		
29/09/23	Plan developed to create strategy, engagement underway, redeployment confirmed until Jan 2024. Some residual risk due to potential insufficient capacity due to workload and partner support (ICP) not secured. Will be fully mitigated as result of proposed restructure. Engagement completed, good response draft strategy completed for review and governance sign off to meet JFP deadline								N/A	Jan 2024		
09/2/24										March 2024		
02/04/24	Draft completed and circulated for comment. Endorsed by ICP. Purdah impacted on publication date, which is now set for 2 nd May 2024.								N/A	May 2024		
09/05/24	HI Framework complete and published 13.5.24								N/A	May 2024		
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	1	1										
change	↓	→										

Parker Rachael
16/05/2024 16:35:18

HI02								
Risk Title		Incomplete data picture for health inequalities						
Risk Description		There is a risk that Health Inequality data sets are not timely and complete and we do not have information to address core20plus5 and establish our baseline/areas of focus.						
		This is due to our data hub not functioning yet, as well as quality issues in terms of our data sets with data gaps existing.						
		The wider determinants of health also need to be defined and understood to support understanding of their role in the reduction of health inequalities.						
		This may result in inequalities and potentially avoidable poorer health outcomes for people living in some areas of Norfolk &Waveney and our Plus groups. This is particularly true of people living with multiple indices of deprivation and so is likely to worsen health inequalities in our system.						
Risk Owner		Responsible Committee		Operational Lead		Date Risk Identified		Target Delivery Date
Dr Frankie Swords		PH&I Board/ HIOG		TBC		01/04/23		
Risk Scores								
Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	2	3	6	2	2	4
Controls					Assurances on controls			
- BI team are ensuring this is addressed within relevant digital meetings and feeding back as appropriate. - Direct data feed from providers to Eclipse PHM software and BI team. - Development of HIOG and PHMOG which reports to the PH&I board for oversight - New clinical director of digital in place, chairing Digital board -					- Governance – PH&I Board, PHIOG, HIOG, HITG			
Gaps in controls or assurances								
• BI team continues to have staffing and capacity challenges. • Data sharing agreements not in place between system partners. • Dedicated HI capacity • Distribution of data sets at Place/development of Place data sets to support Boards & HWP's								
Updates on actions and progress								
Date opened	Action / update						BRAG	Target completion
18/04/23	The PH&I Board has been approved by EMT – the first meeting took place 18/04/2023.							
30.5.23	PB provided an update around data hub - The infrastructure is in place and we're migrating national data from the CSU and then testing over the next couple of months. From there we'll be deploying reports directly from there and looking for use cases to expand the data sets as required. We're a bit behind as can't go out for several roles due to the temporary block and waiting for restructure decisions to unblock.							
26.9.23 9/2/24	Data Hub progressing, but no change in overall risk. Acknowledged data gaps in primary care data and discussion with lead for Primary Care Strategy. Linked into regional discussions to address primary care data gaps. Data hub progressing aligning with PHM strategy, demonstration given at PHMOG 7/2/24							

Parker, Richard
16/05/2024 16:35:18

02/04/24	Data dashboard developed by BI team to support PHM which includes HI data											
09/05/24	PHM strategy published and implementation will further support development of data sets											
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	6	6										
change	➔	➔										

Parker Rachael
16/05/2024 16:35:18

HI03								
Risk Title			Lack of coordination of HI workstreams					
Risk Description			We do not have dedicated health inequalities leadership capacity and resource to support connectivity and coordination of this agenda.					
			We have a number of individuals involved in health inequalities programmes of work, and supporting strategically - the PHM team, Integration & Partnerships, VCSE Partnering Lead, Senior Programme Lead for Community Voices, Inclusion Health Programme Manager and a number of health inequalities leads within different directorates (i.e. maternity), as well as our Clinical Lead for Health Inequalities and Inclusion Health. There is no coordinating function that brings these individuals or work programmes together.					
			This is resulting in a disconnected work programme and approach to inequalities which is not tethered to a strategy or coordinated oversight, and a lack of understanding about our 'system baseline'.					
			This impacts on our ability to coordinate our NHSE health inequalities reporting requirement and may be resulting in duplication of effort & resource and missed opportunities for collaboration and alignment.					
			It also impacts on our ability to lead and develop a health inequalities strategy, with none of the above-mentioned posts mandated to fulfil this function.					
The impact of COVID, cost of living crisis and acute system pressures further contribute to this risk, with the potential for exacerbation of poor health outcomes for our Core20plus communities.								
Risk Owner		Responsible Committee		Operational Lead		Date Risk Identified		Target Delivery Date
Mark Burgis		PH&I Board/HIOG		TBC		01/04/23		01/01/24
Risk Scores								
Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	2	2	4
Controls					Assurances on controls			
- Above mentioned posts – coordination where possible - Consideration for health inequalities within organisational restructure - NHSE stocktake will include maturity matrix for key work programmes and enable a system baseline to be understood - Oversight from Population Health and Inequalities board (PH&I) with support from system partners to coordinate. - HIOG can provide a mechanism to support connectivity & alignment between programmes of work - Scoping best practice and approaches to HI within other systems					Internal: - Progress against key national delivery timelines reported and led by appropriate governance structures: Health Inequalities Oversight Group (HIOG), PHM oversight group and PH and Inequalities board. - Quarterly NHSE reporting of NHS Inequalities stocktake - Health Improvement Transformation Group (HITG), Inclusion Health Group, Integration & Partnership team linked to Place, - PHM team External: - Health & Wellbeing Partnerships, Place Boards, Clinical & Operational Steering Groups			
Gaps in controls or assurances								
0.4FTE capacity inadequate for scale of task – substantive capacity and mandate required - Restructure ahead of strategy development results in potential lack of understanding about what is required - Ring-fenced funding to support system and place delivery of HI programmes								

Parker, Rachael
16/05/2024 16:05:18

- Fixed term contracts for a number of key individuals working on HI programmes of work, likely to pre-date restructure and may require extension to align
- Review of required job descriptions for health inequalities – what does dedicated HI capacity look like, how does it interact with Place agenda

Updates on actions and progress												
Date opened	Action / update								BRAG	Target completion		
30/5/23	HIOG established 30/5/23, monthly meetings scheduled											
12/6/23	Interim 0.4FTE capacity identified from existing workforce pending EOI for formal interim position											
12/6/23	HIOG meeting 20/7/23 cancelled pending organisational change announcements, Aug meeting not scheduled due to availability – no meetings until Sept 2023											
29.09.23	Processes established to provide reporting mechanism to HIOG from some existing work programmes. Core20 & Anchor delivery remains uncoordinated and Armed Forces workstream being scoped.											
08/12/23	Additional programmes being scoped & clarity emerging as a result of HI framework development. Capacity due to increase with restructure.											
9/2/24	FTE secondment in place until restructure and recruitment to posts											
02/04/24	Recruitment of HI team imminent											
09/05/24	Recruitment plan in place											
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12	12										
change	↓	→										

Parker Rachael
16/05/2024 16:35:18

HI04								
Risk Title		Risk of not delivering against NHSE directives e.g Core20plus5 health inequalities improvement framework for adults and CYP, anchor institutions						
Risk Description		There is a clear expectation for delivery against the Core20 and Anchor Institution frameworks, which with a lack of strategy and dedicated leadership are at risk of not being delivered.						
		These frameworks provide a way of working that need to be embedded across the organisation through a strategic approach & coordination, which needs to be developed.						
		Much work is already happening around Core20 and Anchors, but this is not coordinated, and so we risk inability to report, duplication, lack of prioritisation as well as activity not being underpinned by insights and data.						
		The external environment (cost of living, impact of COVID etc) may continue to impact on poor outcomes for these Core20plus groups, further exacerbating the impact of this risk.						
Risk Owner		Responsible Committee		Operational Lead		Date Risk Identified		Target Delivery Date
Mark Burgis		HIOG		TBC		01/04/23		
Risk Scores								
Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
3	4	16	3	3	9	2	2	4
Controls					Assurances on controls			
- Development of health inequalities & PHM strategies - Internal ICB teams already working with Core20 framework i.e. planned care, PHM, Community Voices, mental health, CYP – this lacks coordination - Further development of data intelligence to support prioritisation and decision making - Continued development of Community Voices and inclusion health work programmes to support Core20plus outcomes - CYP and planned care teams continuing to develop their approaches to Core20plus5 - Speciality clinical advisor has been appointed to lead on all Core20plus 5 priority areas along with two advisors to support PHM and another to lead on addressing HI. - Some Core20plus 5 ambassadors across the ICS system. - Regional HI leads supporting within the system					Internal: - Progress against key national delivery timelines reported and led by appropriate governance structures: Health Inequalities Oversight Group (HIOG), PHM oversight group and PH and Inequalities board. - Quarterly NHSE reporting of NHS Inequalities stocktake - Health Improvement Transformation Group (HITG), Inclusion Health Group, Integration & Partnership team linked to Place, External: - Health & Wellbeing Partnerships, Place Boards, Clinical & Operational Steering Groups			
Gaps in controls or assurances								
- Dedicated health inequalities capacity to coordinate delivery of NHSE frameworks - Ring-fenced funding to support system and place delivery of HI programmes - Coverage of Core 20 Ambassadors – some gaps - Utilisation of local Core20Ambassador network – appetite to bring together into community of practice to inform strategy development and support implementation								
Updates on actions and progress								
Date opened	Action / update					BRAG		Target completion

Parker Raghoebar
16/05/2024 15:18

23/06/23	External funding bids in pipeline to support continued development of Community Voices in pursuit of Core20 outcomes (c.£6m investment over 5 years)											
9/2/24	Voices funding secured for project specific work, but some central costs not accounted for from Jan 2024. New Core20 Ambassador wave with some new uptake, gaps remain. Programme remains uncoordinated, but HIOG now maintaining oversight of existing activity. Funding risk to voices going through prioritisation process. Meeting with planned care/cancer team jan 2024 to scope alignment with clinical programmes											
02/04/24	Voices funding risk continues – with this programme being key to delivery of Core20 priorities. Action plan for healthcare inequalities to be developed in Q1.											
09/05/24	Operational plan for 2024/25 developed outlining anticipated approach and key workstream areas – HIOG to agree 14.5.24. Mapping underway for key workstreams including Core20plus5 and inclusion health to inform future prioritisation and detailed programme plans.											
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	9	9										
change	→	→										

Parker Rachael
16/05/2024 16:35:18

HI05												
Risk Title		No ring-fencing of NHSE health inequalities funding allocations										
Risk Description		Our system receives a £3.1m allocation for health inequalities which is currently utilised to off-set our financial deficit. Unlike other systems we are not ring-fencing this investment specifically for an HI programme of our, nor are we considering our strategic approach to this investment, how to utilise it to leverage further investment and how it supports us to deliver the HI agenda. NHSE are directly asking for feedback against spend for this allocation from Q1 via the NHSE stocktake. The lack of resource underpins the lack of capacity to deliver against HI objectives, and impacts on our ability to develop and particularly implement an HI strategy.										
Risk Owner		Responsible Committee			Operational Lead		Date Risk Identified		Target Delivery Date			
Mark Burgis/ Steven Course		PH&I Board			TBC		01/04/23		31/3/24			
Risk Scores												
Unmitigated			Mitigated			Tolerated						
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total				
5	4	20	4	4	16							
Controls					Assurances on controls							
- Commitment to review for 2024/25 agreed by EMT on 13.3.23 0.4FTE temporary capacity identified by EMT to support delivery of agreed HI priorities pending formal position.					- EMT - Director of Finance							
Gaps in controls or assurances												
- No commitment to change position around investment currently - Understanding of practice from other systems												
Updates on actions and progress												
Date opened		Action / update						BRAG	Target completion			
23/6/23		Interim postholder undertaking review of financial ring-fencing undertaken by other systems to establish approaches undertaken										
09/2/24		With strategic framework for action delivery needed highlighted to SRO										
02/04/24		No change in financial picture. Financial risk associated with current HI programmes, including Community Voices, and no resources identified to support implementation of HI Framework.										
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16	16										
change	→	→										

Parker, Michael
16/05/2024 16:35:18

HI06												
Risk Title	No PMO process for EIA’s											
Risk Description	We currently do not have an embedded, consistent and monitored Equality Impact Assessment process within the ICB.											
	This is due to a previous lack of ownership for this process and a lack of capacity to develop and embed across organisational directorates.											
	This may result in inequitable service planning, design and delivery, which will negatively impact on our communities and could further exacerbate health inequalities.											
Risk Owner	Responsible Committee			Operational Lead		Date Risk Identified		Target Delivery Date				
Mark Burgis	HIOG			TBC		1/04/23		31/3/24				
Risk Scores												
Unmitigated			Mitigated			Tolerated						
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total				
4	3	12	2	3	6	1	2	2				
Controls					Assurances on controls							
- HIOG currently has responsibility for establishing an EIA process for NWICB - Planned inclusion in health inequalities strategy					Internal: Health Inequalities Oversight Group (HIOG), PHM oversight group and PH and Inequalities board.							
Gaps in controls or assurances												
- Dedicated HI capacity and resource - Understanding of best practice and examples of how EIA processes are embedded in other systems - Health inequalities strategy, which will define approach												
Updates on actions and progress												
Date opened	Action / update						BRAG	Target completion				
09.05.24	Task and finish group established. Working alongside PMO new form has been drafted and finalised. End to end process to be developed and implemented as a next step.							June 2024				
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	6	6										
change	↓	→										

Parker Rachael
16/05/2024 16:35:18

HI07												
Risk Title		Lack of Place resources to support HI strategy development & implementation										
Risk Description		There is a risk that we cannot effectively co-develop or implement our emerging health inequalities at a Place level, which has a significant contribution and										
		This is due to a current lack of dedicated resource, capacity and mandate within Place to support this work and effectively drive the agenda.										
		With Place (particularly our Health & Wellbeing Partnerships) having a significant role to play in the delivery of HI objectives, this results in a risk that we duplicate effort and resources, miss opportunities for collaboration, and are unable to centre our decision making around community need.										
		The impact of COVID, cost of living crisis and acute system pressures further contribute to this risk, with Place teams and their partners having the greatest influence over the wider determinants of health.										
Risk Owner		Responsible Committee		Operational Lead		Date Risk Identified		Target Delivery Date				
Mark Burgis		PH&I Board/HIOG		TBC		1/04/23						
Risk Scores												
Unmitigated			Mitigated			Tolerated						
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total				
4	4	16	3	4	12							
Controls					Assurances on controls							
- Organisational restructure – consideration for Place function and capacity and HI capacity - I&P team capacity currently – variation in each locality					Internal: - Health Inequalities Oversight Group (HIOG), PHM oversight group and PH and Inequalities board. - Quarterly NHSE reporting of NHS Inequalities stocktake - Integration & Partnerships team External: - Health & Wellbeing Partnerships, Place Boards, Clinical & Operational Steering Groups							
Gaps in controls or assurances												
- Ring-fenced funding to support system and place delivery of HI programmes - Governance established, but substantive capacity & resource to coordinate co-development of strategy and lead implementation is not in place. - Engagement plan to support co-development of strategy and ensure it aligns with existing system commitments & strategies - Understanding of best practice to inform future HI structure												
Updates on actions and progress												
Date opened	Date opened						Date opened	Date opened				
09/05/24	Discussions ongoing about role of Place in relation to health inequalities. Requirement for explicit inclusion of health inequalities in remit of place teams to be established with new Place Director. Health inequalities now included in TOR for Place Boards.											
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12	12										
change	→	→										

Agenda item: 11

Subject:	Update on the work of the Norfolk and Waveney Ageing Well Programme
Presented by:	Janice Shirley, Head of System Clinical Transformation Programmes
Prepared by:	Janice Shirley, Head of System Clinical Transformation Programmes Stephanie Dibley, Clinical Transformation Programme Manager
Submitted to:	N&W ICB Patients and Communities Committee
Date:	20 May 2024

Purpose of paper:

To provide an update to the Patients and Communities Committee on the work of the Norfolk and Waveney Ageing Well Programme. Details of the governance structure and workplan for 24/25 to bring about system wide transformational change based upon the N&W Ageing Well Strategic Framework¹.

Executive Summary:

The Ageing Well Programme consists of a selection of workstreams, identified following the development and publication of the Ageing Well strategic framework.

The Ageing Well Programme Board reports to the Patients and Communities Committee, System Executive Management Team (EMT) and the Integrated Care Board (ICB) Board.

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

Recommendation to the Committee:

To note the content of the report.

Parker, Rachael
16/05/2024 16:35:18

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	N/A
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	1. Norfolk and Waveney Ageing Well Strategic Framework 2. Joining the Dots: A blueprint for preventing and managing frailty in older people British Geriatrics Society (bgs.org.uk) 3. Chief Medical Officer's annual report 2023: health in an ageing society - GOV.UK (www.gov.uk) 4. Norfolk and Waveney 5-Year Joint Forward Plan - Norfolk & Waveney Integrated Care System (ICS) (improvinglivesnw.org.uk) 5. Joint Forward Plan - Ambition 5: Transforming Care in Later Life 6. Home - Knowledge NoW 7. Ageing Well Newsletter - April 2024
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	N/A
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Parker Rachael
16/05/2024 16:35:18

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

1. Statutory Duties, Guidance & Strategic Framework

The Ageing Well Strategic Framework¹ was developed following engagement workshops throughout 2023 and was published in December 2023. The framework is underpinned by twelve recommendations identified in the British Geriatric Society “Joining the Dots” (2023) report², alongside the Chief Medical Officer’s Annual Report: Health in an Ageing Society (November 2023)³.

The strategic framework consists of:

- a) a mission statement which describes the purpose of the ageing well programme.
- b) a vision statement demonstrates what it will look like when we have delivered against this mission; and
- c) a strategic framework of 9 goals to cover all of the work that we need to deliver against the 3 different phases of ageing.

The Ageing Well Programme is also directed by the ICS 5-year Joint Forward Plan⁴, which consists of eight ambitions. Ambition 5 is focused upon transforming care in later life⁵, with our objective “to have health, carer and support services that are fit for our ageing population – supporting people as they age, to lead longer, healthier, happier lives.”

2. The Ageing Well Programme & Workstreams

The initial work of the programme was to undertake a service review and develop a service matrix, this has since allowed the programme team to identify gaps in service areas and potential areas for improvement.

The Ageing Well Programme consists of a selection of workstreams and projects with partners across the ICS working in a system wide, collaborative manner to make improvements for our Norfolk and Waveney population.

Ageing Well Programme Workstreams:

a) Frailty Attuned Acute Care

Led by Dr Katie Honney from the Queen Elizabeth Hospital, the initial focus of this workstream is to agree and implement a standardised frailty screening tool for use across the ICS. The Clinical Ageing Network has been set up to allow clinicians from across the system to give their views and assist with the identification and implementation of a standardised frailty screening tool. Initial workstream objectives: *“1. To have a standardised frailty scoring system that will inform appropriate triage to services.”*

b) Prevention

The Prevention workstream, led by Lee Watson from Norfolk County Council, is working on the following objectives: to define public health approach to healthy

ageing in Norfolk; to understand current position of preventative commissioned and non-commissioned services; and to make evidence-based recommendations for future preventative activity. 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."*

c) Care Homes & Housing with Care

Paul Benton, Director of Quality in Care from the ICB is leading this workstream, focusing on reducing inappropriate conveyance from care market to the acute, supporting the promotion of healthy living across the care market, supporting providers to sign post to clinical pathways and supporting the development of pathway redesign to support care at home. Reduction in inappropriate conveyance from care market to the acute. Workstream objectives: *"1. Support the promotion of healthy living across the care market. 2. Supporting providers/EEAST to sign post to clinical pathways. 3. Support development of pathway redesign to support care at home."*

d) Dementia

Following a realignment to the Ageing Well Programme from the Mental Health Programme, the Dementia workstream is currently still in the scoping phase. The development of the dementia charter will form the backbone of this workstream and has encouraged engagement from all relevant organisations to work in a collaborative approach. Work is planned to develop a system wide Dementia dashboard, identification and roll out of targeted staff dementia education/training, and development of Dementia pages on the Knowledge NoW website⁶ to function as signposting for staff and the public. 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."*

Work in relation to education (both from a clinical and a public viewpoint), alongside transformational work in relation to falls (prevention and recovery) are being woven into each of the workstreams detailed above.

Stakeholder engagement underpins all the work underway across the four workstreams and the programme team have implemented an Ageing Well Newsletter⁷ to ensure progress, good news stories, upcoming events and resources are shared on a regular basis.

3. Governance & the Ageing Well Programme Board

Progress made in relation to the workstreams, and projects detailed above is managed by the appropriate workstream lead. With the workstreams then required to report overall progress to the Ageing Well Programme Board on a regular basis, making use of the ICB PMO template documentation.

Parker
16/05/2024 16:35:18

Reporting processes and escalation routes for the Ageing Well Programme Board have been established, with regular reporting sent to the Patients and Communities Committee, System Executive Management Team (System EMT) and to the Integrated Care Board (ICB).

Identified interdependencies of the Ageing Well Programme include the Palliative and End of Life Care Programme, Urgent and Emergency Care (UEC) Programme, Medicines Management Programme and Population Health Management Programme, as well “Place” based initiatives. These interdependencies are recorded and managed on the programme interdependencies matrix.

Robust governance structures for the Ageing Well Programme will ensure collaborative system working, a reduction in the risk of duplication, appropriate risk management and escalation, as well as opportunities for publicising the programme of work.

Support from the VCSE network has been interlaced into the Ageing Well Programme, with VCSE representatives being identified to support the individual workstreams.

4. Conclusions

Since the development and publication of the Ageing Strategic Framework in December 2023 work has moved at pace to get the Ageing Well Programme up and running, with identified workstreams, objectives and projects.

5. Recommendations

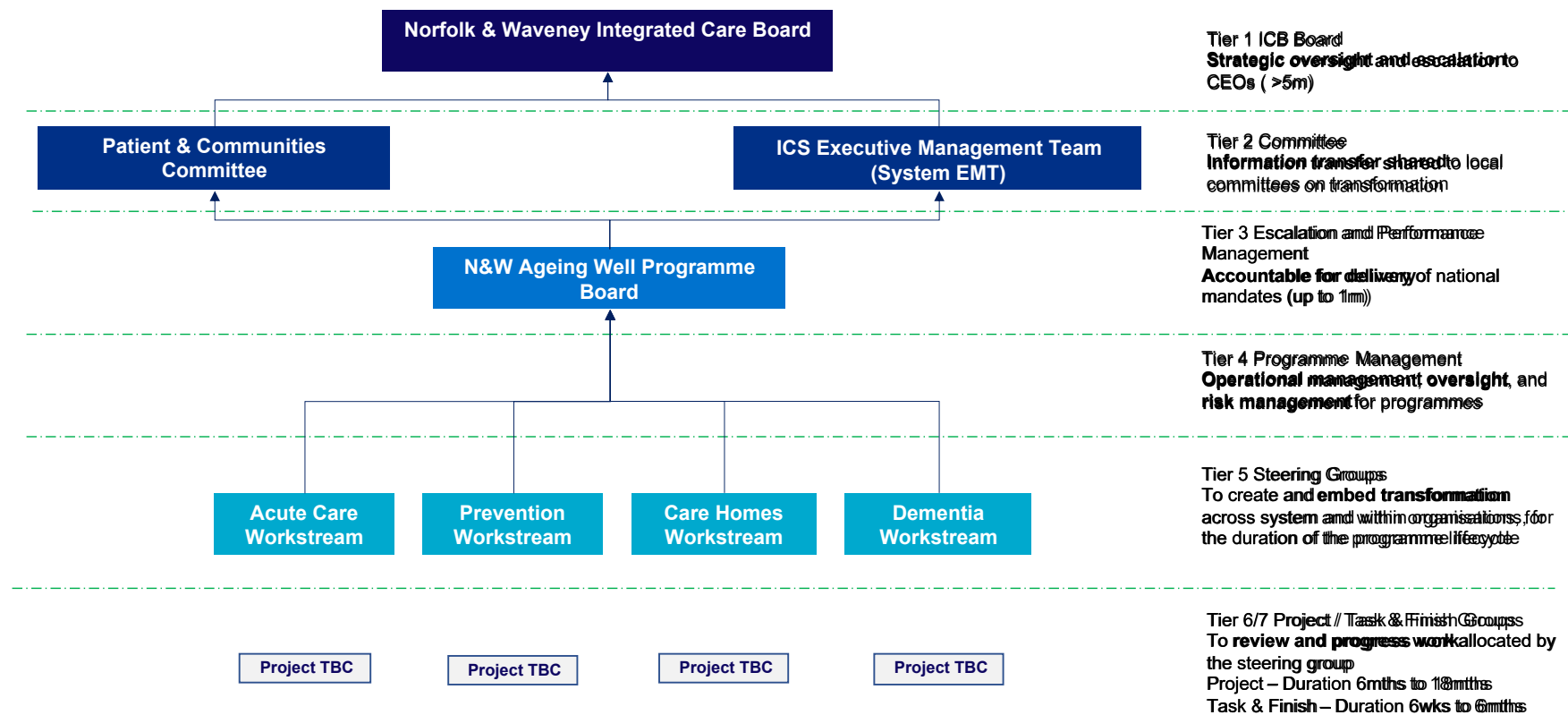
To note the content of the report.

Appendix

- 1) [Norfolk and Waveney Ageing Well Strategic Framework](#)
- 2) [Joining the Dots: A blueprint for preventing and managing frailty in older people | British Geriatrics Society \(bgs.org.uk\)](#)
- 3) [Chief Medical Officer’s annual report 2023: health in an ageing society - GOV.UK \(www.gov.uk\)](#)
- 4) [Norfolk and Waveney 5-Year Joint Forward Plan - Norfolk & Waveney Integrated Care System \(ICS \(improvinglivesnw.org.uk\)](#)
- 5) [Joint Forward Plan - Ambition 5: Transforming Care in Later Life](#)
- 6) [Home - Knowledge NoW](#)
- 7) [Ageing Well Newsletter - April 2024](#)

Parker Rachael
16/05/2024 16:35:18

N&W Ageing Well Programme Governance Structure Current Structure



Parker Rachael
16/05/2024 16:35:18

Ageing Well Programme Board - Points of Escalation

For Patients and Communities Committee 20th May 2024

Item No.	Tier 3 Group Name	Date of meeting where item was raised	Details of Item for Escalation	Requested Outcome/Support	Financial Implication (if any)	Is item recorded on Tier 3 Group Risk Register	Patients and Communities Committee Decision	Fed back to Tier 3 Group Date
1.	Ageing Well Programme Board	09/05/2024	Assurance provided to the Committee that the Ageing Well Programme and appropriate workstreams (Frailty Attuned Acute Care, Prevention, Care Homes & Housing with Care, Dementia) have been set up. Governance, reporting and escalation routes established.	Acknowledge Ageing Well Programme and appropriate workstreams have been set up and reporting processes in place.	N/A	N/A		

Parker Rachael
16/05/2024 16:35:18

Agenda item: 12

Subject:	Healthwatch Suffolk Update
Presented by:	Andy Yacoub, Chief Executive Officer
Prepared by:	Michael Ogden, Communication and Information Services Manager
Submitted to:	N&W ICB Patients and Communities Committee
Date:	20 May 2024

Purpose of paper:

To update the Patients and Communities Committee on the recent work of Healthwatch Suffolk.

Executive Summary:

- COPD and You:** We are currently seeking views and experiences from people living with COPD and professionals. This project with Suffolk's Public Health and Communities team aims to prioritise areas for improvement in COPD support that could help people stay well for longer in their communities. The findings aim to help NHS and other decision-makers to plan better local care, especially in winter when people are at a higher risk of hospital admission. Learn more on our website:
 - Our web form for people living with COPD: <https://healthwatchesuffolk.co.uk/copdform/>
 - Our anonymous survey for health, care and VCFSE professionals: <https://healthwatchesuffolk.co.uk/news/copd-professionals/>
- Smoking, vaping and using tobacco in Suffolk:** Find our report featuring people's views, attitudes and experiences. Produced for Suffolk's Public Health and Communities team, this report will shape the upcoming Tobacco and Vaping Health Needs Assessment (a part of the local JSNA) and therefore also the Suffolk Tobacco Control Strategic Plan. It will also inform local understanding about the support and approaches that could help people to stop smoking now and in the future. Go to our news item to find out more: <https://healthwatchesuffolk.co.uk/news/smokingreport2024/>
- Maternity care and support:** Throughout March 2024, we asked people to share feedback about local maternity care. People were invited to leave comments about services on the Healthwatch Suffolk Feedback Centre and through local

Parker Rachael
16/05/2024 16:35:16

engagement in services (west Suffolk). In total, 124 reviews were analysed for key themes and shared in a briefing report. The brief engagement aimed to update our understanding of people's experiences and how they had changed since a previous engagement in 2022. The report was produced to contribute to local understanding of people's experiences and to inform a debate by the Suffolk Heath Scrutiny Committee. Please visit our news item to find out more: <https://healthwatchsuffolk.co.uk/news/maternity2024/>

- **My Health, Our Future – our latest phase seven reports:** In 2023, more than 13,000 young people took part in our survey across Suffolk. [Our phase seven report](#) was published in January 2024. Since then, we have published focused reports on [sexual harassment in school/college](#), [young people with special educational needs and disabilities](#), [LGBT*Q+ young people](#) and [a report about how the responses varied according to the ethnicity of young people](#). More information about the MHoF programme can be found on <https://healthwatchsuffolk.co.uk/mhof/>.
- **Revisiting our work on living with dementia in Suffolk:** Since our report and videos were published, we know they have been used in many ways to improve understanding of people's experiences and what is needed to help people feel supported. The insights have been woven into a local health and care dementia strategy for Suffolk, and we know they have also been used by CQC nationally to shape priority areas within its national dementia strategy. The video of Peter and Teresa, which you can [find here](#), has often been noted as particularly powerful and has been shown at local and national events/meetings to influence change. Learn more about our hopes for future change on <https://healthwatchsuffolk.co.uk/news/dementia-in-suffolk-an-opportunity-for-an-enduring-commitment-to-change-local-support/>.

Latest PDF newsletter - <https://healthwatchsuffolk.co.uk/news/a-midweek-treat-flick-through-our-newsletter/>

Recommendation to the Committee:

The Committee is asked to note the update provided.

Key Risks

Clinical and Quality:

Finance and Performance:

**Impact Assessment
(environmental and
equalities):**

Reputation:

Legal:

Information Governance:

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

Governance

Process/Committee approval with date(s) (as appropriate)	
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Parker Rachael
16/05/2024 16:35:18

Agenda item: 13i

Subject:	Health Inequalities Strategic Framework for Action
Presented by:	Tracy Williams, ICB Clinical Lead Health Inequalities & Inclusion Health
Prepared by:	Shelley Ames, Acting Head of Health Inequalities & VCSE
Submitted to:	N&W ICB Patients and Communities Committee
Date:	20 May 2024

Purpose of paper:

To present the final Norfolk and Waveney ICS Health Inequalities Framework for Action for agreement.

Executive Summary:

In March 2024 the ICP endorsed a draft ICS Health Inequalities Strategic Framework for Action (Framework) and committed to supporting its implementation. This Framework has been published and is outlined as an objective in the Joint Forward Plan.

The Framework has been developed through extensive engagement, through a 'Health Inequalities Conversation' with stakeholders and people and communities from across the Norfolk and Waveney system, which started in July 2023.

The Framework contains 10 clear actions for the first 12 months of implementation, which focus on how we 'Create the Conditions for Success' and the Integrated Care Board is tasked with leading the Healthcare Inequalities priority action area.

Report

In March 2024 the ICP endorsed a draft ICS Health Inequalities Strategic Framework for Action (Framework) and committed to supporting its implementation. This

Framework has been published and is outlined as an objective in the Joint Forward Plan.

The Framework has been developed through extensive engagement, through a ‘Health Inequalities Conversation’ with stakeholders and people and communities from across the Norfolk and Waveney system, which started in July 2023.

The Framework development was led by Norfolk and Waveney Integrated Care Board and Norfolk County Council Public Health, and its production was coordinated by a small multi-agency ‘Taskforce’ to facilitate a whole-system approach.

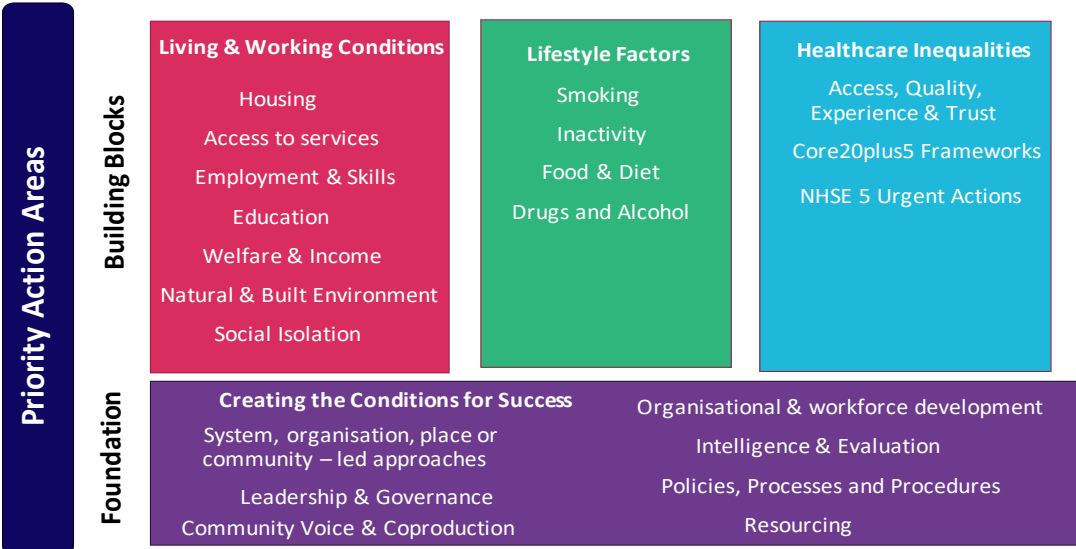
System leaders have reflected on the approach undertaken to date and acknowledge the benefits of integrated, multi-agency working to develop the Framework. There is appetite to build on this experience and the success of a distributed leadership approach as we move into implementation, developing our ways of working to further support continued collaboration.

Following feedback from the draft, the Framework has now been finalised and published and [you can view the Health Inequalities Framework for Action in detail on improvinglivesnw.org](https://improvinglivesnw.org).

The Framework contains 10 clear actions for the first 12 months of implementation, which focus on how we ‘Create the Conditions for Success’.

Our initial focus has been on how we ‘organise ourselves’ as a system to best implement this ambitious framework, taking into consideration our place-based governance arrangements, as well as the strengths, strategic levers, and spheres of influence all of ICS partners.

We have 3 ‘building blocks’ outlined in the Framework as outlined below:



Parker Rachael
16/05/2024 16:35:18

It is recommended that we establish **leadership groups** for each of our building blocks for action, to be led by different parts of our Integrated Care System and enable a distributed leadership approach in line with our Guiding Principles.

Healthcare Inequalities is to be led by the Integrated Care Board via the Healthcare Inequalities Oversight Group (HIOG). This is an already established group with cross-system representation and is overseen by Exec SRO Mark Burgis, Executive Director of Patients & Communities, NWICB. This group will work predominantly alongside the five Place Boards to improve access, outcomes, experience and trust relating to healthcare inequalities and drive implementation of the Core20plus5 frameworks. [Go to NHS England to learn more about The Core20plus5 frameworks.](#)

Recommendation to the Committee:

The Patient & Communities Committee is asked to:

- Endorse the Health Inequalities Strategic Framework for Action.
- Commit to supporting implementation and receive updates on progress, particularly relating to the Healthcare Inequalities work programme.

Key Risks	
Clinical and Quality:	Unfair and avoidable differences in access to care, quality and experience of care within our Core20plus communities and those with protected characteristics. This will impact on outcomes for individuals and contribute to system pressures.
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	
Legal:	The NHS has legal duties that relate to health inequalities as outlined in the NHSE Statement on Information on Health Inequalities. These include to: - Arrange services to meet reasonable needs - Have regard to reducing inequalities in access and outcomes. - To improvement in quality of services. - To promote integration. - To consider effects of wider decisions on inequalities. - Include consideration for inequalities in annual plans, joint forward plans, performance assessments and annual reports.
Information Governance:	N/A

Parker Rachael
 16/05/2024 10:35:18

Resource Required:	N/A
Reference document(s):	Norfolk & Waveney ICS Health Inequalities Strategic Framework for Action
NHS Constitution:	1. The NHS provides a comprehensive service, available to all 3. The NHS aspires to the highest standards of excellence and professionalism 4. The patient will be at the heart of everything the NHS does 5. The NHS works across organisational boundaries 6. The NHS is committed to providing best value for taxpayers' money 7. The NHS is accountable to the public, communities, and patients that it serves
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	BAF06

Governance

Process/Committee approval with date(s) (as appropriate)	
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Parker Rachael
16/05/2024 16:35:18



Improving lives **together**

Norfolk and Waveney Integrated Care System

Norfolk and Waveney Integrated Care System

Health Inequalities Strategic Framework for Action

2024 - 2034

Parker Rachael
16/05/2024 16:35:18

Foreword

Norfolk and Waveney is generally a healthy and safe place to live. We are fortunate that life expectancy locally is higher than the national average for both men and women.

However, there are significant differences between different parts of Norfolk and Waveney, as well as between groups of people. Right now, some people in Norfolk and Waveney are dying a decade younger than they should. This is just one of many statistics that show the avoidable differences in the health of our residents.

Too many people are living for years in poor health; too many families have lost a loved one too soon. Changing this is what is driving us to do better.

Addressing health inequalities is everybody's business. This is because our physical and mental health depends upon so many things, not just health and care services, but economic factors, such as whether we have decent work or enough money, our environment, if we have close family and friends, and of course our own lifestyles.

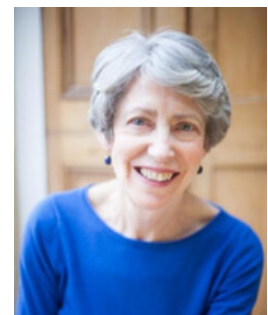
This is why our Integrated Care Systems is so important, as it includes such a wide range of partners, from the voluntary, community and social enterprise sector and our many residential and domiciliary social care providers, to local government, the NHS and other statutory organisations.

There are many people and organisations in Norfolk and Waveney who are already doing excellent work every day to address health inequalities, despite the financial constraints that affect us all. This important new framework will enable us to have a much greater impact than we currently are. We know that by working more closely together we can achieve so much more: this framework gives us all the common vision, purpose and plan that we need.

Over 100 organisations and hundreds of people were involved in developing this framework. We are really grateful to everyone for contributing their time, energy, skills and experience – we will need the same commitment as we work together to change things, not just for the next 12 months, but for the years ahead.

By working together we can create a healthier Norfolk and Waveney for all our residents.

Councillor Bill Borrett, Chair, Norfolk and Waveney Integrated Care Partnership
Rt Hon. Patricia Hewitt, Chair, NHS Norfolk and Waveney Integrated Care Board



A clinical view

As a nurse, I have seen first-hand the impact that health inequalities have on people, families, communities and patients I have cared for. There are many health and care professionals, as well as people who choose to volunteer their time and energy, who work tirelessly to address inequalities which are unfair, unjust and avoidable. I am so pleased with our strategic framework for action because it provides us with a stronger foundation from which we can all work together more effectively to change things for the better for our communities and future generations.

The COVID-19 pandemic played out against a backdrop of multiple inequalities, driven by a range of factors, including levels of poverty and deprivation, systemic discrimination, access to safe and healthy housing, education, employment, healthy food and green spaces. The pandemic highlighted these issues, we cannot now forget about them. We must continue to focus on inclusion, exposing and addressing the stark differences that excluded, minority and vulnerable groups experience.

It's our duty to understand and overcome the root causes of health inequalities, ensuring that the health and care services we offer are inclusive and welcoming to everyone. We must eliminate barriers, bias and discrimination wherever they are identified, with compassion and openness, and by gaining the trust of our communities. We know that this will take time and that it will be challenging, but it is the right thing to do.

This strategy holds at its heart the values of our Integrated Care System. It will build a culture of collective responsibility for the delivery of inclusive and equitable care for all. It will move our care beyond the current boundaries. And it will enhance the experience of our communities, patients and our staff, as we strive to improve the quality of life for all.

Tracy Williams, Queen's Nurse and Clinical Lead for Health Inequalities and Inclusion Health



Parker Rachael
16/05/2024 16:35:18

Introduction

Right now, some people are dying a decade younger than they should. Lives are being cut short because of where someone lives and works, how they are treated and because they might not be able to access services.

This framework for action is designed to change that, to help individuals, families, communities and organisations tackle these issues. Nationally, and locally, we know where and what the causes are, but no one organisation can address it alone. That is why this framework will try and map actions and develop tools and commitments so we can act **together** now.

Many people who are passionate about making a difference have contributed to the ideas and information presented within this framework. Our Health Inequalities Conversations have taken place across Norfolk & Waveney and have helped to shape this framework.

There are many people and organisations in Norfolk & Waveney who are working to address health inequalities every day. Action around health inequalities is not new, but the whole Integrated Care System recognising our key issues and coming together under a common purpose and framework is.

The spotlight on those individuals and communities who have been most affected during the pandemic has meant that we all want to do things differently. Now is the time to act, the creation of our Integrated Care System, and the national drive for change has contributed to the urgency and determination to come together with a common vision, language and goals.

We are focused on our '**building blocks**' for good health, alongside how we strengthen our foundation to **create the conditions for success**.

This is a ten-year framework, which contains within it a requirement to create annual action plans that are to be reviewed every year. Our initial actions detailed in this framework are the **first steps** towards a whole-system approach, and will be valid for our first 12 months of implementation.

Norfolk and Waveney Vision

We will come together to tackle unfair and avoidable differences in health outcomes. We will do this by listening to communities, prioritising prevention, and taking action together, making health inequalities everybody's business.

What are health inequalities?

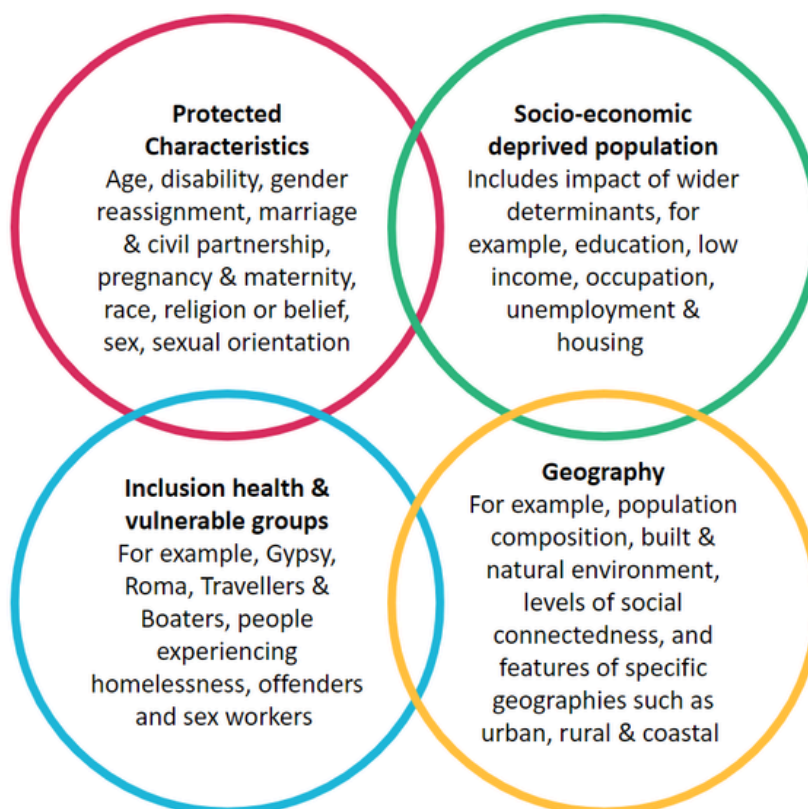
Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing. The effects of inequality are multiplied for those who have more than one type of disadvantage. (Kings Fund)

Inequalities of what?

This can involve differences in outcomes and in known contributing factors to health:

- **Health status** e.g. life expectancy and prevalence of health conditions
- **Access to care** and non-clinical services e.g. availability or waiting times for treatments, take-up of services, access to information
- **Quality and experience of care**, e.g. levels of patient satisfaction, feeling involved
- **Behavioural risks** to health, e.g. smoking rates
- **Mental wellbeing** and exposure to stressors and adversities (or protective factors)
- **Social economic and environmental conditions** that are 'wider determinants' of health e.g. cost of living, housing quality, community life, discrimination

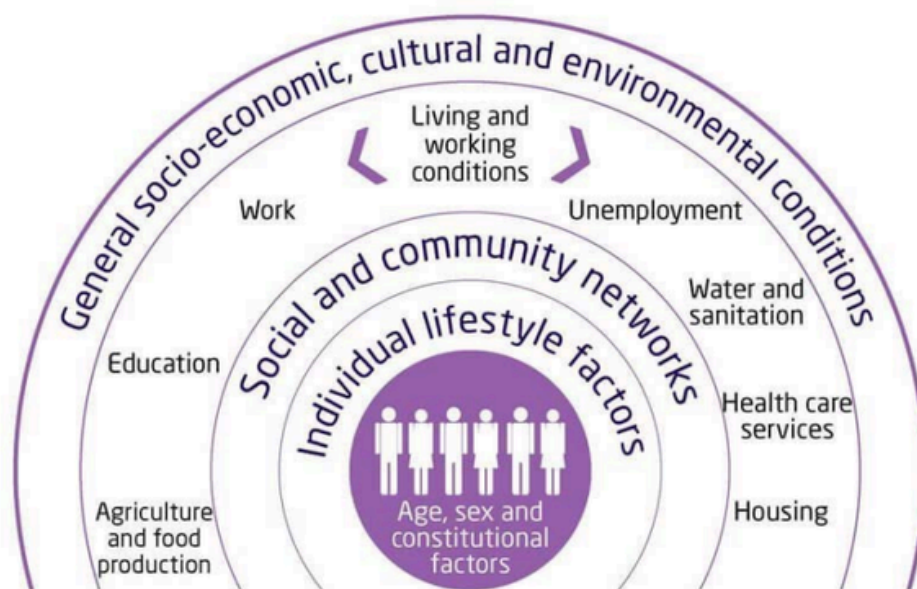
Inequalities between who?



Parker Rachael
16/05/2024 16:35:18

Keeping healthier for longer

There are lots of studies that show us that where we live and work influence our behaviour, as does how we spend our time and who we spend it with. The chart below is a good starting point for understanding all the factors that make up our health and decisions on our health, as well as those things we can't influence on our own.



Key areas that impact the health and wellbeing of our most vulnerable residents include good work, healthy communities and places, having the best start in life, tackling racism, discrimination and its outcomes, and environmental sustainability (Marmot, 2024).

In the Norfolk and Waveney area, there has been an emphasis on place-based approaches, and the need to address the socio-economic factors and geography outlined in the chart above (Figure 1). These are described locally as **Living and Working Conditions**.

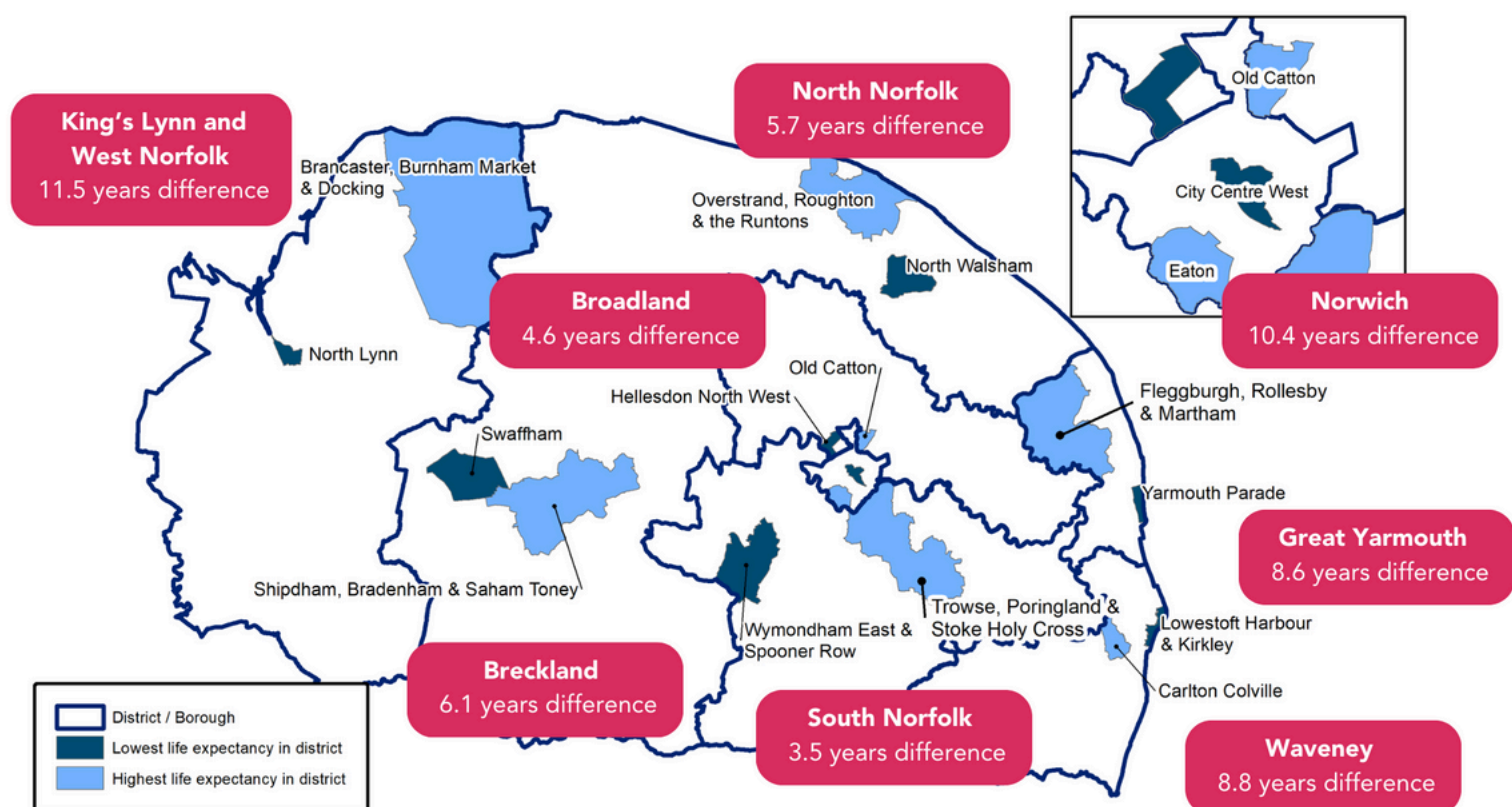
All of us can make a difference to our own health and wellbeing by making good, healthy choices, but sometimes this is not easy to do, especially when faced with a disadvantage because of where you live or if you face discrimination. We have described this as **Lifestyle Factors**.

And of course, when we need help, being able to access services early, and quickly, the same as anyone else with similar issues, but recognising the way in which the services are delivered might need to be different. For example, a person with autism accessing mental health services, someone with a mental health condition accessing stop smoking services, or someone attending a hospital appointment when English is not their first language. We describe this as **Healthcare Inequalities**.

Why are we doing this?

Health equity means everyone should be able to reach their full potential for health and well-being, with fair and just opportunity to do so. Right now, we know this is not happening as some people are dying earlier than we would expect.

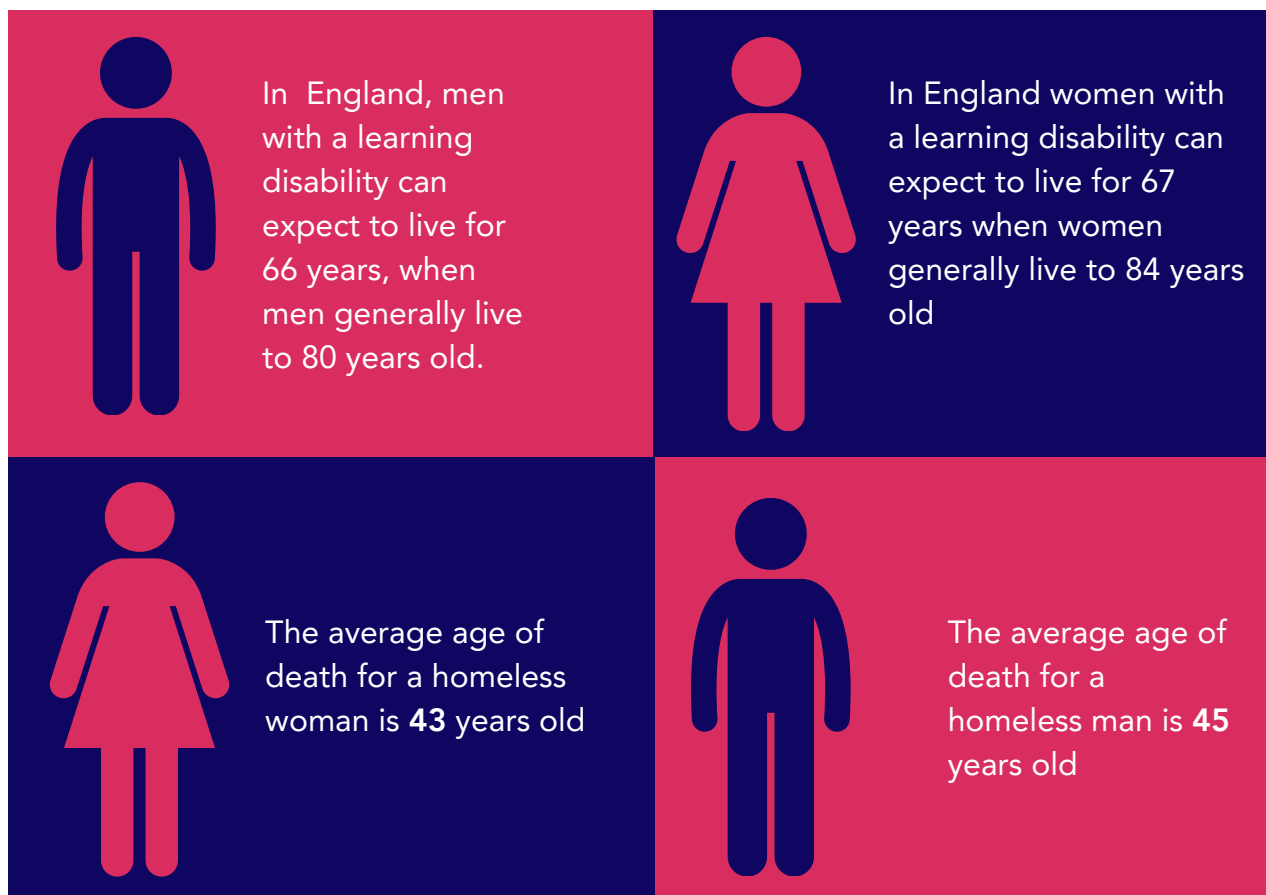
The map below shows that people are dying much earlier in some parts of Norfolk & Waveney than others, for reasons that can be prevented. The difference in average life expectancy between residents in one place compared to another is the kind of gap we want to close.



Across Norfolk & Waveney differences in life expectancy can be seen in each district footprint. There is a 11.9 year age gap between the lowest life expectancy in Norfolk and Waveney (72.2 years as seen in North Lynn & Yarmouth Parade) and the highest (84.1 years seen in Eaton).

Parker Rachael
16/05/2024 16:35:18

This gap in life expectancy is even bigger for some groups, such as those who are homeless, or with a learning disability.



Norfolk insight is our local data hub where anyone can look online at local data about the population of Norfolk and Waveney. We know who lives in poor health, who dies earlier from preventable illnesses, who has worse health outcomes, where they live and much of the time, why they have worse outcomes.

We know that people are dying earlier from preventable illnesses in some communities, with around half (men) to a third (women) of these due to circulatory diseases and cancer in Norfolk.

You can find more data relating to health inequalities by [clicking here](#).

We have also been speaking to our communities that experience inequalities to better understand the barriers and build a rich picture to help close the health gap between groups.

Parker Rachael
16/05/2024 16:35:18

Who will we reach?

Although we have a lot of data telling us about the different outcomes in our communities, we also want to make sure that we are listening to those who are seldom heard, and that people are able to speak for themselves. To help write this framework, we have asked people who experience health inequalities directly, what the issues are that affect them the most.

Community Voices

Using your feedback to improve care

We have targeted these conversations towards the groups that experience the greatest differences in health outcomes, working with our trusted communicators across sectors through our Community Voices programme.

These conversations highlight how important it is to understand how residents who experience health inequalities live and work, those factors that influence their health behaviours and what makes it difficult or possible to access services.

The summary below highlights some of what we have heard and more information can be found in our [summary reports here](#).

"Living in poor housing adds to (my) health issues and stress"

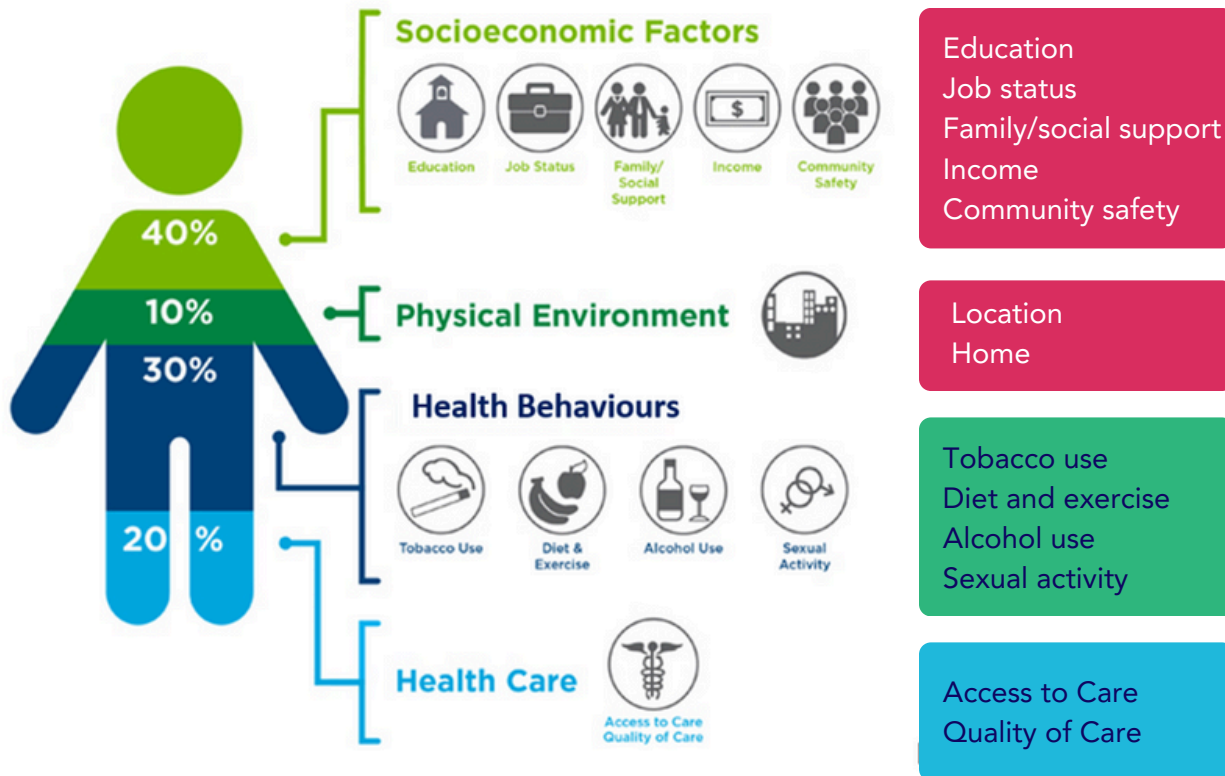
"Gp has told them they must quit (smoking) due to heart condition. Has tried vapes and tablets (chamfix) . Finds current living condition very stressful and feels that quitting now would be a huge stress 'on top of everything'..... Has anti social neighbours and black mould caused by an issue with leak in flat above. Doesn't feel in 'right place mentally' to quit"

"Some residents have concerns they are treated differently due to being a migrant or having a language barrier. Many report a lack of trust in the NHS, often stemming from miscommunications or feeling unheard"

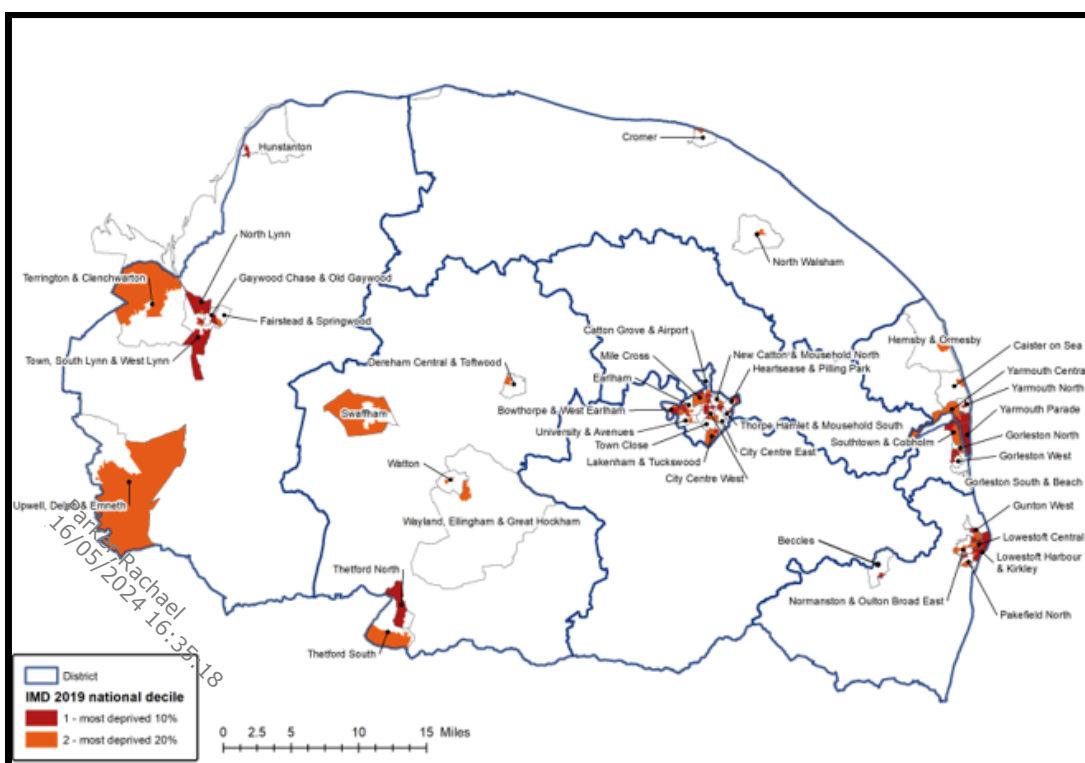
[recently left prison] he has not been able to sort his benefits for the last 5 months and is living on a very limited budget for food which is also playing a big part in his illness [diabetes] and feels he cannot afford to spend what little money he has on a nutritious diet that he needs to try and keep healthy"

Parker Rachael
16/05/2024 16:35:18

Our Community Voices conversations highlight why action should not be limited to health services alone. The causes of disease begin long before someone sees a health professional as outlined below. This image clearly shows the **'building blocks'** for good health.



The NHS has identified the communities and groups we should focus on as the **'Core20plus'** communities. These are the people living in the most deprived areas and vulnerable people in the local area, who are referred to as the **'plus groups'**. Our most deprived **'Core20'** communities are highlighted in the map below - we have 42 of these in Norfolk & Waveney.





The Norfolk & Waveney 'plus' groups have been locally defined and agreed. These are:

- Ethnic minority communities
- Inclusion health groups
 - People experiencing homelessness
 - Drug & alcohol dependence
 - Vulnerable migrants
 - Gypsy, Roma and Traveller communities
 - Sex workers
 - People in contact with the justice system
 - Victims of modern slavery
- People with a learning disability, neurodiversity and autistic people
- People living in coastal and rural communities
- Young carers and looked after children
- Armed forces community

We have produced some fact sheets which give more information about each of our plus groups, [which you can find here.](#)

Health services have a clear call to action outlined via the Core20plus5 health equality improvement frameworks, which map where the inequalities are nationally, and what the NHS should focus on locally. The frameworks also include 5 clinical priority areas, and there is a framework for adults and a framework for children and young people. You can find out more information about the [adult framework here](#) and more about the [children and young people framework here](#).

Parker Rachael
16/05/2024 16:35:18

What difference will we make?

Residents who face the worst health outcomes will:

- Be able to access the right services more easily and get the right support to improve their health and wellbeing.
- Have more say about services, especially feedback on whether they are working well.
- Live longer, healthier, happier lives.

Organisations involved in improving the health of residents will:

- Commit to working together more effectively to tackle the causes of health inequalities.
- Have a common language and purpose and commit to improving outcomes for residents experiencing inequalities.
- Recognise and respond to risk for specific groups, with good quality information and understanding of need and be supported to enable this.
- Detect and manage need early, targeting resources based on preventing further ill health.
- Increase their effectiveness through a healthy and diverse workforce.
- Understand that not taking action early has a negative financial impact on organisations, and worse health outcomes for residents.

Existing commitments



Our organisations and leadership are not new to trying to prevent unfair and avoidable differences in experiences and early deaths from preventable illness. Listed below are the ICS strategies and approaches that include commitments relating to health inequalities. This framework will help to deliver them and a summary of their existing objectives [can be found here.](#)

Our Guiding Principles

Through our Health Inequalities Conversation we have developed the following guiding principles that we ask our partner organisations to adopt. These are guidelines for decision making.

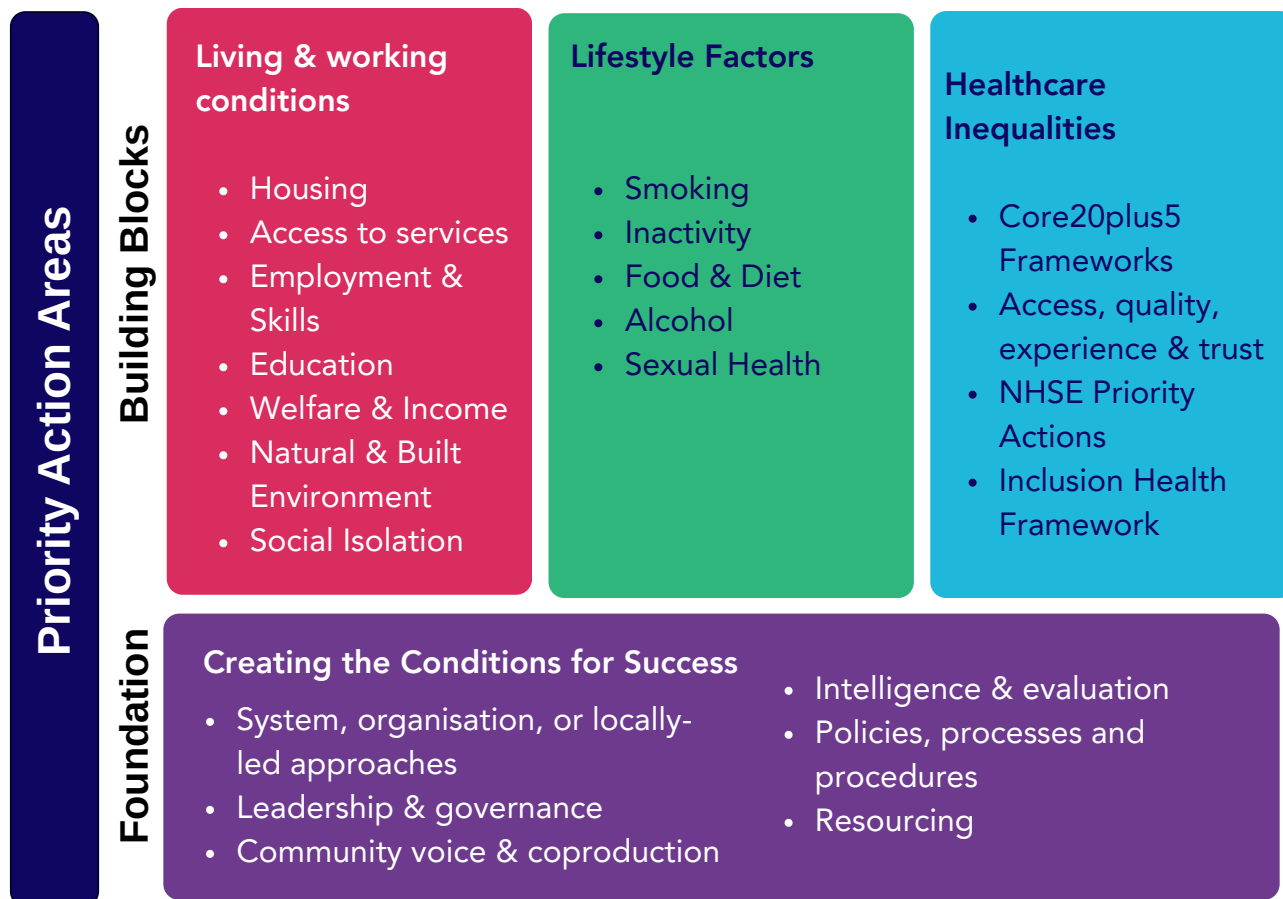
- **Everyone needs something, some people need more.**
- **We know we can make a difference, and this is a long-term commitment.**
- **Enabling communities to have a voice is key and requires creativity and persistence.**
- **We will work as close to people and communities as possible.**
- **Our approach must be personalised to ensure the right action at the right time for the right individual.**
- **We will ensure accessible services for those in greatest need.**
- **We will take an approach that includes consideration for families and all stages of life.**
- **Leading for change requires shared responsibility, collaboration and enduring focus.**
- **We will understand who is accessing our services, who isn't and why in order to act.**
- **Recognising the building blocks for good health & wellbeing are not just in health services.**
- **Building fairer services means supporting change in our organisations.**

Parker Rachael
16/05/2024 16:35:18



Our priority areas for action

Through our Health Inequalities Conversation we have determined our priority areas for action, as described below. We refer to these as our **'building blocks'** and our **'foundation'**.



Living and working conditions

The well-being of a community depends on many things, including education, housing, employment, and access to good healthcare. These factors can affect a person's health throughout their life and can also contribute to health inequalities. (Marmot, 2010). They are also often linked. For example, someone who is unemployed may have a harder time finding good housing and may not have access to healthy food or green spaces.

To address these issues, we need to focus on spending money where it is needed most, to make sure everyone has the same chance at good health. This means investing in the root causes of health inequalities and making sure resources are distributed where there is need. (The King's Fund, 2022).

This may very well be at place level in order to meet local need, and be delivered by organisations and people who know the place and community best.

Lifestyle factors

The choices we make in living our lives impact our health and wellbeing. The impact of smoking, choosing unhealthy foods to eat, not getting enough exercise, and too much alcohol are known as behavioural risk factors. These are a major challenge for health and social care for all residents, not only those communities that experience inequalities in outcomes.

These factors increase our chances of developing chronic conditions like heart disease, cancer or diabetes and can lead to early death. Health inequalities increase the risk of becoming ill and living in poor health among some groups in society and can be seen and measured as a result.

Health and care services

Health and care services are there to maintain and improve our health. The original focus of the NHS was the diagnosis and treatment of disease. Now it plays more of a part in both preventing ill health and improving the physical and mental health of the population.

Health and care services are structured to meet *everyone's* need which at times makes it difficult for some groups or people to get access. This can be due to examples like services not being available, adjustments not being made for disability, people having challenges being understood because of language barriers, or discrimination.

The NHS has legal duties relating to health inequalities, and there are 5 Urgent Actions that are identified in NHS operational planning guidance, which will require a partnership approach to implement. More information about these duties to address health inequalities can be found [here](#).

Please go to the ICS health inequalities webpages for case studies that give examples of the work underway in Norfolk and Waveney by [clicking here](#).

Parker Rachael
16/05/2024 16:35:18

Creating the Conditions for Success

This framework for action is ambitious. We have to work together building on our successes so far, sharing our knowledge, tools and resources to drive change. If we are going to make a difference to health outcomes, so people have a fairer chance to live longer and healthier lives, we have to change the way we work within our organisations and together and with our communities.

Navigating our different duties, relationships, structures and priorities is going to be difficult. However, this is the chance to work more closely with communities, understanding better how we can do differently, and leading more effectively.

Leadership & Governance

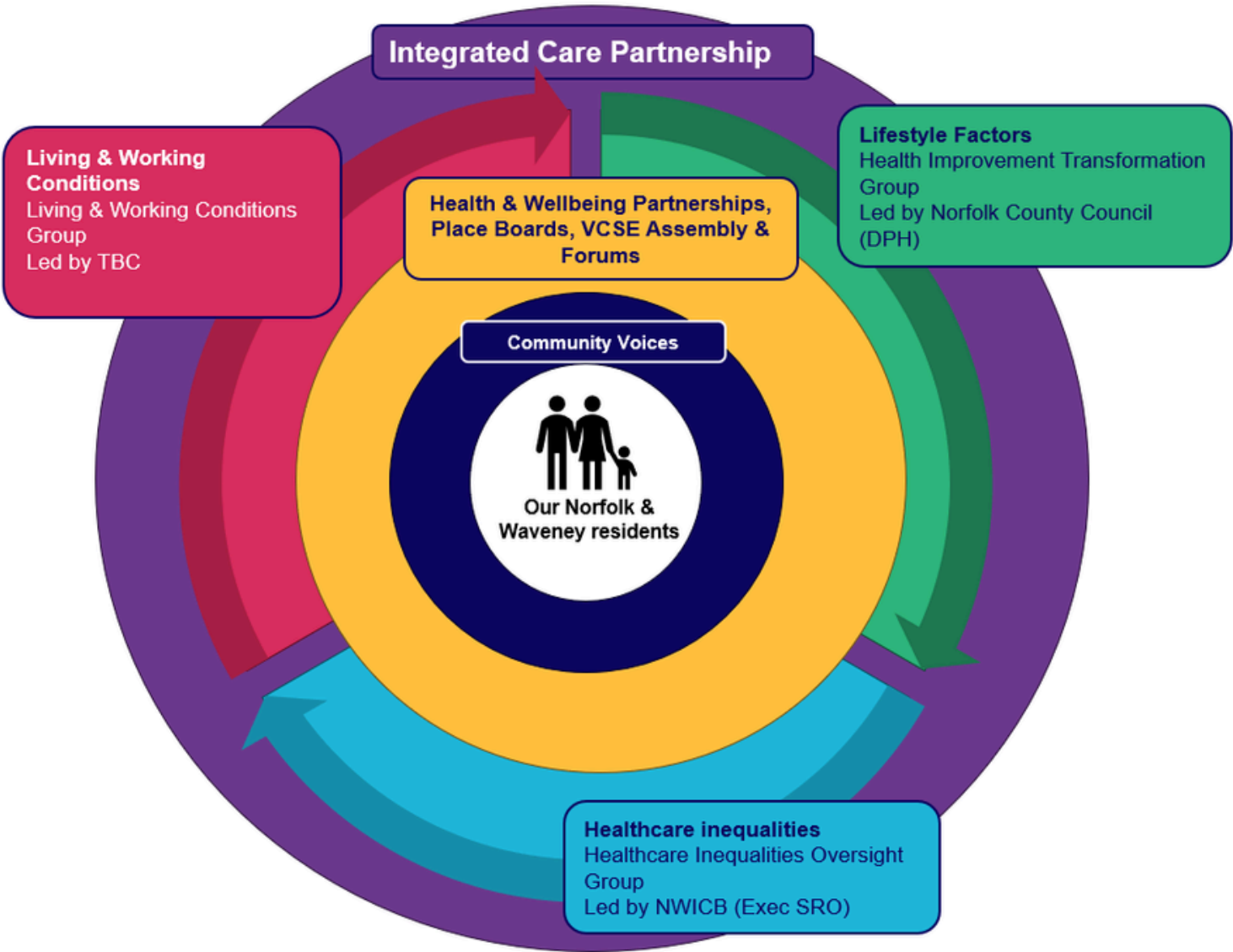
We recommend a leadership and governance structure for health inequalities that maximises our existing resources and expertise and responds to the benefits of working locally.

This proposed structure enables us to share, learn and scale what works and understand what doesn't. This is about what we can do together and all parts of our Integrated Care System have a role to play - this includes our district, city, borough and county councils, Voluntary Community & Social Enterprise (VCSE) sector, the NHS and the independent sector.

Our Norfolk & Waveney Integrated Care Partnership brings together health and social care providers, local government, the VCSE sector and other partners. It will provide oversight and ensure the Health Inequalities Framework is delivered.

Parker Rachael
16/05/2024 16:35:18

How we will organise ourselves



Parker Rachael
16/05/2024 16:35:18

Action within our organisations

Our organisations already make a huge difference to the wellbeing of people living in Norfolk and Waveney right now. Closing the gap so that everyone has a fair chance; stopping the early deaths of vulnerable people, will mean doing some things differently. Organisations involved have a number of ways to make this happen, for example:

- By embedding these guiding principles in their organisational action plans and ways of working
- As 'anchor institutions' working locally to lead by example as an employer and estate owner, as well as through buying power (see below diagram).
- Through good quality equality impact assessments, complaints procedures or by embedding a requirement for social value in contracts.
- A commitment to training and learning.
- Through sharing good practice and intelligence to inform action
- Through a commitment to actively listening to people, especially the most vulnerable
- Through robust data collection and sharing

This isn't everything we can do, and we have outlined below what some of this might look like. UCL Partners, an organisation working alongside NHSE, have produced a useful toolkit that you can [find here](#), which helps anchor organisations understand 'how strong is your anchor' currently.

Anchor Institutions

First developed in the United States, the term anchor institutions refers to large, typically non-profit, public sector organisations whose long-term sustainability is tied to the wellbeing of the populations they serve.



As anchor institutions we can influence the health and wellbeing of communities simply by being there. But by choosing to invest in and work with others locally and responsibly we can have an even greater impact on the wider factors that make us healthy.

Acting as close to communities as possible

Organisations often come together around a 'place'. This might be a few streets, a neighbourhood, a council footprint or a health system boundary. Local services and people have a good idea of what works for them, and how it is best to go about making change happen. There are ways in which people in communities and organisations can plan their place together, that helps identify where the greatest need is, and what the best approach is for that place. This might not be the same everywhere as every place is different.

Place-based partnerships are an important vehicle for tackling health inequalities. They bring together organisations at a local level, including district councils, VCSE organisations and health and care services, to enable greater understanding, connectivity and collaboration.

Place-based partnerships will be supported to close the gaps between groups, through the update and production of tools and guides. Place-based structures will play a key role in developing the action plans for each of the building blocks, with the **Health & Wellbeing Partnerships** coordinating action relating to **Living & Working Conditions** and **Lifestyle Factors**, and **Place Boards** coordinating action relating to **Healthcare Inequalities** and **Creating the Conditions for Success**.

Empowering communities

The Voluntary, Community & Social Enterprise (VCSE) sector plays an important role in addressing health inequalities.

The VCSE sector is a vibrant and creative sector that can lead the way to finding solutions to local health issues. Rooted in communities with established relationships in place, the sector has long been acting as 'trusted communicators' highlighting community need and assets. The sector offers the opportunity for better connection to those who experience the worst health disadvantage. The Covid 19 Pandemic response also reinforced that the VCSE sector is able to shift focus, respond quickly and help meet immediate need.

The VCSE sector are powerful partners needed to succeed in transforming health inequalities, promoting community wellbeing and ensuring equitable access to healthcare. In order to do this successfully more needs to be done to empower organisations in the sector. Therefore, this framework for action commits member organisations to the development of a VCSE partnering work programme, as well as the continued development of a VCSE Assembly that complements what is already in place.

Rachael
16/05/2024 16:35:18

Acting together as a 'system'

The word system has different meaning for different people. Simply put it means organisations coming together to tackle a common goal, considering the desired outcome rather than individual organisational interests.

We need to better coordinate our action to tackle health inequalities as a 'whole system' , so that we can join up and coordinate our existing work, share best practice, scale what works and understand better what doesn't.

Our proposed structure will establish and further develop three groups all of which are to be representative of our Integrated Care System, that will drive further action relating to our building blocks:

- Living & Working Conditions Group to drive action relating to **Living and Working Conditions**
- Health Improvement Transformation Group to drive action relating to **Lifestyle Factors**
- Population Health & inequalities Board to drive action relating to **Healthcare Inequalities**

Further to these groups we will seek to establish a Health Inequalities Coordination Group overseen by a Strategic Steering Group and made up of system partners that will drive implementation of the overall strategy with particular emphasis on **Creating the Conditions for Success**.

Parker Rachael
16/05/2024 16:35:18

Summary of key actions

We have set out here what actions we think need to take place first so that people across all organisations are confident they can tackle local health inequalities. These are based on our Health Inequalities Conversations - what we need to do to make this commitment happen.

We plan to take these **10** actions in the first **12** months of implementation, by 1 June 2025. The Taskforce will be responsible for making sure these actions happen.

Communications & Pledges We will continue our ‘Health Inequalities Conversation’ and roll out a programme which includes commitments and accountability.	Governance We will identify named Senior Responsible Officers/Leaders, Organisational Leads, Clinical leads and Health inequalities champions.	VCSE Integration We will further develop the VCSE Assembly, integrate the VCSE sector into all parts of our planning & decision making and support volunteering.
Action Plans We will produce action plans for each of our building blocks, using existing assets and with our place and system structures working closely together.	Self Assessment We will assess where we are, what good looks like, what we need to do next. We will include actions for anchor institutions.	Organisational Development Including a suite of tools and training, a learning centre to share good practice and case studies, and a health inequalities champions network.
Resources Mapping the flow of health inequalities resources & spend across organisations to further develop the business case for investment.	Intelligence Implement our Population Health Management Strategy, so that we get better at collecting and using data and insights	Monitoring A Health Inequalities Outcomes Framework developed with clear metrics and targets identified to keep us on track
Participation Develop a common approach to engaging our communities that experience health inequalities to enable access to services and ensure voices are heard with equity. We will ensure coproduction with experts by experience.		

Parker Rachael
16/05/2024 16:35:18

Key commitments

Short term actions (year 1)

- Focus on our foundation – improving our ways of working to create the conditions for success
- Strengthen our leadership, governance and partnership working
- Understand our baseline - map and coordinate existing activity and identify gaps
- Clarifying the actions required around our building blocks to further our impact

Medium term actions (2-5 years)

- Implementing our action plans, and understanding our impact
- Organisations taking action utilising the tools provided
- Aligning the action between our building blocks - creating a Health Equity focus
- Measurable differences in our ways of working – improvements on our baseline

Long term actions (5 – 10 years)

- Tackling health inequalities part of our 'business as usual' via a confident and competent workforce
- Demonstrable impact on the metrics within our outcomes framework

Parker Rachael
16/05/2024 16:35:18