



# Health Overview Select Committee Meeting Agenda

## Meeting details

- Date: Thursday 15 January 2026
- Time: 10:00 am
- Venue: **Council Chamber, County Hall, Martineau Lane Norwich NR1 2DH**

## Membership

<b>Name of Member</b>	<b>Representing</b>
Cllr Pallavi Devulapalli	Borough Council of King’s Lynn and West Norfolk
Cllr Peter Wilkinson	Breckland District Council
Cllr Adrian Tipple	Broadland District Council
Cllr Jeanette McMullen	Great Yarmouth Borough Council
Cllr Stuart Dark	Norfolk County Council
Cllr Lesley Bambridge	Norfolk County Council
Cllr Brenda Jones	Norfolk County Council
Cllr Paul Neale	Norfolk County Council
Cllr Richard Price	Norfolk County Council
Cllr Robert Savage	Norfolk County Council
Cllr Lucy Shires	Norfolk County Council
Vacancy	Norfolk County Council
Cllr Dr Victoria Holliday	North Norfolk District Council
Cllr Lucy Galvin	Norwich City Council
Cllr Justin Cork	South Norfolk District Council
<b>Name of Co - Opted Member</b>	<b>Representing</b>
Cllr Edward Back	Suffolk Health Scrutiny Committee
Cllr Edward Thompson	Suffolk Health Scrutiny Committee

## Advice for Members of the Public

This meeting will be held in public and in person.

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Members of the public or interested parties may, at the discretion of the Chair, speak for up to five minutes on a matter relating to the following agenda. A speaker will need to give written notice of their wish to speak by emailing [committees@norfolk.gov.uk](mailto:committees@norfolk.gov.uk) by no later than 5.00pm on 9 January 2026. Speaking will be for the purpose of providing the committee with additional information or a different perspective on an item on the agenda, not for the purposes of seeking information from NHS or other organisations that should more properly be pursued through other channels. Relevant NHS or other organisations represented at the meeting will be given an opportunity to respond but will be under no obligation to do so.

### 1. To receive apologies for absence

### 2. Minutes

Page 5

To confirm the minutes of the meeting held on Thursday 6 November 2025.

### 3. Members to Declare any Interests

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is on your Register of Interests you must not speak or vote on the matter.

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is not on your Register of Interests you must declare that interest at the meeting and not speak or vote on the matter

In either case you may remain in the room where the meeting is taking place. If you consider that it would be inappropriate in the circumstances to remain in the room, you may leave the room while the matter is dealt with.

If you do not have a Disclosable Pecuniary Interest you may nevertheless have an **Other Interest** in a matter to be discussed if it affects, to a greater extent than others in your division

- Your wellbeing or financial position, or
- that of your family or close friends
- Any body -
  - Exercising functions of a public nature.
  - Directed to charitable purposes; or
  - One of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union);

Of which you are in a position of general control or management.

If that is the case then you must declare such an interest but can speak and vote on the matter.

#### **4. Updates from the Chair**

#### **5. Eastern Pathology Alliance (EPA) Weekend Pathology Testing** **Page 15**

Report by the Norfolk and Waveney Integrated Care Board

#### **6. Palliative and End of Life Care Update** **Page 34**

Report by the Norfolk and Waveney Integrated Care Board

#### **7. Norfolk Medicines Support Service** **Page 80**

Report by the Norfolk and Waveney Integrated Care Board

#### **8. Appointment of Link Member to Norfolk and Suffolk Foundation Trust** **Page 88**

Report by the Director of Democratic and Regulatory Services

#### **9. Forward Work Programme** **Page 91**

Report by the Director of Democratic and Regulatory Services

Tom McCabe  
Chief Executive  
Norfolk County Council  
County Hall  
Martineau Lane Norwich  
NR1 2DH

Date Agenda Published: Wednesday 7 January 2026

**For further details and general enquiries about this  
Agenda please contact the Committee Officer:**

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## Health Overview Select Committee Minutes

### Meeting details

Time and date of meeting: 10:00 am, Thursday 6 November 2025

Venue: Council Chamber, County Hall, Martineau Lane Norwich NR1 2DH

### Members Present

Name	Role	Representing
Cllr Brenda Jones	Chair	Norfolk County Council
Cllr Pallavi Devulapalli	Vice-Chair	Borough Council of King's Lynn and West Norfolk
Cllr Lesley Bambridge	Committee Member	Norfolk County Council
Cllr Jill Boyle	Committee Member	North Norfolk District Council
Cllr Justin Cork	Committee Member	South Norfolk District Council
Cllr Lucy Galvin	Committee Member	Norwich City Council
Cllr Jeanette McMullen	Committee Member	Great Yarmouth Borough Council
Cllr Paul Neale	Committee Member	Norfolk County Council
Cllr Robert Savage	Committee Member	Norfolk County Council
Cllr Lucy Shires	Committee Member	Norfolk County Council
Cllr Peter Wilkinson	Committee Member	Breckland District Council

### Also Present

Name	Role
Karin Bryant	Associate Director of Commissioning, Norfolk and Waveney Integrated Care Board (ICB)
Megan Hughes	Committee Officer
Rebecca Hulme	Director of CYPM, Norfolk and Waveney ICB
Abbie Thomas	Trainee Committee Officer
Marcus Thorman	Group Chief Financial Officer, Norfolk and Norwich University Hospitals
Becky Tye	Democratic Support and Scrutiny Manager
Stephanie Walker-Ward	Cellular Pathology Service Manager, Norfolk and Norwich University Hospitals
Dr Stuart Williams	Care Group Associate Clinical Director, Norfolk and Norwich University Hospitals
Emily Woodhouse	Business Development Director, Healthwatch Norfolk

#### 1. Apologies for absence

- 1.1. Apologies for absence were received from Cllr Edward Back, Cllr Richard Price and Cllr Stuart Dark.

#### 2. Minutes

- 2.1. The minutes from the meeting held on Thursday 4 September 2025 were agreed as an accurate record of the meeting and signed by the Chair.

### **3. Declarations of Interest**

- 3.1. No interests were declared.

### **4. Updates from the Chair**

- 4.1. The Chair reported to the Committee of her positive visit to the new Community Diagnostic Centre, reflecting that it showed a promising direction for the health service.

### **5. Histopathology Delays**

- 5.1. The Committee received the annexed report (5), outlining the delays at the Histopathology Department at Norfolk and Norwich University Hospitals (NNUH) and the actions being taken to reduce and mitigate the delays identified.
- 5.2. The Chair noted that the link in paragraph 6.1 on page 14 of the agenda was incorrect. The correct link had been circulated to the committee and found here: [improvinglivesnw.org.uk/~documents/route%3A/download/1387/](https://improvinglivesnw.org.uk/~documents/route%3A/download/1387/)
- 5.3. No members of the public requested to speak on this item.
- 5.4. Dr Stuart Williams introduced the report, explaining the main challenges and mitigation measures outlined in the report, and it was confirmed that progress was being tracked against a recovery trajectory, with early improvements already evident.
- 5.5. The following points were raised and discussed:
  - 5.5.1. A Committee Member queried whether the use of AI could increase workload and whether this had been considered in current planning. Officers responded that it was hoped AI would reduce rather than increase workload, noting its potential role in back-office functions. It was added that any impact would depend on how and when AI was applied, further detail would be needed to plan for those adjustments.
  - 5.5.2. A Committee Member noted the pressure on staff and asked what well-being measures were in place. Officers explained that the team had successfully cleared the laboratory backlog earlier in the year, which had boosted morale. A variety of resources were highlighted, including one-to-one meetings, access to a 24-hour counselling helpline, and monthly visits from well-being practitioners.
  - 5.5.3. Officers confirmed that staff could receive financial rewards for additional work through waiting list initiatives, such as weekend reporting, managed via a fair allocation system. They emphasised that longer-term staff

motivation and retention would be supported by improvements to laboratory space, IT systems, and overall working conditions.

- 5.5.4. A Committee Member referred to data on page 16 showing the rise in the average number of slides per patient. It was asked whether this average was typical and if larger or more complex cases were contributing to delays. Officers explained that the rise was driven by greater case complexity and the need for additional tests. Advances in science and the availability of new tests meant pathologists requested them to inform treatment decisions, which increases slide numbers.
- 5.5.5. A Committee Member requested more detail on turnaround times of reports, specifically the shortest and longest wait times. Officers **AGREED** to provide a written breakdown of turnaround times for histopathology reports.
- 5.5.6. The Committee heard that outsourcing was necessary at present and would be evaluated after experience. It was viewed as a temporary measure to manage peaks in demand rather than a long-term strategy, with the preference being to build internal capacity through robust workforce planning and improved modelling.
- 5.5.7. A Committee Member asked whether it would be possible to work with Queen Elizabeth Hospital Kings Lynn (QEHL) to allow blood samples to go directly to Addenbrooke's, which could reduce pressure on NNUH laboratories. Officers explained that, for histopathology, samples must pass through NNUH systems to ensure proper booking and linkage to patient records before onward referral. This was essential for safe patient management.
- 5.5.8. The Vice-Chair queried whether NNUH had engaged with Addenbrooke's to learn from its success in reducing histopathology backlogs. Officers confirmed regular collaboration through regional forums. Addenbrooke's improvements were driven by prior investment, workforce retention despite reduced workload, and internal process changes. The new Norfolk and Waveney Hospitals Group model aimed to review historic pathways and enhance collaboration.
- 5.5.9. A Committee Member asked for more detail on how clinical harm and patient impact from reporting delays were captured, and whether patient experience was considered in this process. Officers explained that potential harm was identified through incident reporting via the Trust's online system, which included mandatory fields for psychological impact. Additional monitoring occurs through weekly multidisciplinary team (MDT) meetings, patient tracking lists, and escalation processes for urgent cases.
- 5.5.10. The Chair queried how it could be concluded that no significant harm had occurred given the delays, noting the difficulty of capturing the full picture. Officers explained that harm was assessed through incident reporting, patient safety investigations, and learning reviews. While no patient safety incidents had been identified through formal processes, it was noted that

outcomes could be complex. Patient surveys and staff feedback were used, but these provided only a partial insight.

- 5.5.11. A Committee Member asked for clarification on whether the performance targets shown in the recovery chart on page 19 were fixed or varied month to month, noting an apparent dip in August and improvement in September. It was explained that NHS England's current target was 70% of cases reported within 10 days, which was the standard to be achieved and maintained. The dotted line on the chart represented the agreed recovery trajectory, with monthly improvements required to reach the target.
- 5.6. Having reviewed and commented on the report, the Health Overview Select Committee **NOTED** the report and **REQUESTED** a breakdown of turnaround times for histopathology reports exceeding the benchmark, including shortest and longest wait times, to reflect the impact on patients.
- 5.7. The Chair adjourned the meeting for a break at 10:46. Business resumed at 11:10.

## **6. Speech and Language Therapy**

- 6.1. The Committee received the annexed report (6) which provided an update on Speech and Language Therapy (SaLT) services for both children, young persons and adult services.
- 6.2. No members of the public requested to speak on this item.
- 6.3. Rebecca Hulme and Karin Bryant introduced the report, highlighting the following key elements to the Select Committee:
- 6.4. Most issues at QEHL had now been resolved, and services reinstated. Work was underway with the charity STAMMA to update service specifications and explore alternative provision.
- 6.5. East Coast Community Healthcare C.I.C (ECCH) have had successful recruitment to their SaLT, enabling in-house delivery and a move towards a more sustainable service model.
- 6.6. A system-wide review of adult SaLT services, previously delayed, was now scheduled for completion by the end of the calendar year. For children and young people, demand for services had continued to rise, but performance had remained stable with reduced waiting times.
- 6.7. The following points were raised and discussed:
  - 6.7.1. A Committee Member asked how many speech and language therapists are employed across adult and children's services and whether current staffing levels were sufficient. Officers confirmed that exact numbers were not available at the meeting but **AGREED** to provide them after the meeting.
  - 6.7.2. A Committee Member acknowledged the efforts of parents, teaching assistants, and volunteers delivering SaLT in schools and suggested

exploring community-based early years approaches. Officers explained that not all children with communication needs required a therapist, some benefited from reinforcement techniques. The nationally recognised balanced model supported this approach by enabling therapists to train parents and professionals to embed these skills.

- 6.7.3. A Committee Member requested data on referrals and age breakdowns for children supported by speech and language therapy. Officers **AGREED** to provide this data after the meeting.
- 6.7.4. It was queried when the procurement process for the current SaLT contract would begin and what information could help inform the process, noting the proposed recommendation of a task and finish group. Officers confirmed that early procurement planning had already commenced, and discussions were underway to determine the most appropriate route.
- 6.7.5. A Committee member asked what happens after a child was assessed for speech and language therapy, whether they joined another waiting list for provision, and what the waiting time was for receiving support. Officers confirmed that children do not go onto a separate waiting list after assessment. A plan was developed with the family, which may form part of an Education, Health and Care Plan (EHCP) or a separate treatment plan. It was noted that current data only reflected those waiting for assessment and **AGREED** that further data could be provided on how many children were actively receiving support from a speech and language therapist.
- 6.7.6. The Committee heard that adult service contracts with ECCH and NCH&C were continuing, with an indicative end date of March 2027. Discussions were ongoing about future community provision, but there was no immediate review of these contracts. Adult SaLT was also provided by the three acute hospitals under ongoing service arrangements without a fixed end date.
- 6.7.7. The Vice-Chair highlighted wide variation in waiting times for adult services and expressed concern that the 18-week benchmark seemed inadequate for urgent needs. Officers confirmed that urgent clinical cases, including swallowing and post-stroke referrals, were prioritised. It was noted that monthly meetings monitored performance and that the forthcoming system review aimed to create a more joined-up model of care. Officers **AGREED** to provide a breakdown of waiting times by health condition.
- 6.7.8. The Chair expressed concern that there was no commissioned pathway for prisoners requiring SaLT. Officers explained that while there was access to services if needed, conversations were ongoing between providers regarding inreach and outreach. Officers **AGREED** to take this away and provide further details on prisoner access to SaLT.
- 6.7.9. A Committee member asked whether speech and language therapists would be available at the new SEND school opening in Swaffham. Officers confirmed that provision was universal across schools and explained that

therapy was delivered through a team-based, zone approach rather than assigning a single therapist to one school.

- 6.7.10. The Committee heard that provision gaps would be clarified through the ongoing review. It was emphasised that the review would help identify risks and numbers to inform future discussion and solutions. Officers suggested that the review outcomes should be brought back before further consideration of solutions to these gaps.
- 6.7.11. A Committee member asked whether link therapists were planned for early years and secondary schools, noting current provision in primary schools. Officers explained that resources were being aligned through school and community zones to provide a multidisciplinary response across clusters of schools. While the greatest need for SaLT was in younger age groups, provision for directing resources now existed in all schools.
- 6.7.12. Concern was raised on SaLT for young people with SEND transitioning to adult services. Officers confirmed support continued if linked to an EHCP, with adult pathways for differing needs. The transition still remained challenging, but joint commissioning, transition networks, and engagement with families aimed to minimise gaps.
- 6.7.13. A Committee member questioned whether current data was being used effectively to identify and address speech and language needs before problems escalated. Officers referred the committee to the recently published Joint Strategic Needs Assessment for SEND in Norfolk and emphasised the need for a whole-system approach, involving early years settings.
- 6.7.14. The Vice-Chair asked why referrals for SaLT in children were increasing despite a decline in birth rates. Officers explained that there was no single cause, but contributing factors included reduced social interaction during COVID, increased digital device use, and socioeconomic challenges. Improving early language development and school readiness was identified as a priority.
- 6.7.15. The Committee considered a proposal to establish a task and finish group to gather feedback from service users, families, and professionals on SaLT provision. The group would operate for a defined period, focusing on user experience, barriers, and opportunities for improvement, and report back alongside a service update. A Committee member asked whether the scope could be circulated for comment before the group was set up, however, officers advised that parameters must be agreed at this meeting to avoid delays, with the detailed approach developed during the process. Concerns were also raised about potential imbalance if feedback was mainly negative, but officers confirmed that professionals and families would also be consulted. The proposal was **AGREED** with 10 votes in favour and one abstention.

- 6.7.16. Cllr Lucy Shires proposed, and seconded by Cllr Peter Wilkinson, that the Committee send a letter to central government addressing the need for a single, joint policy across health, education, and social care to improve coordination for SaLT, and to request investigation into the rising number of referrals for SaLT in children, with action to address the underlying causes. A second letter may be considered later if appropriate following the task and finish group's findings. The Committee unanimously **AGREED** the proposal.
- 6.8. Having reviewed and commented on the report, the Health Overview Select Committee made the following recommendations:
- 6.8.1. To **ESTABLISH** a task and finish group to gather feedback from service users, families, and professionals on speech and language therapy provision, focusing on user experience, barriers, and opportunities for improvement, and for the ICB to report back to the Committee alongside a service update.
- 6.8.2. To **WRITE** to central government addressing the need for a joint policy across health, education, and social care to improve coordination for SaLT, and to request investigation into the rising number of referrals for speech and language support in children, with action to address the underlying causes.
- 6.8.3. To **REQUEST** the following information:
- Data on how many speech and language therapists were employed across adult and children's services
  - Data on how many children were actively receiving support from a speech and language therapist.
  - A breakdown of waiting times by condition.
  - Further details on prisoner access to SaLT.

## 7. **Forward Work Programme**

- 7.1. The Committee received a report from Becky Tye, Democratic Support and Scrutiny Manager, setting out the forward work programme.
- 7.2. Weekend pathology testing, previously included in a briefing note, would now be brought as a formal report to the January 2026 meeting.
- 7.3. Two items had been added to the December 2025 briefing note: 'Patient satisfaction' and 'Working with the voluntary and community sector'.
- 7.4. At its meeting on 18 September 2025, Norwich City Council's Scrutiny Committee asked the Select Committee to scrutinise the Integrated Care Board (ICB) specification for the vulnerable adult service. The Chair read out a statement from the ICB to the committee (Appendix A). By a majority of seven votes, the Committee **AGREED** that a report on the service would be brought after the procurement process, and the outcome of this decision would be reported back to Norwich City Council's Scrutiny Committee. A

Committee Member proposed Healthwatch undertake checks once the service was recommissioned in April 2026. Officers **AGREED** to liaise with Healthwatch Norfolk on their involvement.

- 7.5. The Committee **AGREED** to add the following to the Forward Work Programme:
- The transition process between Child and Adolescent Mental Health Services (CAMHS) and adult mental health services.
  - An update on intermediate care facilities to assess the impact of closures on discharge options.
  - A briefing note covering the impact of discharge delays, and any associated increase in infection rates.
  - A review of the Wellness on Wheels bus following the current evaluation. A briefing would be provided in December outlining the scope and timescales of the current review being undertaken of the service. The item will then come to the forward work programme in the January 2026 meeting.
  - A briefing note providing an update on the New Hospital Programme.
  - Broaden the planned pathology report to include pathology services.
  - A briefing note on the impact of wellbeing hubs, including data on usage, outcomes, and effectiveness.
- 7.6. A Committee Member raised concerns about over-40s health checks, noting limited availability and reliance on private providers. Officers confirmed recent information had been received and would be shared initially, with the item included for consideration on the forward work programme at the next meeting. The Committee **AGREED** to this approach.
- 7.7. A Committee Member highlighted that future reports should include evidence of service user experience and feedback, ensuring that patient voices were represented alongside provider perspectives. Officers noted this feedback.

There being no other business, the meeting closed at 12:59.

**Councillor Brenda Jones**  
**Chair, Health Overview Select Committee**

## **Statement from NHS Norfolk and Waveney ICB regarding the re-procurement of the Vulnerable Adults Service**

We want to thank members of the committee for their interest in this matter. It is really important that we continue to take action to support people from inclusion health groups.

In summary, our approach to this procurement has been to change very little in the service specification. We value the current service and we are committed to re-procuring specialist support. As members of the committee will have noted, specialist legal advice has confirmed there was no material change to the specification. Our expectation is that where we have added in new elements to the specification, that this will improve outcomes and value for money.

We want to make it easier for people to access the service. At the moment, before people can get support from the service they have to register with the Norwich Health Centre first. We are changing this so that new patients won't have to move their registration to the Health Centre unless they want to, they could instead stay registered with their existing GP practice.

It is worth noting that the Vulnerable Adults Service is not a standalone GP practice and cannot register patients. So even though people's care is provided by the specialist service at their base, as mentioned, all the people that currently use the service have to register with the Norwich Health Centre.

We know that each patient is an individual and should be treated as such. We would expect the professionals providing the service to make a clinical judgement regarding the transfer of care in order to ensure it is appropriate and safe for each individual. We have put 'six weeks or as appropriate' in the service specification because we anticipate that for some individuals the six weeks may need to be flexed in response to their circumstances and needs.

The specification for the current service includes step up and step down aspects, with patients being able to access services at their GP practice, the walk-in centre and other NHS services, whilst also getting additional support from the Vulnerable Adults Service as required – this won't change. We will work with the provider to ensure standard operating procedures and clinical governance are in place to ensure safe clinical practice.

One change we have made to the specification is to add in a requirement for the service provider to help upskill the wider general practice workforce. This will help to ensure there is a consistency of approach between professionals when treating people, support really good dual care, and ensure the step-up / step-down between services works smoothly.

We hope that this provides the committee with further reassurance that we are not proposing to make significant changes to the service. There will continue to be a

specialist service in place, working with general practice and others as it has always done so. People using the service will be registered with the Norwich Health Centre or another GP practice going forward, but as is the case now, they will be treated by specialists. And as is the case now, people's care will continue to be tailored to their specific needs, as it should be.

# Report to Health Overview Select Committee

Item No: 5

## Report Title: Eastern Pathology Alliance (EPA) Weekend Pathology Testing

Date of Meeting: 15 January 2026

### Executive Summary

At its meeting on 4 September 2025, the committee requested further information regarding the cessation of weekend pathology services across Norfolk and Waveney. A briefing paper was circulated to the committee in October 2025 (attached at appendix A). At its meeting on 6 November 2025, the committee requested a report be tabled for its consideration.

This report provides an overview of the Eastern Pathology Alliance (EPA) service, focusing on the decision to cease weekend pathology testing for GP Practices within Norfolk and Waveney.

The paper addresses specific questions raised by Norfolk Health Overview Select Committee (HOSC) members, covering performance criteria, benchmarking, financial implications, and the impact on patients, access, and equality.

### Action

- 1. The Health Overview Select Committee is asked to examine the report and to make any comments or recommendations as a result of today's discussion.**

#### 1. Purpose of today's meeting

- 1.1 To provide members with an overview of the current Eastern Pathology Alliance (EPA) pathology testing provision and information relating to the cessation of weekend services.
- 1.2 Representative of N&WICB and Norfolk and Norwich University Hospital will be in attendance to answer members' questions.

## 2. Previous reports to the Health Overview Select Committee (HOSC)

- 2.1 This is the first time weekend pathology testing has been considered by HOSC.

## 3. Background Information

- 3.1 The EPA, managed by Norfolk and Norwich University Hospitals NHS Foundation Trust, provides pathology services for the region. Historically, routine pathology testing for GP Practices was commissioned for weekdays only, with a temporary Saturday service introduced to support increased demand following changes in national policy and clinical guidelines.
- 3.2 In January 2025, concerns were escalated regarding the sustainability of weekend testing, which was not formally commissioned and relied on temporary funding.
- 3.3 At its meeting on 3 July 2025, the ICB Executive Team decided to cease weekend provision for GP Practices from 31 August 2025, aligning with the original contract and avoiding additional costs.
- 3.4 The requirement for Primary Care Networks (PCNs) to provide Enhanced Access appointments - weekday evenings (18:30–20:00) and Saturdays (09:00–17:00) is part of the Network Contract Directed Enhanced Service (DES)<sup>1</sup>, which is a nationally mandated NHS England specification. This was introduced to standardise access across England and improve convenience for patients.
- 3.5 While the DES aims to improve access to routine care, it does not explicitly mandate that supplementary services operate during these extended hours.
- 3.6 N&WICB has a Health Inequalities Strategic Framework<sup>2</sup> and aligns with Core20PLUS5 priorities, focusing on deprived populations and conditions such as cardiovascular disease and cancer, areas that often require blood tests for diagnosis and monitoring. N&WICB also emphasises improving access and integration of services to reduce inequalities.
- 3.7 The Norfolk and Waveney Integrated Care Strategy<sup>3</sup> highlights integrated, joined-up services as a core priority, aiming for seamless, people-centred care through strong collaboration across all partners.
- 3.8 In response to the committee's request to include additional perspectives, East Norfolk Medical Partnership was invited to provide feedback on the impact of ceasing weekend pathology testing. As one of the largest users

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<sup>1</sup> <https://www.england.nhs.uk/gp/investment/gp-contract/network-contract-directed-enhanced-services/>

<sup>2</sup> [Norfolk and Waveney Health Inequalities Strategic Framework](#)

<sup>3</sup> [Norfolk Joint Health and Wellbeing Strategy - Norfolk County Council](#)

of pathology services identified in the data provided by N&WICB, their input was sought to inform the committee's discussion. The Practice's response is included at Appendix B.

## 4. Suggested Approach

- 4.1 The committee may wish to explore the following areas with representatives from the Norfolk and Waveney Integrated Care Board:
- a) Patient impact and access
    - What evidence supports the conclusion that impacts are limited to “convenience and choice”, given data showing high working-age utilisation of weekend services.
    - How patient experience and continuity of care are affected when bloods cannot be taken at the same appointment and how barriers could be addressed.
  - b) Health inequalities and Core20PLUS5
    - How the decision aligns with stated commitments to Core20PLUS5 populations, particularly in PCNs where over half the population sits within Core20 deprivation.
    - What mitigations exist beyond “enhanced weekday access” and whether those mitigations are realistic for deprived or rural populations.
  - c) Evidence and data interpretation
    - Whether the absence of patient-level data may affect confidence in conclusions about demand, outcomes, and equity.
    - Consideration of whether high weekend utilisation implies unmet weekday access need rather than optional demand.
  - d) Commissioning and cost logic
    - How the £270k recurrent cost was weighed against wider system costs, such as delayed diagnosis or additional appointments.
    - Whether a whole-system cost–benefit analysis will be part of the planned 2027/28 business case and how that will be constructed.
  - e) Integration and system coherence
    - How the discrepancy between primary care access expectations and pathology commissioning arrangements is being addressed system-wide.
    - To what extent neighbourhood health models could practically re-integrate diagnostics into extended access.
  - f) Future options and assurance

- What success criteria will be used in the January 2026 review to determine the impact of the change.
- Whether reinstatement, partial reinstatement, or alternative commissioning models remain live options.
- What assurances can be given that future access-related decisions will be co-produced earlier with practices and patients.

## 5. Recommendations

- 5.1 The committee may wish to consider whether to make comments or recommendations as a result of today's discussion.

## 6. Background Papers

- 6.1 Background papers are referenced as footnotes to section 3.

### Officer Contact

If you have any questions about matters contained within this paper, please get in touch with:

**Officer name: Becky Tye**

**Telephone no.: 01603 679234**

**Email: [becky.tye@norfolk.gov.uk](mailto:becky.tye@norfolk.gov.uk)**



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Agenda item: 5

<b>Subject:</b>	<b>Eastern Pathology Alliance (EPA) Weekend Pathology Testing</b>
<b>Presented by:</b>	<b>Dr Frankie Swords, Executive Medical Director, Norfolk and Waveney ICB</b>
<b>Prepared by:</b>	<b>Bertone Santos Socorro, Head of Acute and Specialised Commissioning, NHS Norfolk and Waveney Integrated Care Board</b>
<b>Submitted to:</b>	<b>Norfolk Health Overview Scrutiny Committee</b>
<b>Date:</b>	<b>15 January 2026</b>

### **Executive Summary:**

This paper provides an overview of the Eastern Pathology Alliance (EPA) service and specifically the background and rationale for ceasing weekend pathology testing for GP Practices.

The paper also addresses additional questions raised by HOSC Members regarding performance criteria, benchmarking, financial considerations and impacts on patients, access and equality.

## **Report**

### **1. Background**

NHS Norfolk and Waveney Integrated Care Board (ICB) commissions pathology services through the Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH), which delivers these services via the Eastern Pathology Alliance (EPA). EPA is the managed pathology network serving NNUH, James Paget University Hospitals (JPUH) and Queen Elizabeth Hospital King's Lynn (QEH), providing diagnostics across blood sciences, immunology, microbiology and transfusion. The service is commissioned through a fixed-value / block contract.

## 2. Demand & Capacity

Both Images 1 and 2 below show increasing demand for services with associated increasing cost. As a block contract, rising activity does not generate additional income for the Trust.

Approximately 70% of EPA activity originates from GP Practices. The increased activity from GP Practices have mainly been as a result of changes to national policy and clinical guidelines (e.g. Quality and Outcomes Framework (QOF)).

Clinical Biochemistry\* testing accounts for the majority of the growth — an estimated 798,000 additional units (97% of activity growth) and £1.5m in cost growth (75.8%).

[\*Clinical biochemistry testing involves analyzing bodily fluids like blood and urine in a lab to measure chemical substances for diagnosing and managing diseases. These tests are used to evaluate the function of organs such as the liver, kidneys, and heart, and to monitor conditions like diabetes, hormone levels, and drug toxicity. The results help clinicians make diagnoses, create treatment plans, and monitor a patient's response to therapy.]

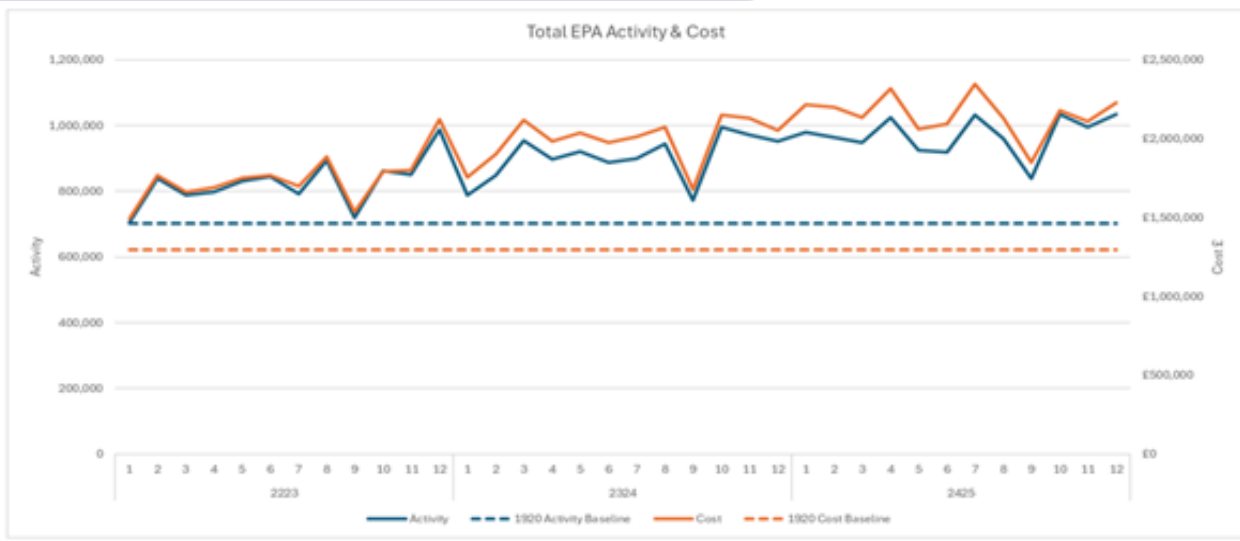
Images 1 and 2 below illustrate these trends. (Produced by ICB BI Team).

Summary – Activity & Cost									
	Activity			Cost			AVG Cost		
	1920	2324	2425	1920	2324	2425	1920	2324	2425
Clinical Biochemistry	7,404,384	9,633,291	10,431,322	£8,429,538	£14,189,952	£15,691,560	£1.14	£1.47	£1.50
Microbiology	273,259	341,079	339,623	£3,915,927	£5,298,077	£5,399,336	£14.33	£15.53	£15.90
Immunology	95,988	127,082	134,663	£1,662,053	£2,403,707	£2,655,536	£17.32	£18.91	£19.72
Haematology	643,861	730,866	748,962	£1,471,153	£1,952,021	£2,069,085	£2.28	£2.67	£2.76
Molecular genetics	584	536	592	£27,794	£24,350	£28,682	£47.59	£45.43	£48.45
SAS Bone service	109	154	359	£1,864	£3,282	£8,396	£17.10	£21.31	£23.39
Andrology	388			£12,596			£32.46	£0.00	£0.00
<b>Grand Total</b>	<b>8,418,573</b>	<b>10,833,008</b>	<b>11,655,521</b>	<b>£15,520,925</b>	<b>£23,871,388</b>	<b>£25,852,596</b>	<b>£1.84</b>	<b>£2.20</b>	<b>£2.22</b>
	Activity Variance		Cost variance		AVG Cost Variance				
	2425 vs 2324 #	2425 vs 2324 %	2425 vs 2324 #	2425 vs 2324 %	2425 vs 2324 #	2425 vs 2324 %			
Clinical Biochemistry	798,031	8.3%	£1,501,609	10.6%	£0.03	2.1%			
Microbiology	1,456	-0.4%	£101,259	1.9%	£0.36	2.3%			
Immunology	7,581	6.0%	£251,830	10.5%	£0.81	4.3%			
Haematology	18,096	2.5%	£117,064	6.0%	£0.09	3.4%			
Molecular genetics	56	10.4%	£4,332	17.8%	£3.02	6.6%			
SAS Bone service	205	133.1%	£5,115	155.9%		0.0%			
Andrology	0		£0						
<b>Grand Total</b>	<b>822,513</b>	<b>7.6%</b>	<b>£1,981,208</b>	<b>8.3%</b>	<b>£0.01</b>	<b>0.7%</b>			

- N&W EPA 2024/25 (Months 1 – 12) Activity at 11.6m units at a cost of £25.8m.
- N&W EPA has risen by 823k (7.6%) units on 2023/24, increasing costs by £1.98m (8.3%). When comparing current year to 2019/20 EPA has risen by 3.2m (38.5%) units with costs increasing by £10.33m (66.6%)
- Clinical Biochemistry accounts for the majority of this increase, equating to 798k units (97% of activity growth) at £1.50m (75.8% of cost growth)
- Unit costs between years are in line with no major casemix or unit price increases outside of ordinary tariff inflators. Casemix between current and last year accounts for £169k out of the £1.98m (8.5% of total cost increase).

**Image 1:** Illustrates the overall increase in EPA activity and the associated increase in the cost of delivery of £3.2 million.

## Trends – Activity & Cost



**Image 2:** Graphical representation of total EPA contract activity and associated cost growth.

In response to escalation from NNUH, on the rising demand a system Diagnostic Stewardship and User Group has been re-established to provide oversight of demand management, system communication and collaborative working for services provided by EPA. The Group is chaired by the ICB Head of Acute and Specialised Commissioning.

The EPA Diagnostic Stewardship and User Group so far has:

- Agreed Terms of Reference and review of membership
- Produced a short-term action plan.
- Co-produced analysis and the supporting paper for the Executive Team regarding the weekend testing decision.
- Begun development of a robust EPA dashboard to improve understanding of key demand drivers.
- Drafted a strategic communications approach, to enable closer working with primary care and partners to understand the rationale for increased demand and strengthen system-wide collaboration to support demand optimisation.

The next stage of work will include:

- Further refresh of group membership to include the ICB Deputy Medical Director, the Local Medical Committee, and key primary care leaders.
- Developing a 12-month plan for 2026/27 with clear milestones to support demand optimisation / productivity (e.g., changes to ICE requesting, optimisation of test markers, and reduction of unnecessary follow-up testing).
- Continuous Enhancing oversight of performance, activity, quality and value for money across the network, informed by dashboard.
- Having implemented quality initiatives to improve productivity, prepare a business case for 2027/28 to secure funding if demand remains above capacity.

### 3. Performance

EPA operates within a structured performance and quality governance framework. While no EPA-specific key performance indicators (KPIs) are embedded within the ICB's block contract, EPA maintains a comprehensive internal KPI framework covering all pathological disciplines. Key areas include: workload, turnaround times (TAT), antenatal screening performance, incident monitoring, complaints and UKAS accreditation.

Additional local criteria include published service documents such as telephoning criteria (for very urgent samples) and factors affecting test performance (via <https://nwknowledgenow.nhs.uk/content-category/clinical-information/diagnostics/pathology/epa-departments-and-website/> ).

EPA also adheres to multiple national frameworks, including:

**a) Royal College of Pathologists (RCPATH) KPIs:**  
<https://www.rcpath.org/static/e7b7b680-a957-4f48-aa78e601e42816de/Key-Performance-Indicators-in-Pathology-Recommendations-from-the-Royal-College-of-Pathologists.pdf>

Standards are widely adopted across UK laboratories and form the baseline for local performance. Examples include:

- Histopathology TAT (proportion reported within 7–10 days)
- A&E blood sciences TAT (typically one hour)
- Blood transfusion response times

- Antenatal screening timeliness

**b) NHS England Pathology Quality Assurance Dashboard (PQAD)**  
[Pathology quality assurance dashboard PQAD.pdf](#)

PQAD sets national quality indicators for comparative benchmarking, including:

- TATs (routine and urgent)
- Sample rejection rates
- Serious incidents and laboratory errors
- Performance in External Quality Assessment (EQA) schemes

Although provider-level comparisons are not routinely published, NHS England uses these for national benchmarking.

**c) UKAS / ISO 15189 Accreditation**

[https://www.easternpathologyalliance.nhs.uk/about-epa/clinical-trials/?utm\\_source](https://www.easternpathologyalliance.nhs.uk/about-epa/clinical-trials/?utm_source)

[https://www.ukas.com/accreditation/standards/medical-laboratory-accreditation/?utm\\_source](https://www.ukas.com/accreditation/standards/medical-laboratory-accreditation/?utm_source)

EPA is a UKAS-accredited medical laboratory network. Requirements include:

- A formal quality management system
- Defined and monitored quality indicators
- Evidence of continual improvement and corrective action

UKAS accreditation enforces consistent national quality standards.

#### **4. Provision for tests taken by GP Practices at weekend**

In summary, EPA is commissioned to provide routine pathology services Monday–Friday and has never been formally commissioned to deliver weekend provision to GP Practices.

From 1<sup>st</sup> October 2022, GP Practices/PCNs were contracted, under the Primary Care Network Contract Enhanced Service, to provide Enhanced Access appointments. These appointments included provision on Friday from 18.30 to 20.00 and on Saturday from 09.00 to 17.00. The EPA service manager advised that as blood tests could not be kept for more than 24hrs (without loss of integrity) there would be a need for blood collections (like those currently in place Monday to Friday) and the corresponding service set up within EPA to accommodate the testing. In response, a temporary Saturday service began to support increased activity with blood samples being taken on Saturday and results followed up by GP Practices during normal working hours. The service was funded using slippage funding.

In January 2025, the NNUH Executive Team escalated concerns regarding the demand, which fell outside of the formally commissioned arrangement of a Monday to Friday service. The issue was initially discussed at the N&W Commissioning and Performance Committee. Subsequently, a formal paper from NNUH was submitted to the ICB Executive Team on 7 July 2025, co-produced with the EPA Diagnostic Stewardship and User Group. The following options were considered:

**Option 1:** Commission weekend service (requiring £270k recurrent funding)

**Option 2:** Cease weekend service (align with contract)

**Option 3:** Cease temporarily and review

Both Quality (QIA) and Health Inequalities (EHIA) Impact Assessments were considered by the ICB QIA/EHIA Panel on 30 June 2025. Feedback from that Panel was shared with the Executive Team and informed their decision making.

Key points from the Impacts assessments were:

- Most GP practices do not review bloods taken on a Saturday until the start of the following week during normal working hours, limiting clinical value
- No impact on urgent care or paediatrics
- Main impact relates to convenience for those who prefer to attend on Saturdays
- Practices are expected to enhance weekday access and make reasonable adjustments

The Executive Team approved Option 2.

The rationale included:

- Weekend processing for GP Practices was not formally commissioned
- No recurrent or non recurrent funds available
- The decision avoided additional cost rather than removing existing cost
- Urgent and emergency testing continues unchanged

A review is underway to understand the impact of the decision and will be completed by the end of January 2026 but this is not currently with the intention to re-instate the routine weekend service.

To note:

- NNUH is working with a small number of GP practices to fully implement the decision by 30 December 2025, at the latest.
- QEHL and JPUH continue to have samples processed at weekends by the EPA service; however, this relates to secondary care activity, primarily supporting consultant-led services (e.g., blood tests for outpatient cardiology clinics).

- There is an exceptional arrangement between NNUH and Theatre Royal Surgery (TRS) to allow weekend sample submissions. This supports the temporary increase in workload following the closure of Toftwood Medical Practice on 1 April 2025, which resulted in approximately 1,800 patients transferring to TRS. The interim arrangement provides additional capacity from November 2025 and will remain in place until end of January 2026, so TRS has sufficient space to deliver phlebotomy clinics during normal weekday hours.

A review of routine weekend processing across the regional shows mixed provision.

### **Suffolk**

Across Suffolk, routine weekend testing is not generally provided. Exceptions include:

- West Suffolk NHS Foundation Trust (WSFT), which supports a morning collection for two GP phlebotomy clinics at weekends.
- WSFT also runs an outpatient phlebotomy service where patients referred by GPs may attend; all samples are processed immediately, and no samples are held until Monday.
- ESNEFT undertakes morning collections on both weekend days for few large GP practices and processes Community Diagnostic Centre (CDC) requests.

### **Cambridgeshire and Peterborough**

- Routine weekend blood sample testing is provided, and discussions are ongoing regarding future funding arrangements.

### **Lincolnshire ICB**

- Lincolnshire ICB has confirmed that routine weekend blood testing is not provided.

Further work will be undertaken to develop a clearer understanding of weekend provision across neighbouring systems to enable learning from peers.

## **5 Additional responses**

Below are responses to specific queries which HOSC wanted covered in the paper.

**5.1 Members are also looking to explore the relationship between Norfolk hospitals and Addenbrooke's, especially in the west of the county where residents are referred to Addenbrooke's for treatment and their pathology pathway is therefore different.**

NNUH is currently exploring this further. Initial feedback from Cambridge indicates that some results can be accessed via the GP Connect system; however, there are limitations in accessing all results through WebICE.

**5.2 The data provided to HOSC members is derived from 39 practices, some of which are not in the Norfolk and Waveney ICB footprint. Why is data provided from these 39 practices in particular?**

Those GP Practices (approximately one third of GP Practices in N&W) were the ones submitting samples for weekend processing.

**5.3 What is the source of this data?**

The data was provided directly by NNUH as the EPA contract holder.

**5.4 Is this the data that was considered when the decision was taken to no longer support the service financially?**

Yes. This data formed part of the evidence base, alongside financial considerations relating to the use of temporary slippage funding and the fact that EPA is not formally commissioned to deliver weekend services.

**5.5 Is data available on the number of patients in addition to the number of tests provided?**

While raw patient-level data was not available due to complexity (multiple tests per patient), laboratory estimates indicate approximately 200 patients per weekend.

**5.6 Please provide specific information on the cost of providing this service and the anticipated saving.**

NNUH requested additional recurrent funding to support three additional posts in order to sustain weekend testing. Without commissioning for weekend provision, these costs would fall outside the contract envelope.

AfC	Cost per weekend (inc. enhancement rates and on-costs)	Annual Costs (based on 25/26*)
Band 7	£1,401	£73,077
Band 6	£2,321	£121,025
Band 3	£1,468	£76,559
<b>Total</b>		<b>£270,660</b>

Assumes 2.8% inflationary uplift for 25/26

**5.7 Please provide clarification as to how removing weekend testing reduces the cost of providing a pathology service, on the basis that the tests will still need to be performed and analysed.**

Weekday staffing levels can absorb weekend-requested tests within Monday–Friday operations. NNUH has stated weekend working would require additional posts, representing new cost, albeit there should be no difference in overall activity.

**5.8 Was a cost/benefit analysis undertaken as part of the financial process?**

Options were presented to EMT with advantages and disadvantages. A broader cost-benefit analysis will be included within the forthcoming EPA business case for 2027/28, overseen by the EPA Diagnostic Stewardship and User Group.

**5.9 A Member has been advised that East Norfolk Medical Practice had a contract with the former CCG covering the provision of weekend pathology. If correct, please can you provide further information on this contract.**

This information is not known by the ICB and is likely to be a historical arrangement which has been superseded. Practices and Primary Care Networks may choose to negotiate directly with the Trust to arrange additional weekend activity to enable them to provide blood testing on Saturdays.

**5.10 A Member has been advised that GP Practices in West Norfolk are not affected by this decision and continue to be able to offer weekend blood tests. Please can you provide further information in respect of this and confirm, if appropriate, the practices which can continue the weekend testing.**

The decision for EPA provision relates to all Norfolk and Waveney GP Practices. Please see earlier in document for additional clarification on testing in West.

**5.12 Was any consultation or engagement undertaken with primary care providers, patient groups or other stakeholders to inform the decision-making process?**

The EPA service continues within its contracted hours. The EPA Diagnostic Stewardship and User Group — including attendance from NNUH, general practice, ICB Primary Care Commissioners, Clinical Leads and Acute Commissioners — was engaged during development of the EMT paper. The ICB has strengthened engagement with General Practice by inviting GP representation from the Local Medical Committee to attend.

**5.13 What impact assessments were carried out as part of the decision-making process and if appropriate, how did these impact the decision and what mitigation measures if any were identified and implemented?**

Quality and Health Inequalities Impact Assessments were completed and informed the decision. The assessment concluded that impacts were limited to convenience and

choice, with no effect on urgent testing. Mitigations include reasonable adjustments via GP practices and increased weekday phlebotomy appointments.

**5.14 If the service needed to be reduced to provision of collection arrangements and testing 5 days per week, what consideration was given to withdrawing collections on a weekday, rather than Saturdays?**

NNUH/EPA have not requested any contractual variation to alter working patterns beyond seeking additional cover to run the service at weekends. This option could be explored further between NNUH and General Practice as part of Neighbourhood Health model development.

**5.15 How does ending the collection of tests at weekends feed into the bigger picture around health inequalities and accessibility?**

It is acknowledged that a small number of patients will lose convenience of Saturday testing however:

- Weekday access has absorbed the Saturday activity.
- Urgent weekend testing remains available
- The development of neighbourhood health models may enable providers to consider future extended access

**WEEKEND PATHOLOGY TESTING – MEMBER BRIEFING NOTE**

At the Health Overview Select Committee meeting on 4 September 2025, Members requested a future report on weekend pathology testing in primary care settings. The following information has been provided in response to initial questions raised by the Chair.

**1. Where was pathology service provided?**

*Pathology activity (tests) does not equate to the number of patients, as one patient may have a number of samples taken at a contact. At this stage we are able to provide a six-month breakdown, but we are in negotiation to provide a whole year data as requested.*

<b>Practice Name</b>	<b>Number of tests performed 01/04/2024 and 22/09/2024</b>
Bungay Medical Practice, St John's Rd, Bungay	4034
East Norfolk Medical Practice	3046
St Clements Surgery, Churchgate Way, Terrington St Clements	1280
Castle Partnership, Norwich	697
Southgates Medical Centre, Goodwins Rd	579
Vida Healthcare, Gayton Road, K Lynn	394
Nelson Medical Practice	382
Theatre Royal Surgery, Theatre St, Dereham	328
St James' Medical Practice, K Lynn	301
Wensum Valley Medical Practice, Adelaide St, Norwich	263
Terrington St John, Wisbech	219
Bridge STREET Surgery, Downham Market	194
Howdale Surgery, Downham Market	174
Long Sutton Medical Centre, Spalding, Lincs	171
Watlington Med Centre, Rowan Close	167
UEA Medical Centre, Earlham Rd, Norwich	146
Fleggburgh Surgery, Mill Ln, Fleggburgh	144
Manor Farm Medical Centre, Mangate St, Swaffham	122
Campingland Surgery, Swaffham	103
Humbleyard Practice, Cringleford	100
Trinity & Bowthorpe Medical Practice, Trinity St, Norwich	99
Feltwell Surgery, Old Brandon Rd	99
Grimston Medical Centre, K Lynn	87
Upwell Health Centre, Wisbech D82035	80
Heacham Group Practice, 45 Station Rd	72

Alexandra Road Surgery, Lowestoft	71
Beccles Medical Centre, St Mary's Rd, Beccles	68
Coltishall Surgery, St John's Close, Rectory Rd, Coltishall	66
Magdalen Medical Practice, Norwich	65
Thorpewood Medical Group, Woodside Rd, Norwich	63
Sole Bay H/C, Southwold	61
Lawson Road Health Centre, Lawson Rd, Norwich	59
Taverham Partnership, Sandy Ln, Taverham	57
Brundall Medical Centre, The Dales, Brundall	55
Rosedale Surgery, Ashburnham Way, Carlton Colville	55
Wymondham Med Pract. Postmill Close D82045	54
Drayton Medical Practice, Manor Farm Close, Drayton	52
Boughton Surgery, Chapel Road, Boughton	51
School Lane Surgery, School Ln, Thetford	50
39 Practices	14,108 Tests

**Table 1:** Total weekend activity.

**2. How was the service funded?**

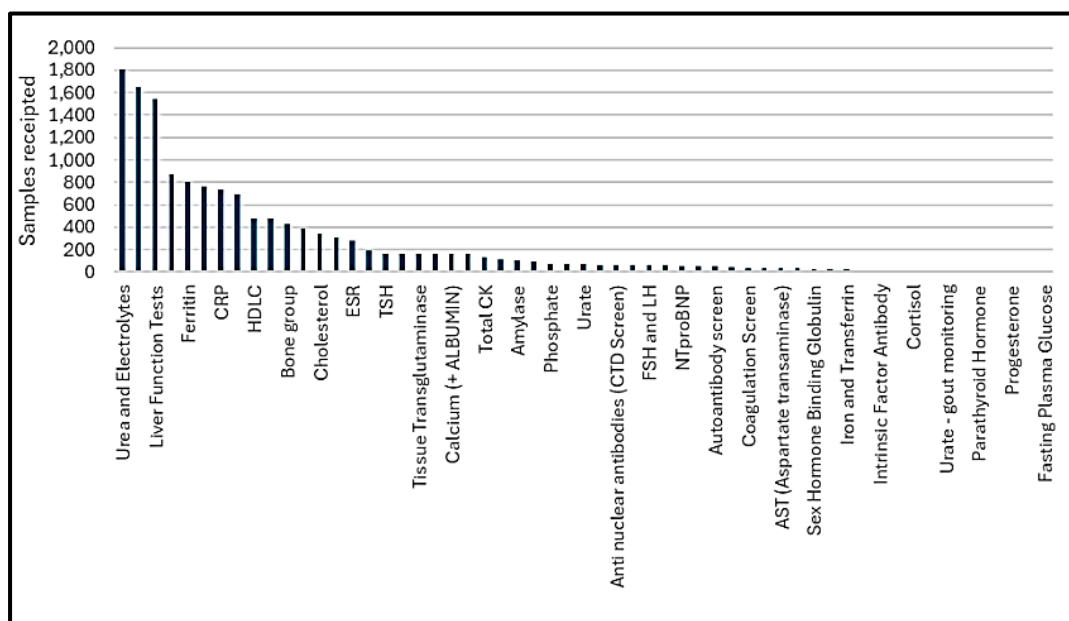
- Funded by non-recurrent slippage from wider ICB budgets
- Service was not commissioned but was funded as temporary provision

**3. Where was the decision taken to no longer support financially?**

ICB Executive Management Team on 3rd of July 2025

**4. How many tests were performed at each venue over the last year?**

- See question 1 above plus data below:



**Figure 1:** Weekend sample 24/25 data.

## WEEKEND PATHOLOGY TESTING – RESPONSE FROM EAST NORFOLK MEDICAL PRACTICE

### 1 Impact on Patient Access

*How has the withdrawal of weekend pathology services affected patients' ability to access timely blood tests, particularly those who work during the week or have mobility challenges?*

The Saturday service gave patients that work Monday to Friday, access to both blood appointments and long-term condition checks that involved bloods. Many of our population are unable to take time off work during the week to attend appointments without loss of income – of course difficult for those already on low incomes. Some of our patients work in factory roles Monday to Friday; long shifts away from the Great Yarmouth area, meaning they would need to miss an entire day of work to attend a weekday appointment. Working age patients make up 57% of our total PCN population yet analysing the attendees for blood appointments from July 24 to July 25, 75% were working age.

The Saturday service was also valuable to patients that needed a relative/friend to attend with them/bring them to their appointments.

### 2. Clinical Consequences

*Have there been any observed delays in diagnosis or treatment plans due to the absence of weekend testing? If so, what examples or data can illustrate this?*

An example of this would be the annual care processes appointments offered to our diabetic patients. In previous years we have been able to offer Saturdays to those who find this most convenient, with our administrative team specifically scheduling clinics/keeping lists of patients that want Saturdays. This year, we can offer only part of this appointment at the weekend – with patients having to come back another time for bloods – which as referenced above can be difficult to do. The blood results are an important part of their diabetic care – and regular checks are important to ensure that their condition is well managed.

### 3. Operational Adjustments

*What changes have PCNs had to make to accommodate the decision (e.g. increased weekday phlebotomy capacity, extended hours)? How sustainable are these adjustments?*

The practice employed phlebotomists to work Saturdays, and as such we have had to re-distribute their hours into the weekdays/evenings. Whilst this has been possible, it is now meaning one member of staff is coming in to work just a 6.30 –

8pm evening slot; a shift that is not overly convenient nor popular – with staff or patients.

The practice also employs health care assistants on Saturdays – who also took bloods either as stand-alone appointments or part of long term condition management. We are now restricted in what we can use their time for and often have empty rotas. We have tried several ways to fill these clinics but are likely looking at a reduction in staffing hours in 2026.

It should be noted that as a practice we have also explored whether we could open on a Sunday instead of a Saturday, centrifuging blood samples taken for collection on a Monday. Unfortunately, the laboratory advice is that the sample stability would be compromised and therefore this is not a viable alternative.

#### **4. Communication and Engagement**

*Were PCNs adequately consulted before the decision was made? What feedback was provided, and how was it considered in the final outcome?*

As a practice and as a PCN we were not consulted at all prior to this decision. We were not asked to provide any information, qualitative or quantitative data to aid decision making; which conflicts with the approach the ICB themselves detail in their Statement on Health Inequalities. We were informed of the decision to cease weekend services on the 23<sup>rd</sup> July, with an implementation date of 31<sup>st</sup> August.

The notice period gave us very little time to consult with staff impacted and adjust our services; a complete failure to recognise the impact on practices.

We discussed the Saturday closure with the pathology transport provider in August – and they were also unaware of the change.

#### **5. Health Inequalities**

*Which patient groups are most affected by the removal of weekend testing? What measures could help mitigate any disproportionate impact on vulnerable populations?*

As previously referenced, working age patients that are unable to attend appointments during the week, and patients that need working relatives to attend with them/transport them to services have been affected. It is also important to note that 54% of the GYNV PCN population are defined as a Core 20 population group: a significant level of deprivation and vulnerability. The decision to reduce services back to five days a week seems to conflict with the guidance set out in the NWICB Statement on Information on Health Inequalities (link below), specifically referencing understanding factors that impact healthcare access and the importance of considering these in decision making. The statement details that *'Some factors may be more likely to negatively impact those in the most deprived areas and people from*

*minority ethnic groups. Other barriers such as location of services, transport, and work commitments may also affect ability to access healthcare.'*

The ICB also recognise the importance of tackling inequality in their Health Inequalities Improvement plan, stating that *'Everyone needs something, some people need more'* and *'We will ensure accessible services for those in greatest need'*, yet this decision to reduce services in an area of significant need seems to go against these statements.

FINAL Norfolk & Waveney Statement on Information on Health Inequalities 2024/25

NWICB Health Inequalities Improvement Plan - Final draft

## **6. Financial and Workforce Implications**

*Has the decision created additional costs or staffing pressures for PCNs? How does this compare to the previous arrangement with weekend services?*

It should be noted that we have been running weekend bloods from our Lighthouse site in Great Yarmouth since 2018, when the new extended access requirements were developed nationally. The phlebotomy service was actually developed with the commissioner (NHS GYWCCG as was then); them being fully supportive of this and arranging and funding the transportation through the laboratory transport provider.

Practices/PCN's have to offer a certain number of out of hours appointments each week; our phlebotomy provision was part of this. It is likely that we will have to utilise different staff now to meet the hours requirement – and these staff are likely to cost more to employ.

## **7. Future Service Design**

*What alternative models or collaborative solutions could be explored to balance cost, capacity, and patient convenience (e.g., shared weekend hubs, neighbourhood health models)?*

If consulted on these plans, we would have recommended increasing provision of weekend access to bloods, not decreasing! We would have been (and still are), open to exploring growing the service – to a bigger population. As a practice we are committed to ensuring that access to our services is as easy as it possibly can be for patients.

# Report to Health Overview Select Committee

Item No: 6

**Report Title: Palliative and End of Life Care Update**

**Date of Meeting: 15 January 2026**

## Executive Summary

An update on palliative and end of life care was identified as a priority during the Committee's Forward Work Programming session in July 2025.

The report includes a detailed update from the Norfolk and Waveney Integrated Care Board (N&WICB), responding directly to the Committee's request.

Additional information is provided from Marie Curie, drawing on findings from their recent public experience study to give further insight into local experiences of palliative and end of life care in Norfolk and Waveney, attached as appendix A.

## Action

1. **The Health Overview Select Committee is asked to examine the report and to make any comments or recommendations as a result of today's discussion.**

### 1. Purpose of today's meeting

- 1.1 To provide members of the Health Overview Select Committee with an updated on palliative and end of life care provision across the Norfolk and Waveney Integrated Care Board (N&WICB) footprint.
- 1.2 Representative of N&WICB will be in attendance to answer members' questions.

### 2. Previous reports to the Health Overview Select Committee (HOSC)

- 2.1 HOSC received a palliative and end of life care update at its meeting on 9 November 2023 which can be found [here](#).

### 3. Background Information

- 3.1 Palliative and end of life care (PEoLC) has become an increasing focus of national health policy, driven by demographic changes and a growing recognition of the importance of high-quality, person-centred care for those approaching the end of life.
- 3.2 The Health and Care Act 2022 places a statutory duty on Integrated Care Boards (ICBs) to commission palliative and end of life care that meets the needs of their local populations.
- 3.3 Nationally, demand for these services is rising: the number of deaths each year in England is projected to increase by over 20% in the next two decades, largely due to an ageing population and more people living with multiple long-term conditions<sup>1</sup>. Alongside this, there is a clear policy direction towards enabling more people to die in their preferred place, often at home or in the community, rather than in hospital.
- 3.4 Despite these ambitions, the national picture remains mixed. While specialist palliative care is available in most hospitals, only a minority offer seven-day, face-to-face services, and access to out-of-hours support is variable.
- 3.5 Independent hospices, which are key partners in the delivery of palliative and end of life care, face significant financial pressures. The government has provided some one-off capital funding to help sustain hospice infrastructure, but the underlying challenge of revenue funding and sustainability remains.
- 3.6 Recent public experience work, such as the Marie Curie study across the East of England<sup>2</sup>, highlights both strengths and persistent gaps. While just over half of respondents rated their overall experience of care as good or very good, a significant minority reported poor experiences, with delays, difficulties navigating services, and lack of timely support being common themes. Carers, in particular, often feel under-supported. The full report can be found [here](#).
- 3.7 The study's recommendations such as improving identification of those approaching end of life, strengthening community nursing, ensuring 24/7 access, and increasing support for carers are highly relevant to the local system.
- 3.8 At a local level, the key challenges identified through the survey were experienced delays in care, treatment or transfer between services and care not being available when needed or quickly enough (e.g. at night) – this includes all 'out of hours' including evenings and weekends. Marie Curie have provided the data and analysis specifically relating to the Norfolk and Waveney area, which is attached at Appendix A.

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<sup>1</sup> ONS Data quoted in 'The financial sustainability of England's adult hospice sector,' National Audit Office Report, 29 October 2025

<sup>2</sup> : Kate Vernon, Emma Maun, Briony Hudson. Experiences of Palliative and End of Life Care in the East of England (March 2025) Health Open Research

- 3.9 While there is clear commitment at both national and local levels to improving palliative and end of life care, the sector faces rising demand, workforce and funding pressures, and ongoing variation in access and experience.
- 3.10 The current focus in Norfolk and Waveney is on strengthening commissioning arrangements, improving data and accountability, and working in partnership with providers and the voluntary sector.
- 3.11 The Terminally Ill Adults (End of Life) Bill, commonly known as the Assisted Dying Bill, would permit certain adults to request and self-administer life-ending medication under strict safeguards, including confirmation by two independent doctors, a multidisciplinary review panel, and oversight by a Voluntary Assisted Dying Commissioner.
- 3.12 The Bill completed its Third Reading in the House of Commons in June 2025 and is currently undergoing detailed scrutiny in the House of Lords, where over 1,000 amendments have been tabled focusing on issues such as residency rules, safeguarding and eligibility criteria.
- 3.13 The Bill explicitly requires integration with existing palliative and hospice care systems. Leading hospice and palliative organisations have noted that the Bill has brought urgent attention to underfunded end-of-life care and that it could serve as a catalyst for service improvements.
- 3.14 Experts, including participants at Royal Society of Medicine events, have cautioned that the current inconsistency and resource shortfall in palliative care may influence demand for assisted dying, reinforcing calls for significant investment in community and hospice services to ensure choices are informed and not driven by gaps in care.

## 4. Suggested Approach

- 4.1 The committee may wish to explore the following areas with representatives from the Norfolk and Waveney Integrated Care Board:
- The learning taken from recent public experience studies, such as the Marie Curie report, and how this is shaping local priorities and service improvements.
  - How the ICB is progressing with moving from grant-based to contract-based commissioning for hospices, and the impact this may have on service accountability and equity.
  - The steps being taken to improve 24/7 access to palliative and end of life care, including a single point of contact for patients and families.
  - How the ICB is addressing gaps in hospice bed capacity and ensuring people have genuine choice over their place of care and death, particularly in under-served areas.
  - How additional winter pressures may impact on palliative and end of life care services.

- How the system is working to improve coordination between hospital, community, and hospice services, and the data being used to monitor outcomes and patient experience
- The specific actions being taken to address the needs of carers, including practical support, information, and bereavement services.
- How inequalities in access and outcomes, such as those related to geography, deprivation, or diagnosis, are being identified and reduced within the local system.
- How the ICB and partners are considering the impact of the Terminally Ill Adults (End of Life) Bill in service provision planning.

## 5. Recommendations

- 5.1 The committee may wish to consider whether to make comments or recommendations as a result of today's discussion.

## 6. Background Papers

- 6.1 The National Audit Office report referenced in paragraph 3.1, 'The financial sustainability of England's adult hospice sector' can be found [here](#).
- 6.2 The full report from Marie Curie, 'Experiences of Palliative and End of Life Care in the East of England' can be accessed [here](#).

### Officer Contact

If you have any questions about matters contained within this paper, please get in touch with:

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Agenda item: 6

<b>Subject:</b>	<b>HOSC All Age Palliative Care Update</b>
<b>Presented by:</b>	<b>Dr Frankie Swords, Executive Medical Director, Norfolk and Waveney ICB</b>
<b>Prepared by:</b>	<b>Maggie Tween, Erica Everett &amp; Zoe Nash, System Clinical Transformation Team, Norfolk and Waveney ICB</b>
<b>Submitted to:</b>	<b>Norfolk Health Overview Select Committee</b>
<b>Date:</b>	<b>15<sup>th</sup> January Meeting</b>

**EXECUTIVE SUMMARY:**

The last update to the Health Overview and Scrutiny Committee (HOSC) was in November 2023. Since then, there has been significant progress in improving palliative and end of life care. This work has been underpinned by a review of local provision, to develop a system plan to meet the growing demand, workforce shortages and inequities in access, particularly for people living in rural or deprived areas and those dying with non-cancer diagnoses. This report provides an update on national policy, local need, current provision and variation, and the ICB’s ongoing work to address gaps in palliative and end of life care (PEoLC) for adults, children and young people (CYP).

The paper also addresses additional questions raised by HOSC Members regarding palliative care in Norfolk and Waveney and provides additional information re the Assisted Dying Bill.

**1. INTRODUCTION:**

Palliative and End of Life Care (PEoLC) is a critical component of the health and care system, supporting individuals with life-shortening conditions to live as well as possible until death, and to die with dignity. In Norfolk and Waveney (N&W), the delivery of PEoLC spans all ages and a range of settings, including hospitals, hospices, care homes, and people’s own homes.

Palliative care addresses the individual and their family’s needs (physical, psychological, social, and spiritual) through a holistic model this is emphasised in National guidance (for example in The Ambitions for Palliative and End of Life Care Framework (2021–2026), The Health and Care Act (2022) and The NHS Long Term Plan and Ambitions for Palliative and End of Life Care (2015–2025) which emphasises the importance of personalised care planning, 24/7 access to community-based support, integrated services across health and social care and reducing inequalities in access and outcomes. The Care Quality Commission (CQC) and NICE also provide frameworks for high-quality PEoLC, including timely access to symptom control, emotional support, and coordinated care.

Approximately 1% of the UK population dies each year, and most of these individuals are older adults with multiple long-term conditions such as cardiovascular disease, chronic respiratory illness and cancer. General practitioners (GPs) and district nurses form the backbone of community-based care<sup>1</sup>. With medical advances, increasing numbers of children are living longer with complex life limiting or life-threatening conditions and are surviving and transitioning into adulthood. The most recent ICB strategy aligns with national policy, aiming to integrate generalist and specialist services to meet growing demand<sup>2</sup>.

<sup>1</sup> [\[england.nhs.uk\]](https://www.england.nhs.uk)

<sup>2</sup> [\[improvinglifesnow.org.uk\]](https://www.improvinglifesnow.org.uk)

## 2. CURRENT PROVISION:

There is currently a range of specialist and generalist palliative care providers, including:

- **Hospices:** Priscilla Bacon Lodge, St Elizabeth Hospice, The Norfolk Hospice Tapping House, East Anglia's Children's Hospices (EACH). Some residents on the borders with Suffolk also access services at St Nicholas Hospice in Bury St Edmunds.
- **Hospice at Home teams**
- **Community Specialist Palliative Care Teams**
- **Primary care and community nursing teams**
- **Continuing Health Care (Fast track) and Children and Young People's Continuing Care**
- **Voluntary sector organisations providing community support**

## 3. PROGRESS SINCE 2023:

Since the last report in 2023, there has been significant progress in improving palliative and End of Life Care across Norfolk and Waveney this work has included:

### 3.1 A Review of Current Provision:

A comprehensive review of current provision has been undertaken. The purpose of this review has been to understand the current variation in quality and access. Patient and carer feedback (direct feedback and via a Marie Curie lived experience survey) has also been considered as part of this review. This review has identified that there are issues with; Inconsistent access (cohorts of patients and due to placement of services), variable models of care, differential funding frameworks across providers, specific issues with bereavement support (being reliant on charitable funding), variable access to out-of-hours medication and under-resourced consultant-led inpatient care and insufficient capacity to meet the population needs according to Nationally defined recommendations<sup>3</sup>. This work has been informed by engagement workshops with providers and service users.

Following on from the review, we plan to continue to refresh and align commissioning for specialist palliative and end of life care with national standards. This shall support improved access, a reduction in variation, and align more closely with the integrated provision in Suffolk.

### 3.2 Collaborative work to Improve Patient Information:

There has been system wide collaboration with providers to improve the consistency and accessibility of information provided to patients in their final year of life. Historically, patients and families faced notable variation in the quality, format, and availability of patient information depending on the provider or care setting. Inconsistency in patient information created barriers to understanding care options, planning effectively, and accessing appropriate support. Progress has been made to standardise information resources, regardless of the provider or setting and to improve accessibility with resources being available in print or via the ICBs Knowledge NoW website, (which is now a single trusted source for end-of-life resources). Patients and families shall now be better supported to make informed decisions and feel reassured that they are receiving equitable care.

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<sup>3</sup> Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives Developed in collaboration with: Association for Palliative Medicine of Great Britain and Ireland, Consultant Nurse in Palliative Care Reference Group, Marie Curie Cancer Care, National Council for Palliative Care, Palliative Care Section of the Royal Society of Medicine December 2012

### 3.3 Planning to Implement the Electronic Palliative Care Co-Ordination System: My Care Choices Register:

The My Care Choices Register (MCCR) will be implemented across Norfolk and Suffolk in early 2026 as part of a system-wide commitment to improve end-of-life care. This work has focused on creating a single, accessible record where patients' preferences and priorities for their care in the last year of life can be documented and shared across services. This represents a major step forward in placing patients at the centre of end-of-life care planning and is predicted to support more patients to be cared for in their preferred place and a reduction in avoidable hospital admissions in the last 3 months of life, through:

- **More personalised care:** Patients' wishes, supporting care that reflects their values and priorities.
- **Improved co-ordination:** Clinicians across different settings can access the same information, improving continuity of care.
- **Greater confidence for families:** Families are reassured that their loved one's preferences are known and respected, reducing uncertainty at difficult times.
- **Improved equity of access:** All patients in their last year of life, regardless of diagnosis, have their choices recorded and honoured.

### 3.4 Collaboration to Improve Access to Medicines:

Timely access to appropriate medications in the last days of life is fundamental to ensuring dignity, comfort, and quality of care for people dying outside of healthcare settings. It plays a critical role in preventing avoidable hospital admissions. We have worked to improve access to medicines by:

- **Improved support for medical and non-medical prescribers:** through prescribing and deprescribing guidance, training and education
- **Acute palliative care formulary group:** to ensure a single formulary across all acute settings
- **Increased the range of medicines available:** to out-of-hour services
- **Improved patient information:** re to how to obtain medicines
- **Syringe pump tracking:** to improve the number of syringe pumps available for clinical use

### 3.5 Workforce and Training:

The palliative and end of life care (PEoLC) workforce in Norfolk is under significant strain, with shortages in specialist consultants, uneven distribution of services, and reliance on generalist staff and voluntary sector support. Workforce gaps are contributing to inequities in access and challenges in delivering 24/7 care. According to Royal College of Physicians guidance, hospitals should have 1 WTE palliative medicine consultant per 250 acute beds. Across Norfolk's acute hospitals (NNUH, JPUH, QEH), there is a shortfall of 3.9–4.9 WTE consultants, depending on whether nurse consultant roles are counted.

Re training, we have focused on those groups who experience barriers in access to healthcare, by delivering two "No Barriers" courses to improve access to advance care planning for people with learning disabilities and dementia. We have also worked in partnership with EACH to train 573 Nurses and other healthcare professionals to support

babies, children and young people who are receiving palliative and/or end of life care, and their families.

### **3.6 Developing a PEOLC Dashboard:**

A PEOLC dashboard is a critical step in strengthening the quality, consistency, and equity of care for people in their last year of life. By collating key data across providers and care settings, the dashboard enables a system-wide view of performance, patient outcomes, and service gaps. The dashboard provides a clear, accessible mechanism for monitoring progress against local and national priorities, ensuring providers are accountable for delivering improvements. The dashboard highlights disparities in access and outcomes, particularly for patients with non-cancer diagnoses or those living in rural areas, enabling targeted interventions to reduce inequalities. Regular reporting through the dashboard creates a feedback loop, allowing services to measure the impact of changes and adjust strategies in real time. Commissioners and service leaders can use the data to identify trends, allocate resources more effectively, and design services that respond to patient needs. A summary of data from the dashboard/National sources is included in Appendix 1.

## **4. CHILDREN AND YOUNG PEOPLE:**

Palliative care for babies, children and young people with life limiting or life-threatening conditions is “an active and total approach to care, from the point of diagnosis or recognition (many children have no diagnosis) throughout the child’s life and death” (Guide to Children’s Palliative Care 2018). Like adult palliative care, it focuses on holistic care, enhancing quality of life both for the child/young person and their family. It includes symptom management, provision of short breaks, and care through death and bereavement. The numbers are small, but the impact of good palliative care resonates long after the death of the child or young person and it is important to ensure that services work together to facilitate this. Children’s palliative care is based on a holistic child and family centered model that combines active treatment with palliative management, including pre-bereavement and bereavement support to the family. As a result, paediatric hospices require different staffing, resources, and care models to meet the complex needs of children and their families<sup>4</sup>.

A key issue is the transition from children to adult hospice care, Norfolk and Waveney ICB has provided funding to EACH via Match Funding monies to lead a test and learn project for young people aged 14 years and over and their families. The aim of the project was to offer families the opportunity to attend a collaborative family drop-in session which offered an accessible, responsive service tailored to the needs of young people and their families.

## **5. CONCLUSIONS**

Following on from the review, we plan to continue to progress the work described in this paper and refresh and align commissioning for specialist palliative and end of life care to national standards. This shall support a reduction in variation and align more closely with national standards and provision in Suffolk. This work shall include specialist paediatric palliative care and Children’s Hospice services for children/young people with life-limiting conditions. This work shall support us to address inequalities in end-of-life outcomes by ensuring more equitable access to advance care planning across all neighborhoods and increasing access to palliative and end-of-life care for children and young people with life-limiting illnesses. More

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<sup>4</sup> [i] [Clark & Seymour, 1999](#)

children and families from Core20PLUS5 groups with palliative/end of life care needs will receive appropriate support.

In the longer term, this shall support the shift from hospital based to more community care, coordinated via a single point of access and shared care records to support more responsive and timely interventions from community-based integrated services at a Neighbourhood level.

**Additional responses:**

Below are responses to specific queries which HOSC wanted to be covered in the paper.

- **Further detail on the outcome of the review outlined in paragraph 3.1, including more specific information on the outcomes and the actions being planned to address areas of improvement, including timescales:** The review sought to gather information from all providers (acute trust, community trust, hospice and VCSE) to have a clear, evidence-based understanding of current service provision and what needs to change to enable the service to deliver high quality, equitable care.

Following initial information gathering, the ICB has hosted engagement workshops involving key stakeholders to further explore gaps in provision, areas of good practice that can be expanded and ideas for developing a new model of PEO LC for Norfolk and Waveney.

**Planned outcomes from the review:**

<b>Planned outcomes</b>	<b>Actions</b>	<b>Timeline</b>
More fair, transparent, and sustainable commissioning and funding model for palliative care in Norfolk and Waveney, with the right capacity to meet demand.	ICB consideration of new model of care and revised service specifications	Feb 2026
Improved discharge planning and admission avoidance through improved clarity in terms of roles and functions between hospice at home, community EOL beds and CHC Fast track.	Inclusion of discharge planning processes and admission avoidance as part of revised specifications	Feb 2026
Improved access to inpatient specialist palliative care, regardless of Place, in line with National benchmarking.	ICB phased business planning for additional inpatient capacity	Phased over 2026/7-2027/8
New outcome-based quality and reporting metrics to embed into contracts, once specifications have been agreed.	ICB consideration of new metrics as part of the new model of care and revised outcome-based service specifications	Feb 2026
Commissioning based on local population health needs, with re-balanced NHS funding contributions across V CSO providers.	ICB phased business planning for re-balanced contributions	Phased over 2026-2028/9

- **Clarification on what steps are being considered to address the capacity shortfall shown in appendix 1.** Table 1 refers to the hospice bed shortfall. The ICB shall progress phased business planning to address the shortfall in the number of specialist palliative care inpatient beds alongside a new model of care for Norfolk and Waveney. This shall also aim to improve access to “hospice at home” services and improved palliative care co-ordination.
  
- **Information on the funding mechanism for commissioned PEOLC services:**
  - *The current total spend on PEOLC services and the per capita spend:* The 25/26 Norfolk & Waveney ICB planned spend is £32,799,100. This comprises the total spend on palliative care paid as part of the block contracts to our acute and community providers for inpatient, outpatient, including hospice at home care, as well as grant and other payments to hospices, and total spend on “fast track” CHC packages. The average number of deaths per year from 2018-2024 is 12,367 per annum, this equates to a per capita spend of approx. £2,652.15 per person.
  
  - *Any differences in funding between hospice and NHS provision and details of how funding is calculated based on the setting:* Current funding arrangements for NHS and hospice providers are a mix of block contracts, annual payments, sub-contracting arrangements and episode/contact-based monitoring. There are also historic arrangements associated with changes to provision in the West locality. Current PEOLC contracts/grants are based on service cost rather than tariff, with negotiations taking place annually between both parties. Please note Norfolk & Waveney ICB general funding is typically based on recurrent exit position of the previous financial position plus cost uplift factor.
  
  - *Perceived issues with funding resulting from current commissioning processes, and/or national guidelines:* There are several perceived challenges affecting the funding and sustainability of Palliative and End of Life Care (PEoLC) services in Norfolk. These include; i) short-term funding arrangements impacting on provider ability to plan workforce and capacity in the long term (we plan to move to longer term funding arrangements over several years), ii) inconsistent investment across localities (our business planning going forward is based on population need, to phase in a more balanced approach to meet demand), iii) insufficient co-ordination of care between services (we have been exploring the different options to improve co-ordination via our engagement workshops).
  
- **Overall impact of funding shortfalls the ICB has experienced which may impact PEOLC provision:** Reduced financial flexibility may limit the ability to invest in proactive, community-based models of care, leading to greater reliance on reactive and acute services. The ICB is reviewing its commissioning arrangements to reduce the current variation in care and improve system value (through the right care being given to the right patient in the right care setting). There is an acknowledgement that investment is needed to address gaps in capacity. The business planning for this is phased to enable this in a sustainable way. This shall support the mitigation of the clinical risks and

variable patient/family experience of care associated with avoidable hospital admissions and insufficient co-ordination of care in the last weeks/days of life.

- **Opportunities identified by the ICB to maximise PEOLC funding, such as informing national government policies, and further service reviews etc:** Local service reviews, particularly around hospital activity, FastTrack Continuing Healthcare spend, and variation in community provision all offer opportunities to identify efficiencies and reinvest savings into proactive, community based PEOLC models. The ICB is actively exploring these opportunities. Strengthening data collection through digital tools such as MCCR and improved granularity of patient experience feedback can also support stronger business cases for sustainable national or regional investment.
- **Information on the approach to commissioning PEOLC services in Suffolk, including how the newly integrated ICB will adopt best practice from both counties into future commissioning and service delivery:** The newly integrated ICB will bring together the strengths, learning, and proven approaches from both ICB's to create a more consistent, high-quality model of Palliative and End of Life Care (PEoLC). Work to systematically review existing service models, performance data, and patient outcomes across the two areas has started, the ICB will identify best practice elements—such as effective digital care planning tools, successful community-based models, and strong multidisciplinary working—that can be standardised and scaled up across the wider system. Collaborative neighbourhood design workshops with providers, primary care, hospices, social care, and voluntary sector partners will ensure that commissioning decisions reflect what works well locally while addressing variation and gaps. The ICB will also use shared intelligence, including patient experience data and population health insights, to inform future service specifications and investment decisions. Through this approach, the ICB will create a unified commissioning framework that embeds evidence-based practice, reduces unwarranted variation, and supports equitable, person-centred care across both counties. Joint commissioning intentions for 2026/27 have been submitted.
- **More information specifically related to 'hospice at home' care, such as provider and funding information, monitoring undertaken:** The funding arrangements for hospice at home are summarised above. The provision of a revised hospice at home service will be addressed within the new model of PEOLC for Norfolk and Waveney. This involves the wider consideration of how hospice at home services relate to wider models such as 111 and virtual wards. Any new provision shall be equitable across Norfolk and Waveney.
- **Reference to planning for the Assisted Dying Bill:** The Assisted Dying Bill is a significant policy context for our work in Norfolk and Waveney. It shall require specific medico-legal processes to be put in place to protect patient wellbeing and preserve patient choice at the end of life. Our current focus is on improving the commissioning of palliative and end of life care, so that the system provision is consistent and of high quality. Once the National policy has been confirmed, there shall be consideration of the new processes that need to be put in place to support patient choice re assisted

dying. This shall need to be within the context of wider societal debate re death and dying and a public health “compassionate communities” approach.

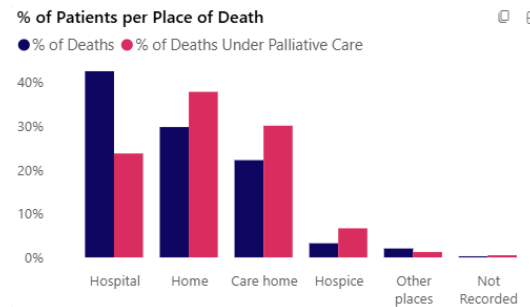
**Norfolk and Waveney ICB, December 2025**

## APPENDIX 1: NORFOLK AND WAVENEY PALLIATIVE CARE DATA

### 1. WHERE PEOPLE DIE

Graph 1 illustrates the distribution of deaths across different settings in 2024/25 (latest full year). This demonstrates that the largest number (~40%) of deaths currently occur in hospital with approximately 30% at home and 25% occurring in care homes. Less than 5% of deaths occur in hospices, although many people are supported by palliative care across all settings.

**Graph 1 - Place of death (2024/25)**



If this is compared with National data, this shows that our % of deaths in hospital are broadly consistent. This also shows that our % of people able to die in a hospice is lower than National data.

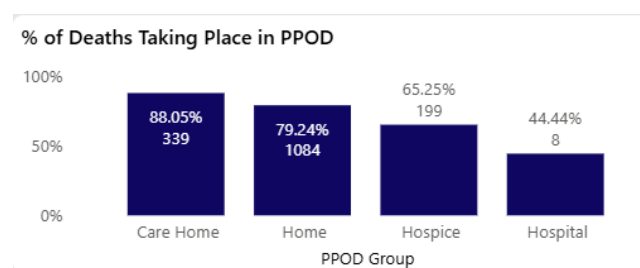
Expected National Variation (for context)	
Across England, regional rates typically fall in these ranges:	
Setting	Usual national range
Hospital	36% – 52%
Home	26% – 33%
Care home	12% – 28%
Hospice	2% – 8%

Gov.UK Palliative and EOL Care Profiles January 2025 Update: Statistical Commentary

### 2. PREFERRED PLACE OF DEATH

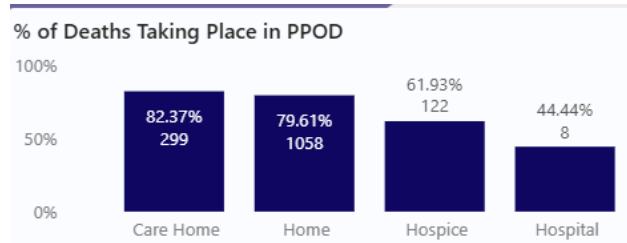
Graph 2 shows the proportion of people who died in their recorded preferred place of death. This demonstrates that many people who died in hospital would have preferred to die elsewhere and so underscores our ambition to provide better access to good quality personalised care at home and community settings, This reflects ongoing challenges in timely access to medicines, advanced care planning, workforce availability, and out-of-hours support.

**Graph 2 - % of deaths in preferred place of death (PPOD) 2024/25 (latest full year)**



When compared with 23/24 data, there has been an increase in the number of patients dying in a care home and also in a hospice.

**Graph 3 - % of deaths in preferred place of death (PPOD) 2023/24**

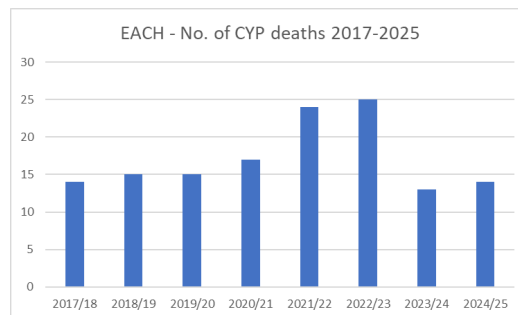


### 3. CHILDREN AND YOUNG PEOPLE

There is under reporting and under referral of children with complex life-limiting or life-threatening conditions which may be due to family’s perceptions of hospice care and therefore not accessing the services, and/or leaving it too late for the child or young person to be referred into hospice care.

Graph 3 shows an average of 17 deaths per annum. This is a small but significant number, given the wider family/community impact.

**Graph 4 – EACH hospice data - number of CYP deaths in PPOD between 2017 – 2025**



National guidance, including Together for Short Lives, NICE (NG61), NHS England Palliative and End of Life Care Strategy and the NHS Planning Guidance, highlights the importance of early identification and referral to holistic, family-centered support, which should run alongside curative or life-prolonging treatment. Therefore, the number of CYP deaths does not reflect the wider cohort of CYP and families who could benefit from ongoing support.

### 4. POPULATION-BASED NEEDS:

#### Adult needs:

The population of Norfolk and Waveney is aging, with increasing levels of co-morbidity and complex health needs. A starting point for understanding the need for palliative care is the number of deaths. In England, approximately 500,000 people die each year. Not all have palliative care needs prior to death, because their death may be unexpected and unpredictable, or from an external cause (such as accidents, homicide, suicide, etc.)

It has been estimated that about 25% of all deaths in England are unexpected deaths from acute causes. Many patients with chronic disease may also die unexpectedly, and it has been suggested that this could increase the proportion of unexpected deaths to 40%.<sup>5</sup> This work from the National Council of Palliative Care has formed the basis for our modelling of beds per 250,000 head of population. This is broadly aligned with The Revised Standards and Norms for Palliative Care in Europe<sup>6</sup>. This study recommends 80 to 100 specialist palliative care or hospice inpatient beds per 1,000,000 population.

**Table 1. Adult palliative care population need, current provision of adult palliative beds per place vs national recommendations**

Place	Total pop.	Pop. >=18	Av deaths per year 2018-2024	N beds for 20 / 250k	N beds for 25 / 250k	Current adult specialist beds	Shortfall 20 /250k	Shortfall 25 /250k
GYW	249,960	206,501	2892	16.52	20.65	6	10.52	14.65
North	180,832	153,167	2356	12.25	15.32	0	12.25	15.32
Norwich	237,683	194,029	2108	15.52	19.4	16	-0.48	3.4
South	251,315	204,763	2732	16.38	20.48	0	16.38	20.48
West	159,597	132,353	2279	10.59	13.24	0	10.59	13.24
System	1,079,387	890,813	12,367	71.26	89.09	22	49.26	67.09

Table 1 shows the number of deaths for the system and per locality compared to the national recommendations. This table also shows that we need between 49-67 specialist beds to meet the current needs of our local population<sup>7</sup>. The current number of specialist beds is 22, which leaves a shortfall of 27-45 beds. We have used the lowest estimate of 49 beds to calculate the inpatient capacity required through the rest of this document.

The 23 CHC fast track block contract beds are currently being re-procured – we are working in close partnership with the ICB Complex Care team to ensure any revisions are linked.

**Children’s palliative care needs:**

Children’s palliative care services also need to be factored into the planning as they include inpatient care. However, the focus in this specialty is often on maintaining care in the child and family’s preferred place of care rather than beds provided in the hospice environment. The current provision is 6 in-house beds for the system. The population health analysis for children’s services is shown below in Table 2.

**Table 2: Children’s palliative care population need:**

Place	Total pop.	Pop. <18	Average number of deaths in 2018-24 (under 18 population)	Av deaths per year 2018-2024
GYW	249,960	43,459		10.29
North	180,832	27,665		6.14
Norwich	237,683	43,654		10.14

<sup>5</sup> Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives Developed in collaboration with: Association for Palliative Medicine of Great Britain and Ireland, Consultant Nurse in Palliative Care Reference Group, Marie Curie Cancer Care, National Council for Palliative Care, Palliative Care Section of the Royal Society of Medicine December 2012

<sup>6</sup> [https://pmc.ncbi.nlm.nih.gov/articles/PMC9006395/?utm\\_source=chatgpt.com](https://pmc.ncbi.nlm.nih.gov/articles/PMC9006395/?utm_source=chatgpt.com)

<sup>7</sup> Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives Developed in collaboration with: Association for Palliative Medicine of Great Britain and Ireland, Consultant Nurse in Palliative Care Reference Group, Marie Curie Cancer Care, National Council for Palliative Care, Palliative Care Section of the Royal Society of Medicine December 2012

South	251,315	46,552		11.29
West	159,597	27,244		12.14
System	1,079,387	188,574	50	1,079,387

This table shows that the ICB needs to plan for approximately 50 under 18-year deaths per annum. NB A number of these deaths are neonatal. The Child Death Overview Panel (2022/23) shows that 34% of BCYP deaths were in the neonatal period, so these infants would not have left the acute hospital setting.

The ICB plans to extend the modelling of population need using National<sup>8</sup> and regional benchmarking tools to support the creation of a phased plan to address this deficit, given the extent of the associated costs.

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<sup>8</sup> [Palliative and end of life care - GOV.UK](https://www.gov.uk/government/collections/palliative-and-end-of-life-care)



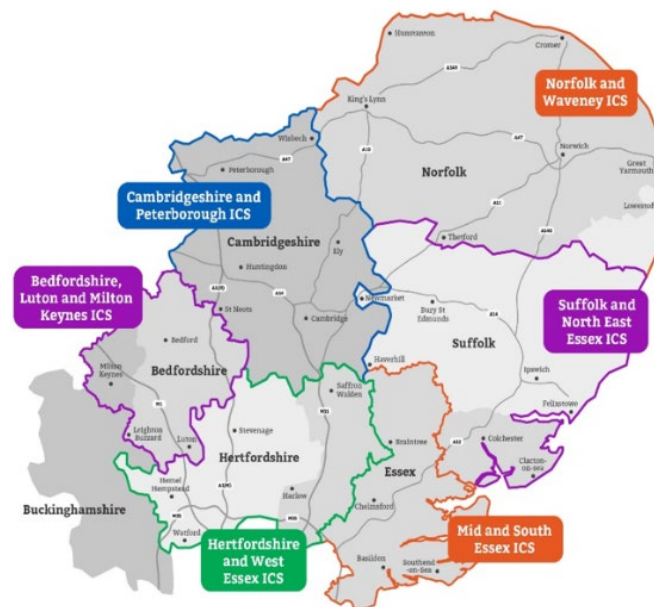
# Summary of Marie Curie Lived Experience Study for Norfolk County Council Health Overview Select Committee

# Background

## Why this study?

- Marie Curie and partners in the **East of England Palliative and End of Life Care Strategic Clinical Network** are committed to improving end of life care for all.
- The **Ambitions for Palliative and End of Life Care** set out a collaborative vision to achieve this.
- **NHS East of England** commissioned **Marie Curie** to conduct a study to understand to what extent the vision is matched by people's lived experience in the East of England.
- By inviting local people to share their perspectives, we were looking to **identify what is working well, as well as prioritise areas for improvement** – at a regional and individual ICS level.
- The findings of the study are to be shared primarily with East of England system leads and service providers for **collective review and action**.

## Geographical Scope



6 ICS in the East of England, including:

1. Bedfordshire, Luton & Milton Keynes (BLMK) ICS
2. Cambridgeshire & Peterborough ICS
3. Hertfordshire & West Essex ICS
4. Norfolk & Waveney ICS
5. Mid & South Essex (MSE) ICS
6. Suffolk & North East Essex (SNEE) ICS

Community engagement and partnership at heart of approach

# Responses

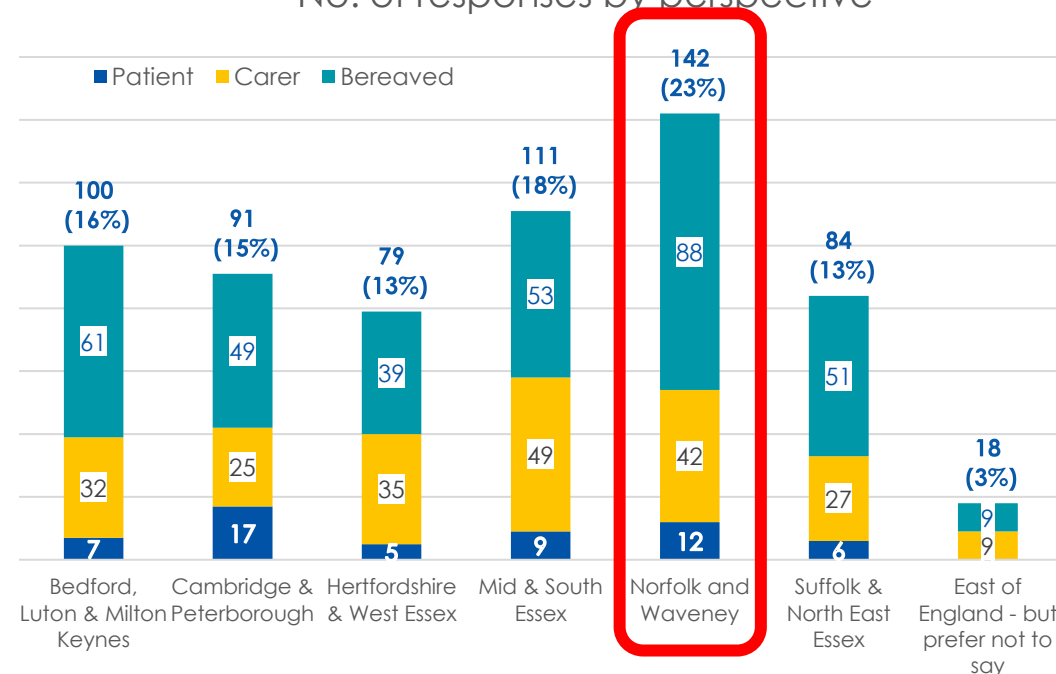
**625** Valid Responses

Location by Integrated Care System (ICS)* <i>(Where the patient/person cared for lives/d)</i>	PERSPECTIVE			Number of Valid Responses	% of Total Responses (625)
	Patient	Carer	Bereaved		
Bedfordshire, Luton & Milton Keynes	7	32	61	100	16%
Cambridgeshire & Peterborough	17	25	49	91	15%
Hertfordshire & West Essex	5	35	39	79	13%
Mid & South Essex	9	49	53	111	18%
Norfolk & Waveney	12	42	88	142	23%
Suffolk & North East Essex	6	27	51	84	13%
East of England - but prefer not to say	0	9	9	18	3%
<b>TOTALS</b>	<b>56</b>	<b>219</b>	<b>350</b>	<b>625</b>	<b>100%</b>

■ Patient ■ Carer ■ Bereaved



No. of responses by perspective



- There was strong engagement in the study. In total there were:
  - **625 valid survey responses**
- This included:
  - **492 free text responses** to the 'Further comments' question (79% people left a comment)
  - **154 free text responses** to a question about the needs of carers (70% of carers left a comment)
- Over **50 individuals** participated in a virtual interview or in-person group discussion

# Executive Summary

## A mixed and inconsistent picture

- **Findings presented a mixed and inconsistent picture**
  - Whilst there are areas of clear progress, many of the Ambitions continue to remain aspirational rather than fully realised.
  - The extent to which the different ambitions are being met varies significantly depending on the setting:
    - Hospices and community palliative care services outperforming hospitals and generalist care providers.
- **Respondents shared a spectrum of experiences**
  - From compassionate and well-coordinated care to distressing accounts of isolation and unmet needs.
- **Many common themes with *Better End of Life* programme**
- **Variation in experience makes it difficult to definitively assess the region's performance or rank achievement of specific ambitions**
  - However, issues around **Ambition 2 (Fair access to care)** and **Ambition 4 (Coordination of care)** stood out most clearly as requiring attention
- **Targeted and continued effort is required to realise the Ambitions in the East of England**
  - Participants shared their views on priority areas for improvement
  - Marie Curie reiterates a number of its key policy recommendations from wider research which would particularly respond to findings on patient experiences in the East of England

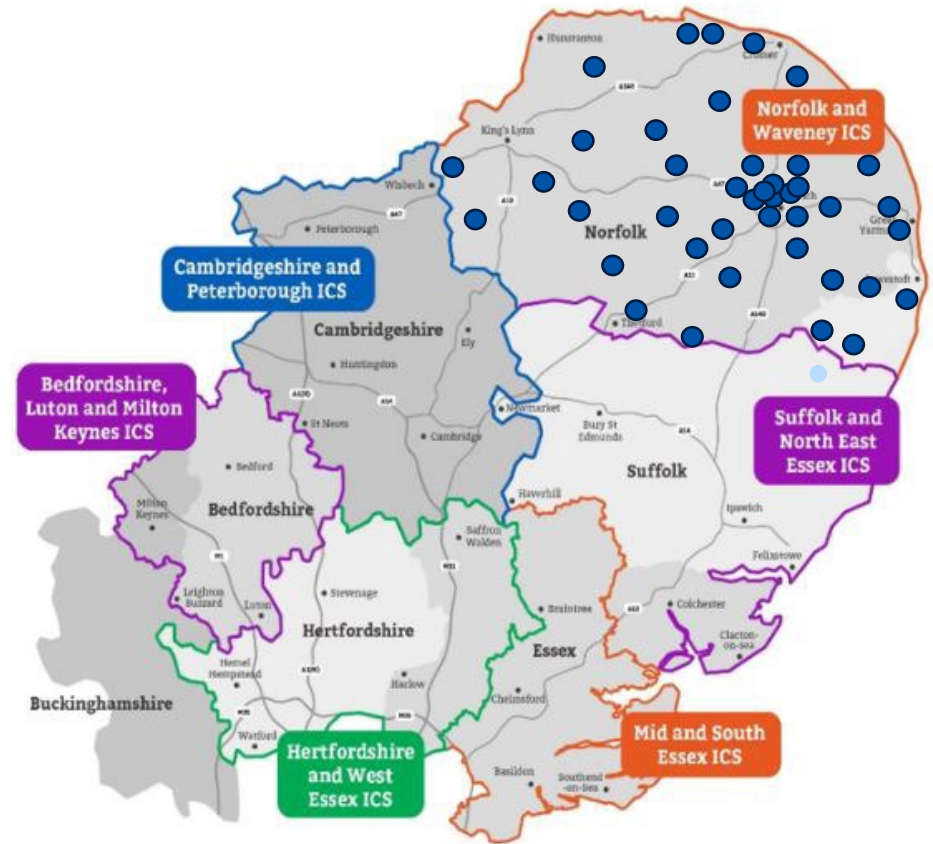


# Norfolk & Waveney ICS

Please note that due to rounding of all percentages, totals may not necessarily equal 100%.

# Overview

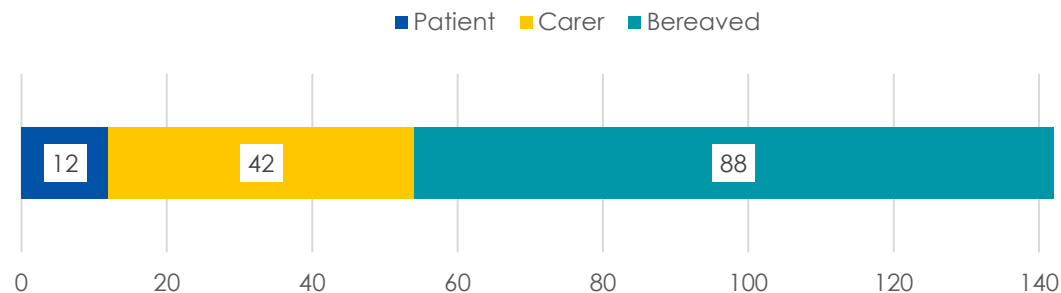
Norfolk & Waveney ICS			
Number of respondents	% of total East of England survey responses	Overall experience of care	
		Very good or good	Poor or very poor
142	23%	54%	27%



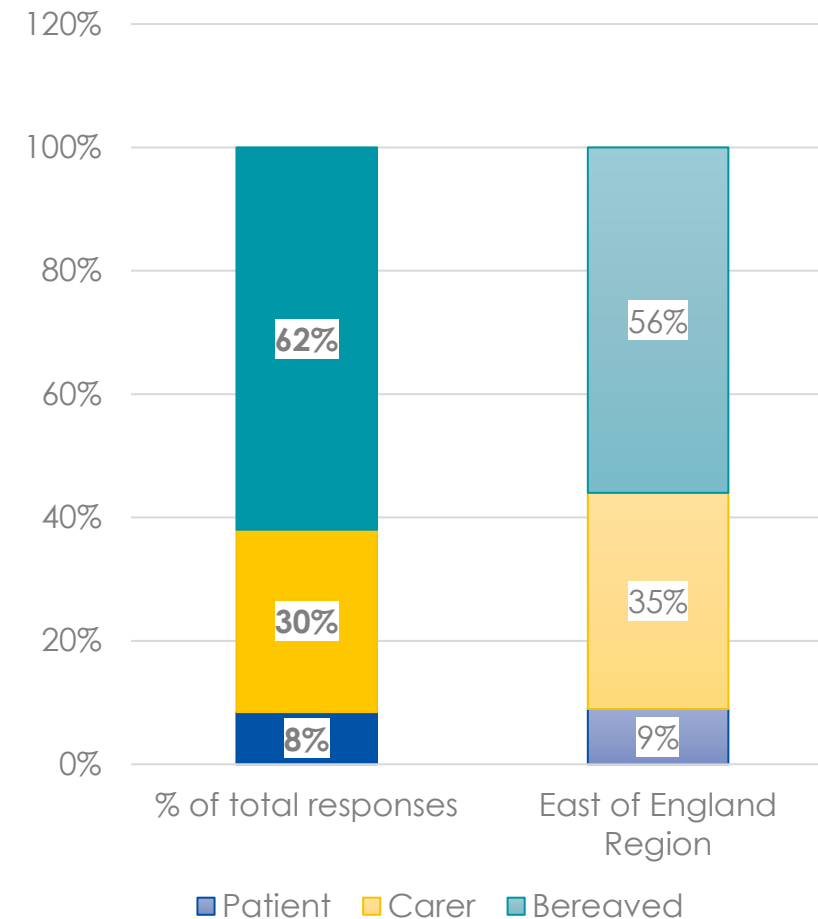
# Responses – By Geography

**142** Valid Responses

ICS	Patient	Carer	Bereaved	Total Number of Valid Responses
Norfolk & Waveney	12	42	88	<b>142</b>
% of Norfolk & Waveney Responses	<b>8%</b>	<b>30%</b>	<b>62%</b>	<b>100%</b>
<b>TOTAL EofE Region Responses</b>	<b>56</b>	<b>219</b>	<b>350</b>	<b>625</b>
Norfolk & Waveney as a % of Total East of England Responses	21%	19%	25%	<b>23%</b>

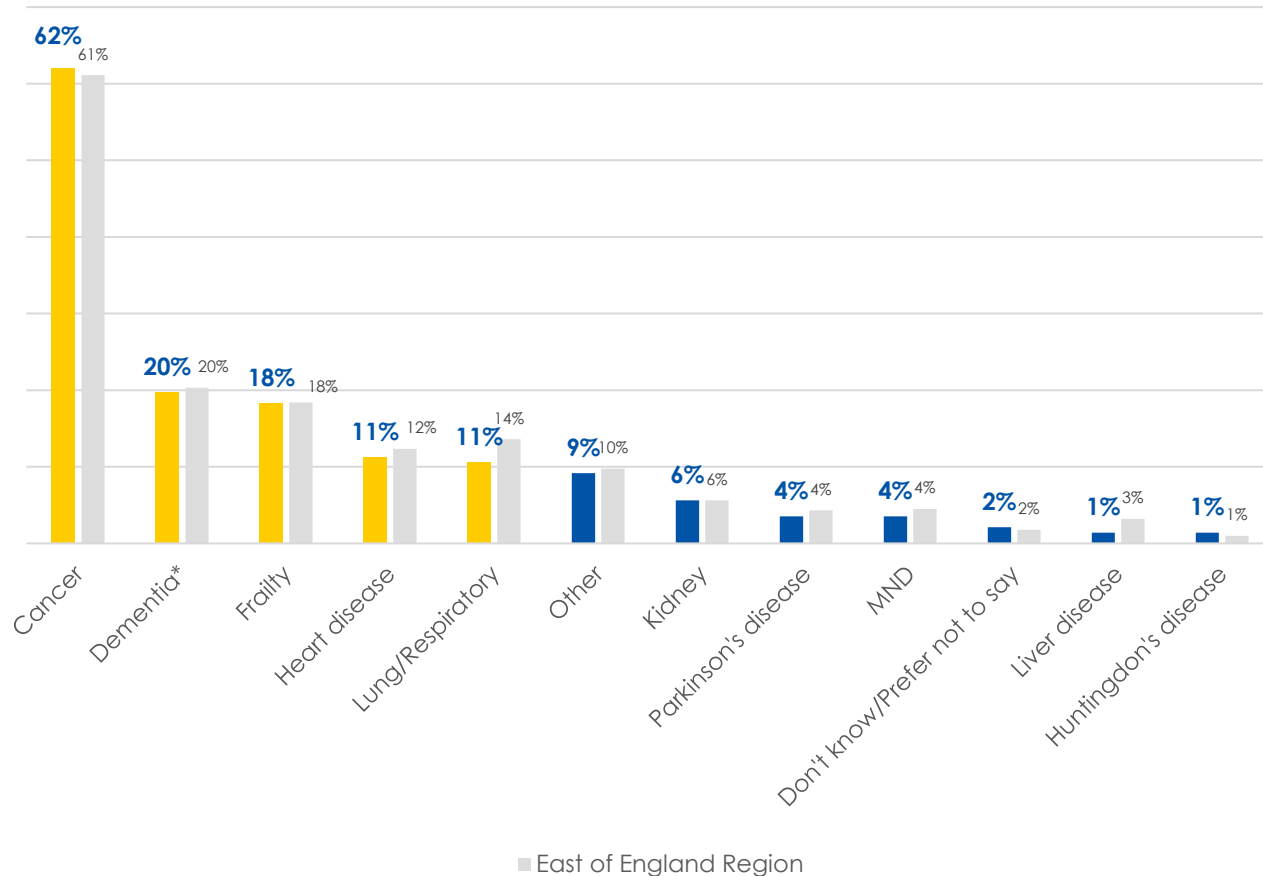


## Profile of respondents



# Patient Profile

Condition



## 5 Most Prevalent Conditions

Condition	No. of responses	% of total (142)	EofE Region
Cancer	88	62%	61%
Dementia*	28	20%	20%
Frailty	26	18%	18%
Heart disease	16	11%	12%
Lung/Respiratory	15	11%	14%

30% selected more than one condition, indicating almost one third living with multiple conditions

**Other** (9%) included:

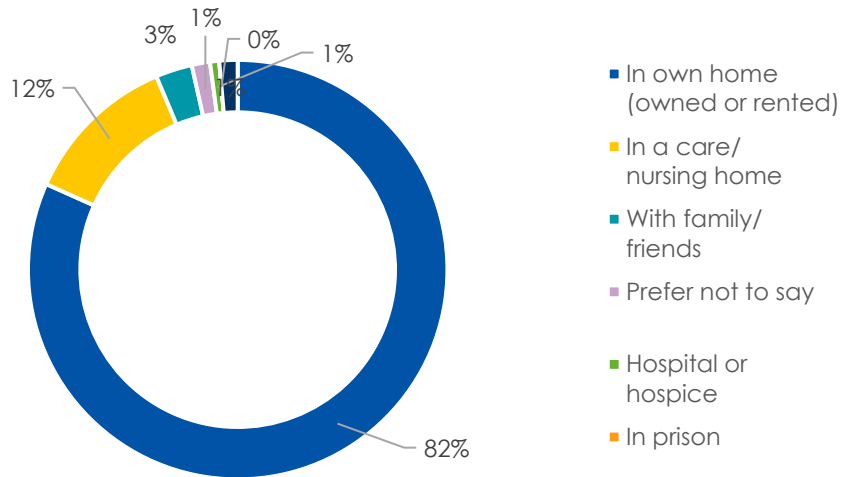
- Diabetes (3); Stroke (1); various (9)

\*including Alzheimer's

# Patient Profile

**Majority (82%) lives/d in own home**

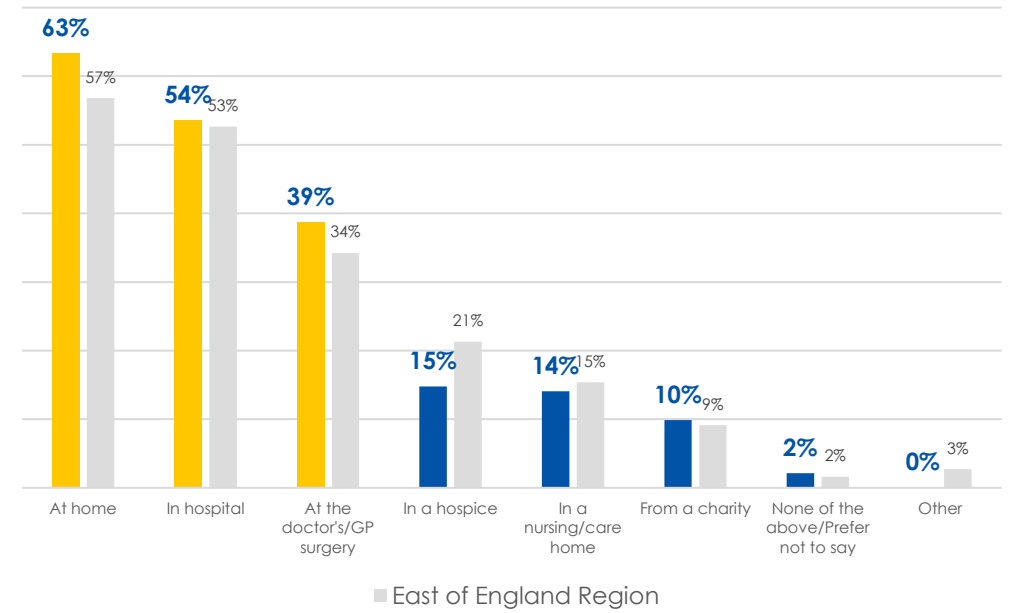
Where person cared for lives/lived



Of those living at home **just under a third (30%)** live(d) on their own

**Care was mostly received at home, in hospital and/or the GP surgery**

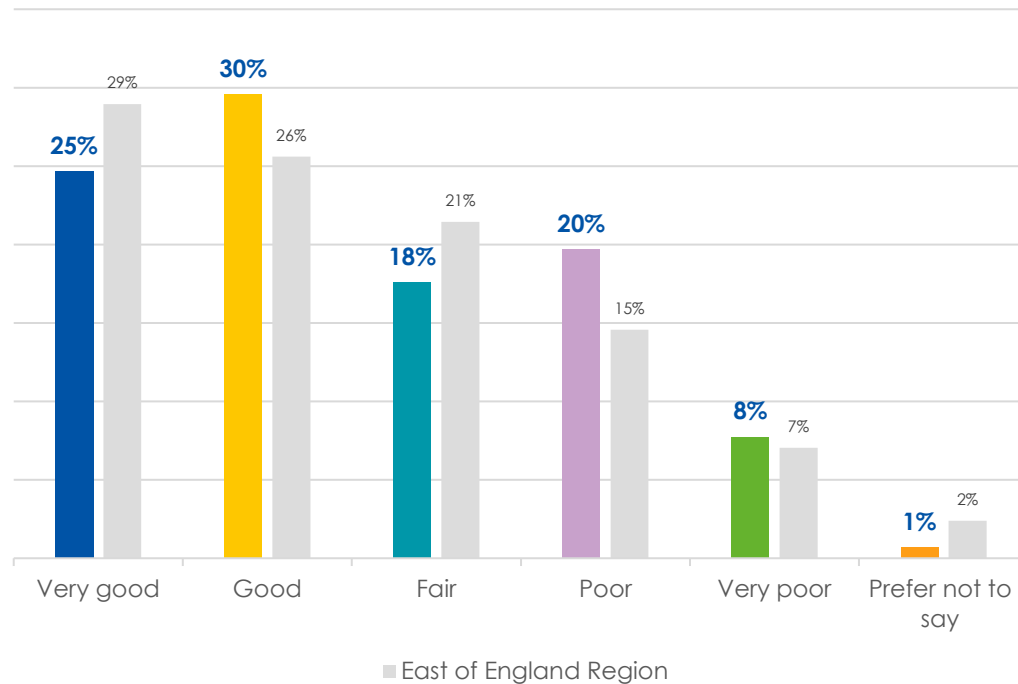
Where care received



# Overall Experience of Care

Q: Overall, how would you rate the experience of care you've received for your terminal illness?:

Overall experience of care



Overall experience	No. of responses	% of total (142)	EofE Region
Very good	35	25%	29%
Good	42	30%	26%
Fair	25	18%	21%
Poor	28	20%	15%
Very poor	11	8%	7%
Prefer not to say	1	1%	2%

**Just over half (54%)** rated their overall experience of care was 'Very good' or 'Good'

**Over a quarter (27%)** rated their overall experience of care was 'Poor' or 'Very poor'



# Ambition 1

Each person is seen as an individual

"I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's possible."

## AMBITION 1: Treated as an individual

# What the data shows ...

### Strongly Agreed and Agreed

- **Nearly two-thirds (63%)** 'Strongly agreed' or 'Agreed' that the person cared for was:
  - treated as an individual
  - treated with dignity and respect
  - involved in decisions about their care
- **Fewer** 'Strongly agreed' or 'Agreed' that the person cared for was:
  - listened to and wishes considered (**58%**)
  - faith and culture was respected (**50%**)

### Other points to note

- **Over a quarter (28%)** thought respect and support for the care recipient faith and culture was not applicable or did not know.

### Disagreed and Strongly Disagreed

- **About a fifth** 'Disagreed' or 'Strongly disagreed' that the person cared for was:
  - listened to and wishes considered (**20%**)
  - treated as an individual (**19%**)
  - treated with dignity and respect (**19%**)
  - involved in decisions about their care (**18%**)

## AMBITION 1: Treated as an individual

### Agree

"Community care (washing dressing etc) fantastic team very supportive always involved patient when able to. Asked questions if didn't know! Empathetic and respectful."

*Bereaved family member for someone with cancer*

"I am grateful the home took into consideration they're favourite music and continued to play it for them in their last days. I was not there for the passing but I hope that they passed listening to it. Still think they need more put in place to stimulate the dementia unit but physical care and kindness are fully there with the carers."

*Bereaved family member or someone with dementia*

## Some of the things people said ...

### Mixed

"My hospital consultant took a few meetings before he understood my wishes and the reasons for refusing the treatment offered which was traumatic for me. Not being truly listened to and trying to placate me. Consultant then placed in care of the GP who has not even contacted me since. I don't want treatment but I thought I'd get some help with end of life plan. But alas nothing."

*Patient living with a terminal illness*

### Disagree

"There has been no ACP discussion no discussion of palliative care no follow up since diagnosis you are left to your own devices. How someone copes who does not have any family/ friends support is beyond me, they are left to fend for themselves."

*Family carer*

"He desperately wanted to die at home, but because nobody listened we were denied that and he died in hospital."

*Bereaved family member for someone with cancer*

"The hardest thing was being able to talk to those providing care. As I had to balance work and caring for my father, the visits and discussions were always during the day with no advance warning so I couldn't arrange to be there. This made it difficult as my father didn't always understand/remember what was said. So advance notice of visits or a wider range of times."

*Family member supporting someone with cancer*

"My father was receiving treatment for cancer, and we were led to believe it was having an impact, to then out of the blue be told he was on end of life care and sent home. He was told on a busy ward and sent home. I contacted the ward to express my concern at his treatment and was told this happened regularly as they didn't have space to have 1-1 discussions."

*Bereaved family member - Child*

### Recommendations

"All care settings including Domiciliary Care Provision should be mandated to undertake RESPECT training and end of life care."

*Bereaved family member – Daughter-in-law*

"As a daughter and carer to be listened to as often close relatives know the ill person best."

*Family member supporting someone with multiple conditions*

"Medical profession should keep carers and kin fully informed of implications and prognoses and processes and protocols."

*Family carer*



## Ambition 2

Each person gets fair access to care

"I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life."

## AMBITION 2: Fair access to care

# What the data shows ...

**Always**

and

**Usually**

- **Over two thirds** felt they or the person cared for 'Always' or 'Usually' had access to:
  - medicines, including prescriptions (**69%**)
  - equipment (**68%**)
- **About half** 'Always' or 'Usually' had access to:
  - specialist advice from a doctor or other healthcare professional (**50%**)
  - general information and support about their illness (**49%**)
  - practical hands-on care (**49%**)
- **Less than a quarter** (**24%**) said they 'Always' or 'Usually' had access to support and advice on money and benefits

**Rarely**

and

**Never**

- **Over a third** (**35%**) said they were 'Rarely' or 'Never' able to access support and advice on money and benefits – however **28%** said it was 'Not applicable or didn't know.'
- **About a fifth** said they 'Rarely' or 'Never' had access to:
  - practical hands-on care (**23%**)
  - general information and support about their illness (**18%**)
  - practical hands-on care (**18%**)

## AMBITION 2: Fair access to care

### Agree

"The Hospice at Home team were absolute heroes. A hospice bed became available at the [hospice] for my Dad (which is what he and my Mum wanted for his place of death due to his condition (acute myeloid leukemia) and risk of catastrophic bleed) and he spent his last 48hrs there, it was a real blessing for us all to be under their care and support."

*Bereaved family member - Daughter*

### Recommendations

"As Norfolk has an aging population, with many over 65s coming here to retire, more needs to be done to ensure end of life care can take place in the patient's own home or hospice should that be the patient's wish. A dedicated Palliative/End-of-Life team is needed as a separate service to community nursing along with additional training for all newly qualified community nurses, who often encounter the dying patient for the first time."

*Health, social or other care professional supporting someone with a terminal illness in a personal capacity*

"Being able to contact someone by telephone instead of internet."

*Family member supporting someone with MND*

## Some of the things people said ...

### Mixed

"Most of the care was first class. What let it down was the medication side where Doctors were issuing prescriptions for items that were unavailable & having to travel around to find alternatives."

*Bereaved family member*

"The service has been very good, but I have only found out about things, like having a hospital bed, simply because when things became so bad, it was then offered as an option."

*Family carer*

"We were incredibly fortunate that hospice at home care (including a night sitter) was available where my parents live, however we were very aware that it was a postcode lottery situation (20 mins down the road in Suffolk, the same support was not available)."

*Bereaved family member*

### Recommendations

"A more succinct approach across the whole of the area, instead of a post code lottery." *Family member supporting someone with MND*

"Norfolk and Waveney need to review their approach to end of life care, patients who wish to remain at and die at home need ready access to generalist and specialist palliative in their home, telephone support is insufficient and leads to ambulance call outs and unnecessary attendances at accident and emergency." *Bereaved family member*

### Disagree

"The biggest concern is lack of care and support in the home environment, no palliative care or district nurse support available."

*Family carer*

"Prescriptions could not be fulfilled resulting in family members having to drive miles round Norfolk to find medication."

*Bereaved family member*

"Obtaining pain relief especially at night took more than 2 hours, sometimes even longer. On one occasion pain relief was delayed because controlled meds were discovered to be out of date which meant a delay of about 5 hours for pain relief. Very distressing for the patients and carer."

*Bereaved family member*

"My husband wished to die in The Hospice. Sadly this was unable to be facilitated, firstly because there were no beds and secondly when there was a bed available the ambulance service were unable to transfer him from hospital because of the amount of oxygen he was on. He died on a totally inappropriate area of [the hospital] as they didn't even have a side room we could use. As a nurse myself I feel the NHS really let us down."

*Bereaved family member - Wife*



## Ambition 3

Maximising comfort and wellbeing

"My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible."

**AMBITION 3:**  
Maximising comfort and wellbeing

## What the data shows ...

**Always**

and

**Usually**

- **Nearly two-thirds (61%)** felt the person cared for 'Always' or 'Usually' had support to make them feel as comfortable and free from pain as possible
- **Over half (58%)** felt the person cared for 'Always' or 'Usually' had help to manage their symptoms
- **Just under half (49%)** felt the person cared for 'Always' or 'Usually' had their needs regularly reviewed
- **Under a third (32%)** felt the person cared for 'Always' or 'Usually' had support to talk about their thoughts and feelings

**Rarely**

and

**Never**

- **A third (33%)** felt the person cared for 'Rarely' or 'Never' had support to talk about their thoughts and feelings
- **Half (50%)** felt the person cared for only 'Sometimes', 'Rarely' or 'Never' had their needs regularly reviewed with **just over a fifth (21%)** saying 'Rarely' or 'Never'

### AMBITION 3: Maximising comfort and wellbeing

## Some of the things people said ...

### Agree

"We have experienced an end of life care where a 24 hours support worker has been employed to be with the dying person and our carers where the 2nd person and carried out the night time care. This was amazing support and the gentleman had the care he deserved and support for the family could be given TIME is such a big thing in all of this we need to give end of life care time and support for things to go well."

*Family member supporting someone with multiple conditions*

### Recommendations

"Put psychological support in place for people as a matter of course, for both those with the terminal illness and their support network."

*Bereaved family member*

"Holistic approaches on all wards in a hospital. Recognition that a person is nearing end of life and for treatment to focus on the person and their needs rather than treating just a specific condition and carrying out unnecessary and sometime painful and invasive tests."

*Family member or friend supporting someone with a terminal illness*

### Mixed

"Also in relation to provision of necessary helpful equipment the professionals making the decisions should discuss and take into consideration the opinions of the carers actually caring for the patient as they actually are experiencing what is actually helping and what is not."

*Bereaved family member - Husband*

"My experience of [the Hospice] was amazing. However, main stream care via [ ] was awful. No compassion was given, treatment was mediocre."

*Family member supporting someone with cancer*

"Previous experience in caring for a terminally ill has been much more positive than this. Rather than getting better it appears that things are sadly getting worse, especially from a Social Services point of view".

*Family member supporting someone with cancer*

### Disagree

"Support in caring ie how to do things. Managing the medication which is very scary. Especially controlled drugs".

*Family member supporting someone with cancer*

"Two women and NO men to provide same sex intimate care; and also for some of the cares to be much more gentle with mum - ..... any cleaning necessary is excruciatingly painful."

*Family member someone living with cancer*

"The situation we were in was abhorrent. ...The team involved with us were in life saving mode and even discussed getting my Mum back home and getting her home care back in front of her the day before she passed. Numerous times we pressed the alarm for help and the help never came, I had to beg for pain relief for her in the corridor."

*Bereaved family member - Daughter*

"My Dad only wanted to die with dignity and pain-free, and I had to fight for both of those. It was clear that he was in the last hours of life and yet I had to argue with the medical team to stop trying to catheterise, cannulate, send him for xrays and just give him analgesia. "

*Bereaved family member - Daughter*



## Ambition 4

Care is co-ordinated

"I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night."

**AMBITION 4:**  
Care is co-ordinated

## What the data shows ...

**Strongly Agree** and **Agree**

- **Under a third (30%)** 'Strongly agreed' or 'Agreed' that different healthcare professionals know their medical history and talked to each other

**Disagree** and **Strongly Disagree**

- **Over a half (51%)** 'Disagreed' or 'Strongly disagreed' that different healthcare professionals know their medical history and talked to each other - a further **15%** were neutral about this

## AMBITION 4: Care is co-ordinated

### Agree

"Therapy Team (OT and PT) very very good. Listened to patients wishes, pushed for GP to listen and write Respect form following conversations. Ordered equipment quickly and supported use of this equipment, referred for help in regards to washing and dressing."

*Bereaved family member*

### Recommendations

"I'd like to see something more joined up and more information for families about what's available to them. More information about what to expect would be helpful and tools for planning end of life."

*Bereaved family member*

"There needs to be more collaborative working, with a single point of contact at home or in a care home for the NOK."

*Bereaved family member - Daughter*

"End of life home care needs massive improvements if wish to keep these people out of hospital taking up a bed where no medical involvement is needed anyhow."

*Bereaved family member*

## Some of the things people said ...

### Mixed

"As my husband's carer the biggest issue was getting end of life care promptly. He'd been referred to palliative care but because he'd not needed it immediately he'd dropped off the list, which seemed crazy and it was hard to get responses from anyone. Eventually we got help via an ambulance crew who could talk to people who wouldn't talk to me, but it made for a very stressful period when we both knew he was dying. When carers came they were lovely."

*Bereaved family member - Wife*

### Recommendations

"Update the old system that is currently based on community care being provided by a patient's postcode when there are nearer options that would save a lot of unnecessary waiting especially overnight and out of hours. Receiving split community care is not in the best interest of a dying patient and is not acceptable. Change is needed!"

*Bereaved family member*

### Disagree

"Joined up communications, so many mixed messages and a total lack of joined up care/interventions. Patients and carers are passed on to other services. It always seems to be another services responsibility and we all just go around in circles, which is time consuming, frustrating and breaks down trust in our services."

*Volunteer/community member supporting and/or caring for someone living in the East of England with a terminal illness*

"When discharged from the hospital we were told that dad would have 24/7 palliative care available. This was not the case. He was discharged with no community nursing in place, there was little or no assistance when we needed help. And when they did arrive, sometimes it was 5 hours later."

*Family carer - Child*

"My mother was discharged from [hospital] on a Friday afternoon/evening. I would advise that no one is ever released from hospital at this time, as getting any kind of coherent help on a Saturday or Sunday was dreadful. The joining up of her discharge with the palliative care in the community team just didn't happen, nor with the district nursing team."

*Bereaved family member - Daughter*

"We were not given any information about benefits and only found out very late on that he could have claimed Attendance Allowance. We struggled to know where to get help and eventually managed to get a hospital bed and help from [the hospice] in the last week of his life. [The Health Centre] were dreadful and the doctor was disrespectful. Struggled to get pain relief. Social Services were useless and gave incorrect information to us which delayed us getting help."

*Bereaved family member*



## Ambition 5

All staff are prepared to care

"Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care."

**AMBITION 5:**  
All staff are prepared to care

## What the data shows ...

**Strongly Agree** and **Agree**

- **Only about half** 'Strongly agreed' or 'Agreed' that those who provided care:
  - were knowledgeable, confident and compassionate (**58%**)
  - understood what mattered most to the patient and worked with them to do what was possible (**50%**)
- **Under half (46%)** 'Strongly agreed' or 'Agreed' that those who provided care gave enough information so that the patient/carer knew what to expect and could make choices about care

**Disagree** and **Strongly Disagree**

- **Nearly a third (32%)** 'Disagreed' or 'Strongly disagreed' that that those who provided care gave enough information so that the patient/carer knew what to expect and could make choices about care
- **About a quarter** 'Disagreed' or 'Strongly disagreed' that that those who provided care:
  - were knowledgeable, confident and compassionate (**28%**)
  - understood what mattered most to the patient and worked with them to do what was possible (**24%**)

**AMBITION 5:**  
All staff are prepared to care

## Some of the things people said ...

### Agree

"The end of life nurses were exceptional we couldn't of asked for more."

*Bereaved family member*

"My hospital oncology team and hospice team are excellent and connect me to lots of support including [charity groups]. My consultant speaks to me every month to see how I'm doing and my LCNS is always helpful if I need anything. The hospice are outstanding. Without them I'd have given up by now."

*Patient living with cancer*

"Community services are stretched but the teams on the ground respond appropriately and with timeliness and professionalism."

*Bereaved family member*

### Recommendations

"Please improve the training that some doctors appear to need in caring and supporting death."

*Bereaved family member*

### Mixed

"Before my husband went into the Hospice his care was not particularly good but once the hospice got involved we could not have asked for more - they were all brilliant."

*Bereaved family member - Wife*

"I have been shocked at the variation in both the compassion and competence of the carers who were looking after my friend. Carers smelling strongly of smoke, not talking to the patient at all, treating the family in a manner that is not acceptable. There were some very good carers but this sadly is not the overriding memory the family will be left with."

*Volunteer supporting someone with cancer*

"Nursing care varies enormously in hospital. Some nurses are not taking their roles seriously beyond the drugs round. Few nurses observe or make assessments of the patient. Some nurses are not compassionate towards family of patient."

*Family member supporting someone with cancer*

"GP support could have been better, they were kind but did not offer any home visits to understand how unwell /in pain my husband was, just kept upping the morphine patches by phone appointments."

*Bereaved family member - Wife*

### Disagree

"A dedicated Palliative/End-of-Life team is needed as a separate service to community nursing along with additional training for all newly qualified community nurses, who often encounter the dying patient for the first time."

*Family member supporting someone with multiple diagnoses*

"Some of the carers coming into the home were patronising and not very knowledgeable. They were often in a rush."

*Bereaved family member - Wife*

"Gp and the whole practice very poor. Communication between different Gps very poor. Anticipatory medication written up incorrectly. Difficulty in getting pain relief out of normal hours."

*Bereaved family member*



## Ambition 6

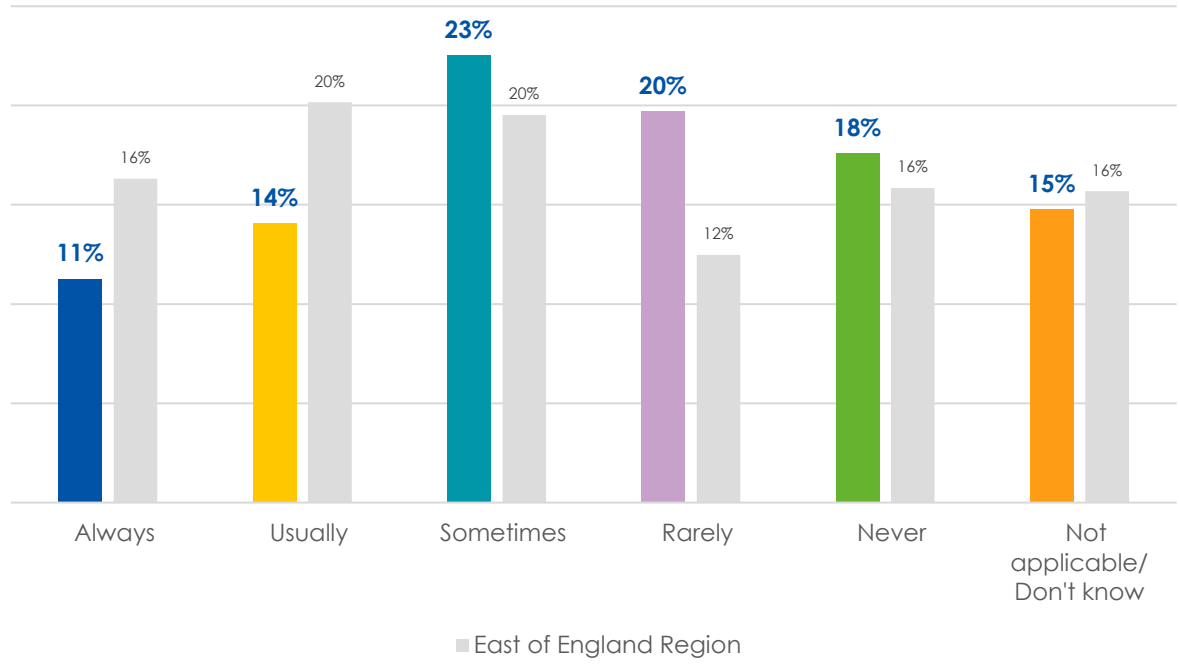
Each community is prepared to help

"I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways."

**AMBITION 6:**  
Each community is prepared to help

Q: Are you able to get the following help and support when needed?

Emotional and practical support from people and groups in your community



Emotional and practical support from people and groups in the community	No. of responses	% of total (142)	EofE Region
Always	16	11%	16%
Usually	20	14%	20%
Sometimes	32	23%	20%
Rarely	28	20%	12%
Never	25	18%	16%
Not applicable/Don't know	21	15%	16%

**A quarter (25%) said they 'Always' or 'Usually' received emotional and practical support from groups in the community**

**Over a third (37%) 'Rarely' or 'Never' had this support and a further 23% only 'Sometimes'**

**AMBITION 6:**  
Each community is prepared to help

## Some of the things people said ...

### Agree

*No supporting quotes in survey responses*

### Mixed

"Most support came via community and charities at end of life not within healthcare."

*Bereaved family member*

### Disagree

"How someone copes who does not have any family/friends support is beyond me, they are left to fend for themselves."

*Family member supporting someone with dementia*

### Recommendations

"More availability to access voluntary workers for one to one during end of life periods."

*Family member supporting someone with dementia*

"It would be really helpful to be told about the 'process of dying' and all the different stages. My family and I weren't prepared for the changes / deterioration / reactions / the ways that a body shuts down. There were lots of occasions towards the final stages that were horrific and harrowing and we just weren't prepared."

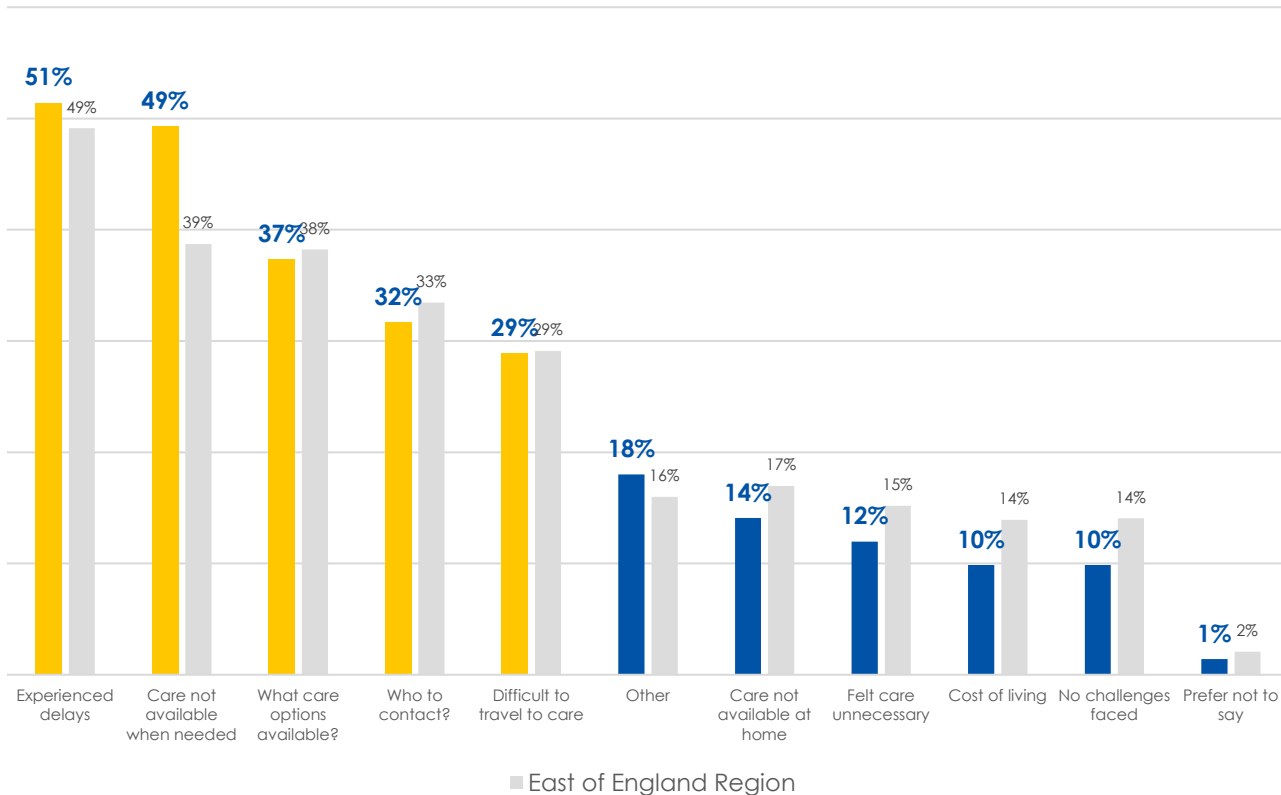
*Bereaved family member*



# Challenges

# Challenges

Challenges in order of most frequently selected



## 5 Most Commonly Experienced Challenges

Challenge	No. of responses	% of total (142)	EofE Region
1. Experienced delays in care, treatment or transfer between services	73	51%	49%
2. Care not available when needed or quickly enough (eg at night)	70	49%	39%
3. Not sure what care options are available	53	37%	38%
4. Not sure whom to contact or how to reach them	45	32%	33%
5. Difficult to travel to where care provided	41	29%	29%

**89%** experienced at least one challenge with regards to their care

**66%** selected multiple challenges

# Report to Health Overview Select Committee

Item No: 7

**Report Title: Norfolk Medicines Support Service**

**Date of Meeting: 15 January 2026**

## Executive Summary

This report sets out the planned closure of the Norfolk Medicines Support Service (NMSS) from 31 March 2026, following a review that found the service's model outdated and not integrated with current NHS systems. The decision to decommission NMSS was made by the ICB executive management team, based on recommendations from the Medicines Optimisation Team.

A transition plan is being developed to ensure patients continue to receive appropriate support, with care moving into primary care teams and structured medication reviews.

Stakeholder engagement and patient feedback will shape the transition, aiming to improve outcomes and ensure a smooth handover for all affected patients. The changes reflect a broader move towards more integrated, sustainable medicines support across Norfolk.

## Action

- 1. The Health Overview Select Committee is asked to examine the report and to make any comments or recommendations on the transition plan as a result of today's discussion.**

## 1. Purpose of today's meeting

- 1.1 To provide members with an opportunity to consider and inform the transition plan being developed to support patients following the closure of the Norfolk Medicines Support Service.
- 1.2 Representative of Norfolk and Waveney Integrated Care Board will be in attendance to answer members' questions.

## **2. Previous reports to the Health Overview Select Committee (HOSC)**

- 2.1 This is the first time the Norfolk Medicines Support Service has been considered by HOSC.

## **3. Background Information**

- 3.1 NMSS has supported Norfolk residents with medication compliance since 2003, but recent reviews found the service outdated and poorly integrated with modern NHS systems.
- 3.2 Currently, around 2,000 patients are registered for ongoing support, either receiving compliance aids or Medication Administration Record (MAR) charts.
- 3.3 Nationally, similar services have been withdrawn as care increasingly shifts to primary care teams and integrated neighbourhood models. Norfolk's transition reflects this wider move, aiming for more efficient, joined-up support that better meets current patient needs.
- 3.4 Standalone services like NMSS have largely been phased out, in line with national guidance from the Royal Pharmaceutical Society and NHS England, which emphasise individual assessment, patient independence, and the use of original packaging wherever possible.
- 3.5 Local authorities and ICBs commission medicines optimisation services tailored to their populations, and guidance is regularly updated to reflect best practice and statutory requirements.

## **4. Suggested Approach**

- 4.1 The committee may wish to explore the following areas with representatives from the Norfolk and Waveney Integrated Care Board:
- a) Transition Planning and Patient Safety
- How the transition plan will ensure that all current NMSS patients will continue to receive safe and effective support.
  - The measures in place to identify and mitigate risks for vulnerable patients during and after the transition.
- b) Integration and Workforce Development
- How primary care teams will be supported and upskilled to take on responsibilities previously managed by NMSS.
  - Whether additional training and resources will be provided to ensure consistency and quality in medication support across Norfolk.

- c) Stakeholder and Patient Engagement
  - How the views and experiences of service users will be captured and used to shape future medicines support.
  - What communication strategies are in place to keep patients, carers, and providers informed throughout the transition.
  
- d) Equality and Access
  - How the transition plan will address potential inequalities in access to medication support, particularly for those in rural areas or with complex needs.
  - The steps being taken to ensure that alternative providers (such as online pharmacies) are accessible and appropriate for all patients.

## 5. Recommendations

- 5.1 The Health Overview Select Committee is asked to examine the report and to make any comments or recommendations on the transition plan as a result of today's discussion.

## 6. Background Papers

- 6.1 None.

### Officer Contact

If you have any questions about matters contained within this paper, please get in touch with:

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Agenda item: 7

<b>Subject:</b>	<b>Norfolk Medicines Support Service – closure and transition planning</b>
<b>Presented by:</b>	<b>Dr Frankie Swords, Executive Medical Director, Norfolk and Waveney ICB</b>
<b>Prepared by:</b>	<b>Helen Palmer, Head of Pharmacy Workforce and Business Development</b>
<b>Submitted to:</b>	<b>Norfolk Health Overview Select Committee</b>
<b>Date:</b>	<b>15 January 2026</b>

### **Executive Summary**

The Norfolk Medicines Support Service will be decommissioned from 31 March 2026 following a service review.

A transition plan is being written by the ICB’s Medicines Optimisation Team to support the provision of care within primary care teams, to ensure patients continue to receive appropriate support.

## **Report**

### **1. Background**

The Norfolk Medicines Support Service (NMSS) has operated since 2003 to support patients with medication compliance issues in Norfolk.

NMSS receives funding from both health (ICB) and social care (Norfolk County Council) commissioners, to support people identified with medication compliance problems. The service specification includes:

- Assessment of patients and recommendation of interventions
- Funding supply of medicines compliance aids through pharmacies and dispensing surgeries and Medicines Administration Record charts for home care support workers
- Some training for care workers and support with NCC policy writing

In recent months, the service has been reviewed in line with sustainable commissioning processes which found that its aims and methods are outdated and no longer fit for purpose. The service is not integrated with wider NHS systems, it has limited pharmacy capacity, and it cannot demonstrate value for money. The contracts with suppliers have also expired, and funding from Norfolk County Council will cease after 2026/27.

The ICB executive management team have therefore taken the decision to decommission the current service provision. The contract expires on 31 March 2026, and notice has been given to the provider that the contract will not continue post this date.

The ICB medicines optimisation team is currently constructing a transition plan with the provider, other stakeholders and service users, to ensure that alternative and more appropriate services are put in place to support these patients, including structured medication reviews in primary care and improved guidance on how medicines can be supplied.

## **2. Service review outcomes**

The following issues were found during the service review:

- Very limited understanding of the patient cohort using the service due to the operational and technological isolation of the current service provision. Patient records are separate and as such, do not allow for data utilisation to understand how needs may be supported in an integrated manner with their usual service providers in primary care settings
- Current service is not fit for purpose in modern NHS provision and operates in isolation from other NHS services. The aims and objectives of the service are over 20 years old, and predate the development of PCNs, online pharmacies, and the move to work in Integrated Neighbourhood Teams
- The service has not been able to evidence value for money, and evidence of benefit has always been difficult to demonstrate throughout its operation. Support to social care has reduced over time from the current service providers
- NMSS only supports patients in the county of Norfolk – service for the Waveney area has never been commissioned. There is no similar service that operates in the Suffolk geography.
- Pharmacy and dispensing surgery capacity for the provision of medicine compliance aids is also limited with around one-third unable to support patients with additional aids once assessed, leading to further inequity of service provision, and reliance on unfunded courier services.

During this review period, NHS reorganisations have been announced, which impacts on the long-term ability of the current service provider to continue provision. Due to the small number of staff associated with the service this also creates a risk of service instability in the short term.

Throughout England, several similar services used to exist, but many have been withdrawn over the last 2-5 years – usually for reasons of affordability and value. Discussions have taken place with North Central London ICB who withdrew funding support in March 2024,

and they have reported no significant ongoing issues. This ICB produced supporting guidance for suppliers and has agreed that this can be amended for local use.

### **3. Transition Plan and Future Patients**

There are approx. 2,000 patients who are registered for ongoing support, either supplied a compliance aid or Medication Administration Record (MAR) chart. Equality and Clinical Quality impact assessments were undertaken and passed at ICB panel in November 2025, which is supporting the development of transition planning. We anticipate that referrals into NMSS will cease mid-January to enable the service activity to wind down.

The transition plan is an active document being used by all parties in NMSS (i.e. Arden GEM CSU, ICB and NCC) to identify and mitigate issues, plan training, required resources and communications. These discussions are active and in development through a Working Group.

An outline summary of the developing transition plan is:

- MAR charts – are documentation used by social care, and as such will become a responsibility of the home care provider to supply. NCC will support the specific elements of transition relating to MAR charts and care worker training.
- New patients i.e. those who will present in the future – a resource pack is being developed to support primary care health professionals to provide appropriate advice and guidance to patients who might previously have been referred into this service. In addition, training sessions will be provided to upskill conversations in this area of practice. This provides opportunity for professionals to work together to ensure that patient's needs are supported.
- Legacy patients i.e. those in receipt of medicines compliance aids – all legacy patients will be offered a personalised review process. This will include a Structured Medication Review by a pharmacist where appropriate, (incentivisation is included within the Prescribing Quality Scheme 25/26), to ensure that their current medication is optimised for their needs. It will also include a review by the current medication supplier to recheck whether a compliance aid is still in the best interests of the individual, and to ascertain eligibility for compliance aid supply under the Equality Act, and or to consider alternative means, including consideration of home delivery via national online pharmacies Documentation is being developed to support this review by the medication supplier.

The ICB is in process of obtaining pseudonymised data of current NMSS users. This data will be utilised amongst other planning aspects to highlight other services that patients are in receipt of – or who may benefit from additional service referrals due to previously unidentified risks e.g. falls or frequent hospital admissions. It will also support patient communications and engagement by giving detailed demographic data – which has to date been unavailable from the service provider.

Communications will start with health and social care providers in early January with next steps and ongoing feedback taken into consideration for transition planning.

#### **4. Stakeholder engagement**

The ICB recognises the impact and value of the patient's perspective. In the New Year an engagement activity is planned to conduct semi-structured interviews with a sample of service users to capture views on how assessments and ongoing care could be provided in the future.

Feedback captured by the current service provider demonstrates a high level of satisfaction with NMSS. The most prominent themes are improved medication safety, enhanced independence, and appreciation for the staff's caring and responsive approach. The service's adaptability and integration of technology are also valued, helping to address individual needs and support ongoing wellbeing. The transition planning will embed this approach within broader care pathways that are accessible to all patients through their usual health care provision.

#### **5. Risks of compliance aids and alternative providers**

Compliance aids (otherwise known as MDS or "Dossett" boxes) offer a way to organise medicines into days of the week and times of the day. Whilst traditionally seen as beneficial to improve compliance, risks associated with these devices are increasingly being recognised, for example:

- Confusion with use of the device – leading to taking incorrect medicines.
- Not all medicines being suitable for use in a device. For example regular medications that need refrigeration, those which need to be taken separately from other medications (but at a similar time of day), injectable medications, and medications which need to be taken in relation to food not to time of day can lead to inconsistent compliance.
- Loss of flexibility - short term medications are not suitable for addition to Dossett boxes, and they are not flexible enough for rapid dose changes for example where a medication is paused or increased due to a short-term illness.
- Difficulty opening devices – dropping tablets or omitting doses.
- Difficulty storing and transporting devices – meaning that tablets may skip between boxes making concordance worse.
- Increased risk of dispensing errors – redispensing of medicines from original packaging by pharmacies, increases pressure on their workload and reduces pharmacy time on other activity.
- Increased risk of out of date dispensing due to siloed working and the separation between prescribing and dispensing.
- Memory issues – if present can still lead to medicines not being taken.
- Reliance on a compliance aid may also reduce patient understanding of what their medication is for and when to take it, undermining moves to empower people to understand what they are taking, why, when and how, as they take only what is in the box.

Professional guidance is available to support pharmacists and associated professionals with the supply of compliance aids which will be referred to in the transition resource pack.

Should the patient's usual pharmacy or dispensing surgery be unable to supply a compliance aid, several online providers have been identified where patients can be signposted to if they wish to use this service.

## **6. Conclusion**

In summary, the decommissioning of this service is an opportunity for refreshed collaborative approaches between primary care teams, and to upskill healthcare professionals, to better address the needs of patients, and reduce the reliance on compliance aids.

# Report to Health Overview Select Committee

Item No: 8

**Report Title: Appointment of Link Member to Norfolk and Suffolk Foundation Trust**

**Date of Meeting: 15 January 2026**

**Responsible Cabinet Member: N/A**

**Responsible Director: Caroline Clarke, Director of Democratic and Regulatory Services**

## Executive Summary

The Health Overview Select Committee is requested to appoint a Member to act as a link with the Norfolk and Suffolk Foundation Trust (NSFT).

## Action Required:

1. To appoint a link Member for NSFT for the Select Committee.

## 1. Background and Purpose

- 1.1 The Health Overview Select Committee (HOSC) appoints Link Members to attend local NHS meetings held in public in the same way as a member of the public might attend. Their role is to attend and observe public meetings, meet regularly with provider representatives and provide a link between HOSC and the organisations – providing updates where appropriate.
- 1.2 A nominated Member may attend in the capacity of a HOSC Link Member. Other Members of HOSC may also attend meetings as a member of the public if they wish.
- 1.3 At its meeting on 24 July 2025, Cllr Jill Boyle was appointed Link Member to NSFT. Following her recent resignation from HOSC due to new responsibilities at North Norfolk District Council, the link member position is now vacant.

## 2. Proposal

- 2.1 For HOSC to appoint a Link Member for NSFT.

### **3. Impact of the Proposal**

- 3.1 Having a link member to NSFT strengthens democratic oversight by improving transparency, enabling early identification of issues, and ensuring local concerns influence service improvements.

### **4. Evidence and Reasons for Decision**

- 4.1 As above.

### **5. Alternative Options**

- 5.1 If a link member is not approved at this meeting, the position will remain vacant and the committee can revisit the issue at a future meeting.

### **6. Financial Implications**

- 6.1 None identified.

### **7. Resource Implications**

- 7.1 Workforce: None identified.
- 7.2 Property: None identified.
- 7.3 IT: None identified.

### **8. Other Implications**

- 8.1 Legal Implications: None identified.
- 8.2 Human Rights Implications: None identified.
- 8.3 Equality Impact Assessment: Not required
- 8.4 Data Protection Impact Assessments (DPIA): Not required
- 8.5 Health and Safety implications: None identified.
- 8.6 Sustainability Implications: None identified.
- 8.7 Impact of Devolution on the decision: None identified.
- 8.8 Impact on Devolution of the decision: None identified.
- 8.9 Impact of Local Government Reorganisation on the decision: None identified.
- 8.10 Impact on Local Government Reorganisation of the decision: None identified.
- 8.11 Any Other Implications: None identified.

## **9. Risk Implications / Assessment**

**9.1** None identified.

## **10. Background Papers**

**10.1** None.

### **Officer Contact**

If you have any questions about matters contained within this paper, please get in touch with:

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# Report to Health Overview Select Committee

Item No: 9

**Report Title: Forward Work Programme**

**Date of Meeting: 15 January 2026**

**Responsible Cabinet Member: N/A**

**Responsible Director: Caroline Clarke, Director of Democratic and Regulatory Services**

## **Executive Summary**

This report sets out a proposed Forward Work Programme for the Health Overview Select Committee, for Members to review.

## **Action required**

To agree a Forward Work Programme for the Select Committee.

## **1. Background and Purpose**

- 1.1 Members should set a work programme annually and review it on a regular basis to ensure that it continues to add value to decision-making and supports the continuous improvement of local services.
- 1.2 A well-designed scrutiny work programme should prioritise issues of public concern, align with strategic goals, and provide a clear framework for addressing community needs and challenges.

## **2. Proposal**

- 2.1 The proposed Forward Work Programme for the Select Committee is set out at **Appendix A**, for Members to review.

## **3. Impact of the Proposal**

- 3.1 Regular review of the Forward Work Programme will ensure that scrutiny remains relevant, transparent, and impactful.

- 3.2 By maintaining a dynamic and regularly reviewed work programme, the committee ensures its scrutiny aligns with service developments and transformation initiatives across the health and care landscape.

## **4. Evidence and Reasons for Decision**

- 4.1 As above.

## **5. Alternative Options**

- 5.1 The Committee can amend the proposed work programme.

## **6. Financial Implications**

- 6.1 None identified.

## **7. Resource Implications**

- 7.1 Workforce: None identified.  
7.2 Property: None identified.  
7.3 IT: None identified.

## **8. Other Implications**

- 8.1 Legal Implications: None identified.  
8.2 Human Rights Implications: None identified.  
8.3 Equality Impact Assessment: None identified.  
8.4 Data Protection Impact Assessments (DPIA): None identified.  
8.5 Health and Safety implications: None identified.  
8.6 Sustainability Implications: None identified.  
8.7 Impact of Devolution on the decision: None identified.  
8.8 Impact on Devolution of the decision: None identified.  
8.9 Impact of Local Government Reorganisation on the decision: None identified.  
8.10 Impact on Local Government Reorganisation of the decision: None identified.  
8.11 Any Other Implications: None identified.

## **9. Risk Implications / Assessment**

- 9.1 None identified.

## 10. Action required

10.1 To agree a Forward Work Programme for the Select Committee.

## 11. Background Papers

11.1 None.

### Officer Contact

If you have any questions about matters contained within this paper, please get in touch with:

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## Forward Work Programme – Health Overview Select Committee

<b>19 March 2026 meeting</b>	
<b>Report title</b>	<b>Reason for report</b>
Digital Transformation and Electronic Patient Record (EPR)	Request from Members to follow up September 2023 report and review digitalisation plans under NHS 10 Year Plan
NSFT	Request from Members at March 2025 meeting to review service provision.
Strategic Review of Outreach Services	To engage with the ICB review and provide comment on the learning gathered to date.
Forward Work Programme	To review and agree the programme.

<b>16 July 2026 meeting</b>	
<b>Report title</b>	<b>Reason for report</b>
Norfolk and Waveney University Hospitals Group update	To update members on the group's progress since May 2025.
SaLT Task and Finish Report	To allow members to consider outcomes from the task and finish group.
Appointment of Link Members	To appoint Link Members for NHS organisations.
Select Committee Annual Work Programming	To review and agree the programme.

<b>17 September 2026 meeting</b>	
<b>Report title</b>	<b>Reason for report</b>
Advice and Guidance Update	Request from members at September 2025 meeting for an update on the impact of Advice and Guidance across Norfolk and Waveney.
Vulnerable Adults Service Health Inclusion Hub	Member request to review service following recent public consultation and in relation to NHS 10 Year Plan provisions.
Forward Work Programme	To review and agree the programme.

<b>19 November 2026 meeting</b>	
<b>Report title</b>	<b>Reason for report</b>
Update on Dentistry Services	Request from Members to consider specific areas of dentistry provision including out of hours and emergency appointments, practice audits, dentistry in schools and NHS 10 Year Plan provisions.
Transition process between Child and Adolescent Mental Health Services (CAMHS) and adult mental health services.	Member request at the November 2025 meeting.
Forward Work Programme	To review and agree the programme.

<b>21 January 2027 meeting</b>	
<b>Report title</b>	<b>Reason for report</b>
Audiology services	Member request for report.
Pharmacies	Request from Health and Wellbeing Board for HOSC to work with partners to review pharmacies.
Forward Work Programme	To review and agree the programme.

<b>18 March 2027 meeting</b>	
<b>Report title</b>	<b>Reason for report</b>
Autism Services	Member request to receive an overview of services available to people with autism.
Forward Work Programme	To review and agree the programme.

<b>Current Briefing items on Forward Work Programme</b>	
<b>February 2026</b>	
Intermediate Care	An update on intermediate care facilities.
Discharge delays	The impact of discharge delays, and any associated increase in infection rates.
New Hospitals programme	An update on the New Hospital Programme.
Wellbeing hubs	The impact of wellbeing hubs, including data on usage, outcomes, and effectiveness.