Meeting of the Board of NHS Norfolk and Waveney Integrated Care Board (ICB)

Tue 22 November 2022, 13:30 - 15:30

Council Chamber, Great Yarmouth Town Hall, Hall Plain, NR30 2QF

NHS
Norfolk and Waveney
Integrated Care Board

Agenda

13:30 - 13:30
0 min

Meeting Agenda

00. 2022.11.22 NW ICB Public Meeting Agenda.pdf (3 pages)

13:30 - 13:45
15 min

1. Welcome and introductions - Apologies for absence

Chair

13:45 - 13:45
0 min

2. Minutes from previous meeting and matters arising

Chair

02. DRAFT NW ICB Board Part 1 Minutes 27092022.pdf (9 pages)

13:45 - 13:45
0 min

3. Declarations of interest

Chair

To declare any interests that board members may have specific to agenda items that could influence the decisions they make. Declarations made by members of the ICB Board are listed in the ICB's Register of Interests. The Register is available via the ICB's website.

03. ICB Board Register - Nov 22 V2.pdf (4 pages)

13:45 - 13:45
0 min

4. Chairs Action Log

Chair

To receive an update from the Chair on actions taken since the last meeting.

04. Chairs Action Log Nov 22 V2.pdf (1 pages)

13:45 - 13:45
0 min

5. Action log – things we have said we will do

Chair

To make sure the ICB completes all the actions it agrees are needed.

05. ICB Board Action Log Nov 22.pdf (1 pages)

13:45 - 13:45
0 min

6. Chairs and Chief Executives Report

Chair and Tracey Bleakley

To note an update from the Chair and the Chief Executive of the ICB about the work the ICB has done since the last meeting.

06. Chair and Chief Executive's ICB Board report - Final.pdf (7 pages)

Learning from people, staff, and communities

13:45 - 14:05
20 min

7.

To hear the learning from people, staff and communities in Norfolk and Waveney with lived experience around the importance of timely communication and understanding during end of life care to understand what matters to them, and to discuss and learn. This item will be a video presentation.

Items for Sharing and Board Consideration

14:05 - 14:15
10 min

8. ICP Strategy

Debbie Bartlett /James Bullion

To receive and endorse the transitional Norfolk and Waveney Integrated Care strategy and joint Health and Wellbeing Strategy.

08. Integrated care strategy update - ICB Board 221122 (003).pdf (6 pages)
08.i Integrated Care Strategy V4.pdf (35 pages)

14:15 - 14:40
25 min

9. Winter Plan

Mark Burgis

To discuss the current operational pressures facing the system and the plans for winter.

09. ICS Winter Plan - ICB Board Report 22.11.22 v2 (Final Draft).pdf (10 pages)

14:40 - 14:45
5 min

10. East Kent Report

Patricia D'Orsi

To provide an overview of the content of the East Kent report. This is a briefing for the ICB Board to have an overview of the content of the East Kent report, an understanding of current position and ambitions for the future.

10. LMNS East Kent Report to QPC 15 Nov 22 V 2.pdf (5 pages)

14:45 - 15:05
20 min

11. Digital Transformation:

Andrew Palmer/ Toni Jeary

- Digital Transformation Strategic Plan and Roadmap
- Local Maternity and Neonatal System Digital Strategy

11. Digital Roadmap Summary.pdf (12 pages)
11. N&W ICS Digital Transformation Strategic Plan and Roadmap.pdf (137 pages)
11.i ICB Board Report Maternity Digital Strategies Nov 22.pdf (3 pages)
11.ii Draft Digital Strategy for Maternity - JPUH.pdf (20 pages)
11.iii NNUH Maternity Digital Strategy Sept 22.pdf (17 pages)
11.iiii Digital & Data Transformation strategy in Maternity N&W LMNS.pdf (20 pages)
11.iiiii Midwifery Digital Strategy 2022-2023 QEH.pdf (15 pages)

Finance and Corporate Affairs

15:05 - 15:15
10 min

12. Financial Report for Month 7

Steven Course

To receive a summary of the financial position as at month 7

- 12.i ICB Finance Report - Month 07 - Board.pdf (10 pages)
- 12. Month 7 ICB Finance Report.pdf (2 pages)

15:15 - 15:20
5 min

13. Board Assurance Framework

Karen Barker

A review of the risks (things that might go wrong and how we can alleviate them) within the Integrated Care system.

- 13. BAF Paper for ICB Board - November 22.pdf (3 pages)
- 13.i 2022.11.07 - ICB Board Assurance Framework (BAF).pdf (44 pages)

Committees Update

15:20 - 15:20
0 min

14. Report from the Quality and Safety Committee

Cathy Armor

- 14. 2022 11 11 - Quality and Safety Committee Report to Board v1.0.pdf (5 pages)

15:20 - 15:20
0 min

15. Report from the Primary Care Commissioning Committee

James Bullion

- 15. 22-11-14 PCCC for ICB Board.pdf (3 pages)

15:20 - 15:20
0 min

16. Report the Finance Committee

Hein Van Den Wildenberg

- 16. 2022.11.22 - Fin Com Chair Report to Board FINAL.pdf (4 pages)

15:20 - 15:20
0 min

17. Report from the Performance Committee (verbal due to meeting schedule)

Dr Hilary Byrne

15:20 - 15:25
5 min

18. Report from the Audit Committee

David Holt

- 18 20222.10.11-ARC Report to Board.pdf (3 pages)

15:25 - 15:30
5 min

19. Questions from the Public. Where question in advance relates to items

Chair

15:30 - 15:30
0 min

20. Any other business

Chair

15:30 - 15:30
0 min

Date, time and venue of next meeting:

Tuesday, 24 January 2023, 1.30pm – 3.30pm, via Microsoft teams

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15:30 - 15:30
0 min

Any queries or items for the next agenda please contact:nwccg.corporateaffairs@nhs.net

NHS
Norfolk and Waveney
Integrated Care Board

Meeting of the Board of NHS Norfolk and Waveney Integrated Care Board (ICB)

Tuesday, 22 November 2022, 1.30pm – 3.30pm

(In Public)

Council Chamber, Great Yarmouth Town Hall, Hall Plain, NR30 2QF

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

Our goals:

1. **To make sure that people can live as healthy a life as possible.**
2. **To make sure that you only have to tell your story once.**
3. **To make Norfolk and Waveney the best place to work in health and care.**

Chair: Rt Hon. Patricia Hewitt

Item	Time	Agenda Item	Lead
1.	1.30	**Welcome and introductions - Apologies for absence**	Chair
2.		**Minutes from previous meeting and matters arising** To approve the part 1 public minutes of the previous Board meeting.	Chair
3.		**Declarations of interest** To declare any interests that board members may have specific to agenda items that could influence the decisions they make. Declarations made by members of the ICB Board are listed in the ICB's Register of Interests. The Register is available via the ICB's website.	Chair
4.		**Chairs Action Log** To receive an update from the Chair on actions taken since the last meeting.	Chair
5.		**Action log – things we have said we will do** To make sure the ICB completes all the actions it agrees are needed.	Chair
6.		**Chairs and Chief Executives Report** To note an update from the Chair and the Chief Executive of the ICB about the work the ICB has done since the last meeting.	Chair and Tracey Bleakley

Item	Time	Agenda Item	Lead
		Learning from people, staff, and communities	
7.	1.45	To hear the learning from people, staff and communities in Norfolk and Waveney with lived experience around the importance of timely communication and understanding during end of life care to understand what matters to them, and to discuss and learn. This item will be a video presentation.	Tricia D'Orsi
		Items for Sharing and Board Consideration	
8.	2.05	**ICP Strategy** To receive and endorse the transitional Norfolk and Waveney Integrated Care strategy and joint Health and Wellbeing Strategy	James Bullion Debbie Bartlett
9.	2.15	**Norfolk and Waveney ICS Winter Plan 2022 Update** To discuss the current operational pressures facing the system and the plans for winter.	Mark Burgis
10.	2.40	**East Kent Report** To provide an overview of the content of the East Kent report. This is a briefing for the ICB Board to have an overview of the content of the East Kent report, an understanding of current position and ambitions for the future.	Tricia D'Orsi
11.	2.45	**Digital Transformation:** • Digital Transformation Strategic Plan and Roadmap (summary and full version included) • Local Maternity and Neonatal System Digital Strategy	Andrew Palmer Tricia D'orsi Toni Jeary
		Finance and Corporate Affairs	
12.	3.05	**Financial Report for Month 7** To receive a summary of the financial position as at month 7	Jason Hollidge
13.	3.15	**Board Assurance Framework** A review of the risks (things that might go wrong and how we can alleviate them) within the Integrated Care system.	Karen Barker
		Committees Update and Questions from the public	
14.	3.20	**Report from the Quality and Safety Committee**	Cathy Armor
15.		**Report from the Finance Committee**	Hein Van Den Wildenberg
16.		**Report from the Primary Care Commissioning Committee**	James Bullion
17.		**Report from the Performance Committee (verbal due to meeting schedule)**	Dr Hilary Byrne
18.		**Report from the Audit and Risk Committee**	David Holt
19.	3.25	**Questions from the Public. Where question in advance relates to items**	Chair
20.	3.30	**Any other business**	Chair

Item	Time	Agenda Item	Lead
Date, time and venue of next meeting: **Tuesday, 24 January 2023, 1.30pm – 3.30pm, via Microsoft teams**			
Any queries or items for the next agenda please contact: **nwccg.corporateaffairs@nhs.net**			

Note of future ICB Board public meeting dates for diaries:

Date	Time	Type of meeting
30 May 2023	1:30pm – 3.30pm	Virtual
25 July 2023	1:30pm – 3.30pm	Face to face
26 September 2023	1:30pm – 3.30pm	Virtual
28 November 2023	1:30pm – 3.30pm	Face to face
23 January 2024	1:30pm – 3.30pm	Virtual
26 March 2024	1:30pm – 3.30pm	Face to face

Some explanations of terms used in this Agenda.

Please see further terms defined on our website www.improvinglivesnw.org.uk

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

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

Clinical Commissioning Group (CCG) – NHS bodies that will be replaced by ICBs on 1st July 2022.

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

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

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

NHS Norfolk and Waveney Integrated Care Board

DRAFT Minutes of the meeting on Tuesday, 27 September 2022

PART 1 – Meeting in public

Board members present:

- Rt Hon. Patricia Hewitt (PH), Chair, NHS Norfolk and Waveney ICB
- Tracey Bleakley (TB), Chief Executive, NHS Norfolk and Waveney ICB
- Steven Course (SC), Director of Finance, NHS Norfolk and Waveney ICB
- Dr Frankie Swords (FS), Medical Director, NHS Norfolk and Waveney ICB
- Patricia D'Orsi (PD'O), Director of Nursing, NHS Norfolk and Waveney ICB
- Hein Van Den Wildenberg (HvdW), Non-Executive Member, NHS Norfolk and Waveney ICB
- Cathy Armor (CA), Non-Executive Member, NHS Norfolk and Waveney ICB
- David Holt (DH), Non-Executive Member, NHS Norfolk and Waveney ICB
- Cllr Bill Borrett (BB), Chair, Norfolk Health and Wellbeing Board, and Chair, Norfolk and Waveney ICP
- Dr Hilary Byrne (HB), Partner Member – NHS Primary Medical Services
- Jonathan Barber (JBa), Partner Member – NHS Trusts (Acutes)
- Sue Cook (SCo), Local Authority Partner Member
- James Bullion (JBu), Local Authority Partner Member
- Emma Ratzer (ER), Voluntary, Community and Social Enterprise Sector Board Member

Participants and observers in attendance:

- Karen Barker (KB), Director of Corporate Affairs and ICS Development, NHS Norfolk and Waveney ICB
- Mark Burgis (MB), Patients and Communities Director, NHS Norfolk and Waveney ICB
- Jocelyn Pike (JP), Acting Director of Mental Health Transformation, NHS Norfolk and Waveney ICB
- Howard Martin (HM), Director of Population Health Management, NHS Norfolk and Waveney ICB
- Anne Borrows (AB), Acting Director of Place Development and System Support, NHS Norfolk and Waveney ICB
- Alex Stewart (AS), Chief Executive, Healthwatch Norfolk

Attending to support the meeting:

- Tim Eyres (TE), Assistant Director for Commissioning and Partnerships – Norfolk Children's Services, Norfolk County Council (for item 10)
- Rebecca Hulme (RH), Associate Director of Children, Young People and Maternity, NHS Norfolk and Waveney ICB and Norfolk County Council (for item 10)
- Chris Williams (CW), Senior Support Manager, NHS Norfolk and Waveney ICB (Minutes)

1.	**Welcome and introductions - apologies for absence**	
	The Chair welcomed everyone to the meeting, including Cllr Bill Borrett who had been appointed as the Integrated Care Partnership's member of the ICB Board. Apologies were received from the following Board members: • Stuart Richardson (SR), Partner Member – NHS Trusts (Mental Health and Community Services)	
2.	**Minutes from previous meeting and matters arising**	
	Agreed: The draft minutes from the meeting held on 1 July 2022 were approved as an accurate record of the meeting.	
3.	**Declarations of interest**	
	The Chair noted that all Board members had refreshed their declarations of interest and that these are available on the ICS's website.	
4.	**Chair's action log**	
	The Chair noted that, as set-out in the action log, the following two procurements had been approved since the Board last met: 1. Provision of Mental Health Support Teams in Schools 2. Integrated Front Door for Children and Young People's Mental Health Services in Norfolk and Waveney	
5.	**Action log**	
	The Chair noted that maternity services would be discussed at the meeting and that an update on the Carer's Passport would be presented to the Board at their meeting in November 2022.	
6.	**Chair and Chief Executive's Report**	
	TB introduced the item, highlighting key points from the report. Questions and comments from Board members: • DH asked whether an audit is done of 'hear and treat' so that we know if we are getting triage decisions right. FS replied that a proactive approach is taken to prevent problems as we don't have resource to audit the advice given by call handlers. This is done by first giving patients advice on what to do and then adding 'safety netting' to explain what patients should do if their symptoms or needs change following their call. • JB noted that with the winter funding it would be good to see it allocated to a mix of system and place level projects. • CA asked how we are linking with volunteers to help with discharge. TB noted that our workforce team is linking with local voluntary, community and social enterprise sectors organisations. ER reinforced that there is good communication between statutory and and voluntary sector partners about how volunteers can help with discharge this winter. The report was discussed and noted.	

7.	**Nomination and Approval of Integrated Care Board - Vice Chair**	
	The Chair explained there is a clause in the constitution that says the ICB Board will have a vice-chair. The Chair proposed HvdW to be vice-chair, which was seconded by DH. **Agreed:** HvdW appointed as vice-chair of the ICB Board.	
	Learning from people, staff and communities	
8.	**Learning from people, staff and communities**	
	PD'O introduced the item, which focused on how the system had responded to feedback from pregnant women and pregnant people regarding information about and access to the COVID-19 vaccines. Questions and comments from Board members: • FS noted that it can be hard for staff as well as patients when guidance changes regularly. The Chair thanked the patients who had shared their feedback and congratulated the team at the James Paget University Hospital who responded to it and who had received national recognition for their work to increase take-up of the COVID-19 vaccines during pregnancy.	
	Items for sharing and Board consideration	
9.	**Maternity Transformation and Local Maternity and Neonatal System (LMNS) Programme report**	
	PD'O introduced the item, informing the Board of progress against the local maternity and neonatal plan and the recommendations from the Ockenden report. She highlighted the importance of this work and the plan to do more to improve the Local Maternity and Neonatal System Board's access to and use of data and insight. She also provided an overview of the governance arrangements in place regarding the oversight of serious incidents. Questions and comments from Board members: • SCo suggested it would be helpful to see the actions detailed in the plan that we have taken in response to feedback from the local maternity voice partnerships. She also asked if our local system was sighted on a birth wallet that has been produced by two mothers that has been rolled out in areas of London. PD'O replied it would be helpful to see the birth wallet, noting that we want to learn from best practice. She added that we also want to increase the diversity of those involved in our local maternity voice partnerships. • JBa asked when the mandatory training would be delivered to all the necessary practitioners. PD'O recognised the importance of the training as well as the challenges of achieving this when the workforce is busy, but said she expected progress to be made quickly and to show in the next quarter's report. • DH highlighted the importance of 'freedom to speak up' arrangements. He asked if we have anything to triangulate against this from staff or spot surveys to ensure we have an accurate	

	understanding of the situation with maternity services. PD'O explained that our equity and equitability plan had been informed by a confidential staff survey and what patients are saying, but that there is more work to do on this. Over time we want to link corporate feedback and mechanisms with 'freedom to speak up' channels. • The Chair asked for further clarification about what needs to be done to improve our data. PD'O noted that we are looking to improve how our data is presented and used by the system, rarther than how it is collected. The three hospitals all have the data, but we want to combine this and triangulate it more effectively for the Board of the Local Maternity and Neonatal System. She added that work is being done to see how we can best present the data we have, including regarding serious incidents and neonatal deaths. **Agreed:** The ICB Board: • Noted the work undertaken by the LMNS to deliver the Maternity Transformation Programme • Recognised their responsibility under the Capacity and Capability Framework • Noted the LMNS role in Quality and Safety Oversight and response to the Ockenden report • Noted the LMNS Programme risks and mitigating actions being undertaken to address these • Agreed that a LMNS Programme update is presented to the ICB in 6 months' time.	
10	**Flourish – the ambition for the Children and Young People of Norfolk**	
	TE and TH introduced the item, explaining that FLOURISH is both our collective ambition and a shared outcomes framework. TE noted that a set of proxy indicators is being developed to help us understand what progress we are making as a system. Questions and comments from Board members: • HvdW asked what we have learnt from children and young people. TE explained children and young people regularly highlight the importance of looking at their whole life experience and that their mental health and wellbeing are really important. RH added that feedback has also challenged some of our assumptions about where and who children and young people want to get support from, with family and teachers often being cited as the people they would most like to get support from. • JBu noted that we need to consider what the ICB can do for families as a whole, rather than just for children and young people, particularly in light of the increased pressures on families at the moment. With regards to mental health and neuro diversity, he suggested this may be an area that primary care could benefit from having more tools to help with.	

	• TE noted that we are on the cusp of entering into a family hub programme with the Department for Education that will be really important for the youngest children in Norfolk and Waveney. **Agreed:** The ICB Board agreed: • To provide leadership within the health system to secure continued commitment to Flourish as our shared ambition for children and young people. • To promote and encourage health partners to make and deliver a Flourish Pledge. • To work with CYPSA as a strategic partnership mechanism to champion the needs of children and young people within the all-age focus of ICS, to help ensure that they are flourishing. • To support the development and operation of a Joint Social Care and Health Assurance Board that enables Children's and Adult Services to jointly commission and address system issues with the ICB, including in relation to our Flourishing in Norfolk priorities. • To help embed effective joint funding arrangements for children and young people with complex needs so that they can Flourish. • To continue to support CYPSA's work in relation to data about how well children and young people are flourishing, sharing stakeholder engagement and insight, and collaborative workforce development.	
11	**Mental health transformation update**	
	JP introduced the item by outlining the programme of work being undertaken to tansform mental health services, including a period of engagement to consider what, if any services could be better provided in an alternative setting. Questions and comments from Board members: • DH asked about how we can articulate and show our ambition, suggesting it could help to have a graphic showing the difference between how people are supported now and what this could look like in future. • HB welcomed the work and noted that workforce is likely to be a challenge, adding that the additional roles in primary care have been a success, but that they hadn't all been easy to recruit to. • JP replied that we need to be able to clearly demonstrate our short, medium and longer term ambitions, and that we need to deliver in the short-term so that people have confidence we can deliver the longer-term work. She explained that the ICB's workforce team is supporting the transformation work, and that work is to be done to both understand the current challenges facing the workforce and to consider what an alternative workforce could look like. • The Chair noted the honesty and openness at the September 2022 Board meeting of Norfolk and Suffolk NHS Foundation Trust regarding the views of their workforce and the culture at the Trust.	

	The presentation was discussed and noted.	
12	**Adult eating disorders procurement**	
	SC introduced the item which asked the Board to approve the approach to procuring eating disorder services for adults, as set out in the paper. He noted that it is likely the ICB would have to run a procurement process because multiple expressions of interest had been received and that this would be confirmed once all the expressions of interest had been assessed against the pass/fail criteria for the procurement. **Agreed:** The ICB Board approved that: 1) If a single capable provider has been identified through the expression of interest process, that the ICB makes an award to a single capable provider (as described in option 1 in the paper), or 2) If there is more than one capable provider identified through the expression of interest that the ICB commences a Light Touch Regime procurement as defined in the Public Contracts Regulations 2015.	
	Finance and Corporate Affairs	
13	**Financial Report for Month 5**	
	SC introduced the item, noting that the forecast outturn position for the ICB for the year remained a break-even position in line with our plan. Similarly, he explained that the forecast for the Integrated Care System was also break-even as planned. The report was noted.	
14.	**NHS Norfolk and Waveney Clinical Commissioning Group Annual Report**	
	KB introduced the item, explaining that this was the launch of the former Clinical Commissioning Group's annual report and accounts, and that it was just for noting by the Board. **Agreed:** The ICB Board noted the Annual Report and Accounts for the former NHS Norfolk and Waveney CCG for the period 1 April 2021 to 31 March 2022.	
15.	**ICB Constitution Amendments**	
	KB introduced the item, noting that the proposed amendments were requested by NHS England and that all Integrated Care Boards in England had been asked to make these changes to their constitutions. **Agreed:** The ICB Board: • Approved the proposed amendments to the Constitution (as set out in the paper). • Agreed to submit the revised Constitution to NHS England.	

16.	**Board Assurance Framework**	
	KB introduced the item, noting that work is ongoing to develop both the risk management framework to ensure it encapsulates wider system risks, as well as to develop the Board Assurance Framework. Questions and comments from Board members: • HvdW welcomed the inclusion of risk appetite and suggested that risks 5A and 5B could warrant another look as the level of risk could be higher. • DH said it would be helpful to understand the trajectory of the risks identified, particularly risks 7, 12 and 13 in the paper. **Action:** PD'O to review risks 5A and 5B. **Action:** The ICB Executive Management Team to do further work on risk appetite and risks 7, 12 and 13, to then present and discuss this with the Audit Committee, before bringing it back to the ICB Board. **Agreed:** The ICB Board: • Approved the Risk Management Framework. • Received and reviewed the risks presented in the Board Assurance Framework.	**P'DO** **KB**
	Committees update and questions from the public	
17.	**Report from the Audit Committee**	
	The report was noted.	
18.	**Report from the Quality and Safety Committee**	
	The report was noted.	
19.	**Report from the Finance Committee**	
	HvdW introduced the item, noting that the Committee is closley monitoring the risks in our financial planning.	
20.	**Report from the Primary Care Commissioning Committee**	
	JB introduced the item, noting that good progress is being made on health assessments.	
21.	**Report from the Performance Committee**	
	HB introduced the item, explaining that the Committee had met for first time the previous week, where they had discussed the exit criteria for System Oversight Framework level 4, integrated performance reporting and looking at data and information from across the system. She highlighted the risk to our elective recovery programme arising from a reduction in theatre capacity due work relating to the Reinforced Autoclaved Aerated Concrete planks at the Queen Elizabeth Hospital, as well as the risks related to the significant numbers of patients with 'no criteria to reside' who don't need to be hospital for medical reasons.	

22.	**Question from the public**	
	The following question was received in advance of the meeting: **Question:** The decision at item 6 (d) to fully fund the NICE guidelines on the use of scanned and continuous glucose monitoring sensors will be warmly welcomed by diabetics in Norfolk and Waveney who currently have the worst access to this life changing technology in the country, meaning Norfolk sadly has a national reputation as a diabetic backwater. How has the ICB managed to address this issue successfully in its short life when its predecessor the Clinical Commissioning Group failed to badly? Also, many diabetics motivated by a desire to improve their own health and fed up by the lack of action by the CCG, have been self-funding these devices for months and years at a cost of around £100 a month. They require no training to use the technology and evidence of how well it is being used by them is already available at diabetic clinics across the country. Can these patients be spared any delay caused by the involvement of the Diabetes Programme Board and simply have these devices added to their repeat prescriptions? In short, how long will the 'roll out' take given, that I understand the Board only meets once every couple of months. **Response:** This is positive news and demonstrates that the ICB has a very strong clinical voice, which is championing the needs of our patients. We have agreed to significantly expand access to devices that help people with diabetes to monitor their blood glucose levels. It is a substantial piece of work and so there will be a staged implementation. In the first year our focus will be on: • providing continuous glucose monitors to all under 18s with type 1 diabetes (although children and young people with type 1 diabetes aged 4 years and over who are unable to use continuous monitoring or who express a clear preference for intermittent monitoring, will be offered intermittently scanned glucose monitors). • providing intermittently scanned glucose monitors to adults with type 1 diabetes. The diabetes technology group has been tasked with putting this into practise as smoothly as we can and currently the plan is for patients to be considered for a switch, if clinically appropriate, at their next routine appointment. This may not be quite as fast as some people will want, but we think this is the most practical way. We have also given express guidance to our hospital teams that if patients are admitted to hospital with hypoglycaemia, then they could also be switched if their consultant considers they would benefit from this because they are at a high risk of being readmitted again with hypoglycaemia in the short-term.	

	The following question was asked at the meeting: **Question:** I didn't see the slides for the mental health item in the pack of papers. It would be helpful if presentations and papers can be shared in advance of the meeting as it helps people to follow the discussion and understand the item. **Response:** The Chair noted that the papers for the meeting were long and did contain the mental health slides, adding that we would keep under review how we can make it easy for people to find the papers for Board meetings and ensure they are written in plain English so that the public can understand them.	
23.	**Any other business**	
	No other business was raised.	
Date, time, and venue of next meeting: **Tuesday, 22 November 2022, 1.30pm – 3.30pm, Council Chamber, Great Yarmouth Town Hall, Hall Plain, NR30 2QF**		
	Any queries or items for the next agenda please contact: nwccg.corporateaffairs@nhs.net	

Minutes agreed as accurate record of meeting:

Signed: …… Date: ……...
Chair

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

Declared interests of the Board

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
Patricia Hewitt	Chair, Norfolk and Waveney ICB	FTI Consulting	X			Direct	Senior advisor, FTI Consulting	2015	Present	Since January 2022 I have not undertaken any work on healthcare or life sciences. Will declare at relevant meetings if a risk arises.
		Newnham College Cambridge			X	Direct	Honorary Associate, Newnham College Cambridge	2018	Present	No conflicts have arisen or foreseen
		Oxford India Centre for Sustainable Development			X	Direct	Chair, Oxford India Centre for Sustainable Development	2018	Present	No conflicts have arisen or foreseen
		ORA Choral Ensemble			X	Direct	Chair, trustees, ORA Choral Ensemble	2020	Present	No conflicts have arisen or foreseen
		Age UK Norfolk			X	Direct	Volunteer, Age UK Norfolk	2020	Present	Declaration of interest made in any relevant conversation
Catherine Armor	Non-Executive Member, Norfolk and Waveney ICB	Brundall Medical Practice			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Norwich University of the Arts			X	Direct	Deputy Chair of Council, Norwich University of the Arts	2019	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		Evolution Academy Trust			X	Direct	Trustee, Evolution Academy Trust	2022	Present	
		Cambridge University Press		X		Direct	Trustee, Cambridge University Press	Ongoing		
		East of England Ambulance Service NHS Trust		N/A		Indirect	Daughter-in-law is Technician for East of England Ambulance Service NHS Trust	Ongoing		
Jon Barber	Partner Member - Acute, Norfolk and Waveney ICB	James Paget university Hospitals Trust		X		Direct	Director of Strategy & Transformation James Paget university Hospitals Trust	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Broadland St Benedict			X	Direct	Non-executive Director of Broadland St Benedicts – the property development subsidiary of Broadland housing Group	2020	Present	
Tracey Bleakley	Chief Executive Officer, Norfolk and Waveney ICB	Nothing to Declare		N/A			N/A	N/A	N/A	N/A
James Bullion	Partner Member - Local Authority (Norfolk), Norfolk and Waveney ICB	Norfolk County Council	X			Direct	Executive Director Adult Social Services, Norfolk County Council	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Skills for Care	X			Direct	Trustee of Skills for Care	Ongoing		Member prepared to leave any meeting where training and development provision might be likely awarded or recommended to be provided by skills for care

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

Declared interests of the Board

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
Dr Hilary Byrne	Partner Member - Primary Medical Services	Attleborough Surgeries	X			Direct	GP Partner at Attleborough Surgeries	2001	Present	To be raised at all meetings to discuss prescribing or similar subject. Risk to be discussed on an individual basis. Individual to be prepared to leave the meeting if necessary.
		MPT Healthcare Ltd	X			Direct	Director of MPT Healthcare Ltd	2020	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Norfolk Community Health and Care Trust (NCH&C)				Indirect	Spouse is employee of NCH&C (Improvement Manager)	2021	Present	
Sue Cook	Partner Member - Local Authority (Suffolk), Norfolk and Waveney ICB	Suffolk County Council	X			Direct	Executive Director Adult Social Services, Suffolk County Council	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
Steven Course	Director of Finance, Norfolk and Waveney ICB	March Physiotherapy Clinic Limited				Indirect	Wife is a Physiotherapist for March Physiotherapy Clinic Limited	2015	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards March Physiotherapy Clinic Limited
Tricia D'Orsi	Director of Nursing, Norfolk and Waveney ICB	Royal College of Nursing		X		Direct	Member of Royal College of Nursing	Ongoing		Inform Chair and will not take part in any discussions or decisions relating to RCN
David Holt	Non-Executive Member, Norfolk and Waveney ICB	Solebay Health Centre			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Tavistock and Portman NHS Foundation Trust	X			Direct	Senior Independent Director, Tavistock and Portman NHS Foundation Trust	2013	2022	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards Tavistock and Portman NHSFT
		Department of Work and Pensions	X			Direct	Non-Executive Board Member, Department of Work and Pensions. Chair of the Audit Committee and Chair of the Health Transformation Programme Board	2019	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		Ministry of Defence	X				Non Executive Director, Audit and Risk Assurance Committee, Ministry of Defence	2022	Present	In the unlikely event that a decision having an impact on either of the declared parties arises, a decision will be

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

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			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
		Newberry Clinic				Indirect	Wife is Consultant Community Paediatrician, Newberry Clinic (Great Yarmouth)	Ongoing		declared parties arises, a decision will be made with the relevant chair to assess the risks. Appropriate action will be taken accordingly.
Emma Ratzer	Partner Member - VCSE	Access Community Trust	X			Direct	I am the Chief Executive Officer of Access Community Trust, an organisation which holds contracts with NWICB	2009	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards Community Access Trust
		VCSE Assembly			X	Direct	I am CEO of a voluntary sector organisation operating in NWCCG and Independent Chair of NWVCSE Assembly	2021	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest
Stuart Richardson	Partner Member - Mental Health and Community, Norfolk and Waveney ICB	Norfolk and Suffolk Foundation Trust	X			Direct	Chief Executive Officer, Norfolk and Suffolk Foundation Trust	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest
Dr Frankie Swords	Medical Director, Norfolk and Waveney ICB	Norfolk and Norwich University Hospitals NHS FT	X			Direct	Honorary Consultant Physician and Endocrinologist at Norfolk and Norwich University Hospitals NHS FT (1 day a week)	2008	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		N/A			X	Direct	Clinical Advisor of multiple patient charities - Addison Self Help Group - Orchid Testicular Cancer Trust - Pituitary Patient Support Group - Turner syndrome Society	2008	Present	
		Long Stratton Medical Partnership			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		British Medical Association	X			Direct	Member of the BMA	Ongoing		Inform Chair and will not take part in any discussions or decisions relating to BMA
		Ruby Media	N/A			Indirect	Husband is director of Ruby Media which commissions various professional conferences and other events relating to health and care	2008	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards Ruby Media
Hein van den Wildenberg	Non-Executive Member, Norfolk and Waveney ICB	Lakenham Surgery			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest

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

Declared interests of the Board

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest					Date of Interest		
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?	Nature of Interest	From	To	Action taken to mitigate risk
		College of West Anglia			X	Direct	Governor at College of West Anglia (Note: the College hosts the School of Nursing, in partnership with QEHKL and borough council)	2021	Present	Low risk. If there is an issue it will be raised at the time.

NORFOLK & WAVENEY ICB Chairs Action Log - Tuesday 22 November 2022				
Date	**Matter**	**Details of discussion**	**Decision**	**Date Reported to ICB Board**
19-Oct-22	Approval of an award of Adult Eating Disorder Services.	We have undertaken an exercise to request expressions of interest from the market for the provision of an Adult Eating Disorders Service. The result of this was that there was a single provider that responded and was capable of meeting the requirements of the service. Therefore the ICB can make an award without undertaking any further procurement activity. A full report is availble unpon request which describes the process and outcome in more detail. Due to the ICB Board being established 01.07.22 no further Board meeting was available within month for approval within the timeframe required	This report has been reviewed and approved by Steven Course Chief Finance Officer and by the Chair by email on 20.10.22.	22.11.22
10-Oct-22	Approval of an award of Short Stay Recovery Houses Project.	This has been approved for review and requires Board approval for the proposed contract award. We would like to commence the mobilisation of the Recovery Houses as soon as possible, therefore, please will you review and advise whether you are willing to approve this under Chairs action?	This report has been reviewed and approved by the Chair by email on 10.10.22.	22.11.22

NORFOLK & WAVENEY ICB Action Log - Tuesday 22 November 2022							
No:	**Date of Meeting**	**Description**		**RESP**	**Due Date**	**ACTION / UPDATE**	**Status**
2	01-Jul-22	Carers Passport Update	PD'O to provide a briefing paper to the next ICB Board meeting to report on follow-up actions taken in response to the recommendations made by Carers Voice Norfolk and Caring Together. This is to include options for the carers passport to be included as an alert on clinical systems to help with the identification of carers	Tricia D'Orsi	22/11/2022	Carers Passport goes live on 24.11.22 as referenced within the Chief and Chief Executives Report to November Board.	Propose to Close
3	27-Sep-22	Review of risks 5A and 5B.	PD'O to review risks 5A and 5B.	Tricia D'Orsi	22/11/2022	This has been completed. Please see the Board Assurance Framework Paper.	Propose to Close
4	27-Sep-22	ICB EMT to work on risk appetite.	The ICB Executive Management Team to do further work on risk appetite and risks 7, 12 and 13, to then present and discuss this with the Audit Committee, before bringing it back to the ICB Board	Karen Barker	22/11/2022	This has been completed. Please see the Board Assurance Framework Paper.	Propose to Close

Norfolk and Waveney
Integrated Care Board

Agenda item: 6

Subject:	**Chair and Chief Executive's report**
Presented by:	**Rt Hon. Patricia Hewitt, Chair, NHS Norfolk and Waveney ICB** **Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney ICB**
Prepared by:	**Rt Hon. Patricia Hewitt, Chair, NHS Norfolk and Waveney ICB** **Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney ICB**
Submitted to:	**ICB Board**
Date:	**22 November 2022**

Purpose of paper:

To update members of the Board on the work of the ICB.

Executive Summary:

The report covers the following:

A. System pressures and winter planning
B. Our Integrated Care Strategy
C. Mental health workforce plan
D. Launch of our Carers Identity Passport
E. Our Green Plan for achieving net zero by 2045
F. Visits
G. Delegation and joint exercise of statutory functions
H. Change to Accountable Emergency Officer
I. Appointments

Report

A. System pressures and winter planning

Our urgent and emergency care services continue to be under significant pressure – as they are across the country – and staff are working incredibly hard to provide the best possible care to patients. Our thanks go to all health and care staff for their hard work and dedication, including of course colleagues working for the Integrated Care Board.

There's a detailed paper on the agenda for this meeting which sets out the actions we have taken and are taking to prepare for winter and to reduce the pressure on services. The paper explains how services are working differently and how we are investing £11.7m of additional funding to improve the situation and address the challenges we face.

In our report to September's Board meeting we noted the improvements made to the care people get before they go to a hospital, which is preventing unnecessary trips to Emergency Departments and ensuring that the ambulance service can focus on people who have a serious or life-threatening condition.

Our focus now is on improving our discharge arrangements and the flow of patients through our hospitals and back into the community. Getting this right will make a significant difference to people's lives and their care, it will help ambulances get to people quicker, enable people to be seen quicker when they go to the Emergency Department and prevent people waiting in an ambulance outside a hospital.

Actions being taken to improve discharge and flow include:

- Increasing home support, investing to create the equivalent of 100 beds.
- Increasing community bed capacity by 87 beds.
- Mobilising virtual wards earlier than planned to help prevent patients being admitted to hospital unnecessarily, with 46 additional beds being provided.
- Strengthening our existing Home First Hubs.
- Additional schemes with the voluntary, community and social enterprise sector.

The situation is very challenging and complex. The progress we made in the pre-hospital care was the result of a determined and concerted effort before the pandemic by all system partners, including GPs and primary care teams, community services and social care, 111 and the ambulance trust, as well as the acute hospitals. We are applying that same rigour, focus and collective action now to improving discharge and flow through the system.

B. Our Integrated Care Strategy

We are really pleased that our system, through the Integrated Care Partnership, has recently agreed a transitional Integrated Care Strategy for Norfolk and Waveney, a copy of which is included with the papers for this meeting. This is an important document, based on the updated Joint Strategic Needs Assessments and the other

work of both the Norfolk and Suffolk Health and Wellbeing Boards, that will guide our work as a system and as individual organisations.

The strategy sets four priorities which will help us to achieve our mission, which is: to help the people of Norfolk and Waveney to live longer, healthier and happier lives. The four priorities in the strategy are:

1. **Driving integration**
   Collaborating in the delivery of people-centred care to make sure services are joined-up, consistent and make sense to those who use them.

2. **Prioritising prevention**
   A shared commitment to supporting people to be healthy, independent, and resilient throughout life. Offering our help early to prevent and reduce demand for specialist services.

3. **Addressing inequalities**
   Providing support for those who are most vulnerable using resources and assets to address wider factors that impact on people's health and wellbeing.

4. **Enabling resilient communities**
   Supporting people to remain independent whenever possible, through promotion of self-care, early prevention and digital technology where appropriate.

Work has also started on the ICB's Joint Forward Plan, which will set out how we will deliver the NHS elements of the strategy over the next five years – we expect national guidance on the development of these plans to be published soon.

C. Mental health workforce plan

Improving mental health services and supporting people's wellbeing is one of the highest priorities for our system. Norfolk and Suffolk NHS Foundation Trust continues to implement its improvement plan, with support from NHS England, the two local integrated care boards and others, and wider developments to transform mental health and wellbeing support are also ongoing.

We would like to draw the Board's attention to the Mental Health Workforce Plan for Norfolk and Waveney which was recently launched. Investing in the mental health workforce is vital for improving both the wellbeing of our staff as well as the care people receive. The plan is based on four priorities:

Priority 1 - Creating new opportunities for our people
We'll introduce new roles and competency-based career paths. Develop flexible rotational or joint roles working with education partners, placements in the voluntary sector and opportunities for portfolio careers.

Priority 2 - Promoting good health and wellbeing
We'll take action to create a culture that is safe for staff as well as patients and carers, including taking action to address racism and micro-aggressions.

Priority 3 - Creating a positive and inclusive culture
We'll take action to improve equality, diversity and inclusion and promote the anti-racism strategy. Create leadership development programmes and provide access to team and individual coaching.

Priority 4 - Maximising the skills of our people
We'll develop a collaborative training offer for communities, patients/carers, people working in mental health and volunteers, and we'll create a Children and Young People mental health academy.

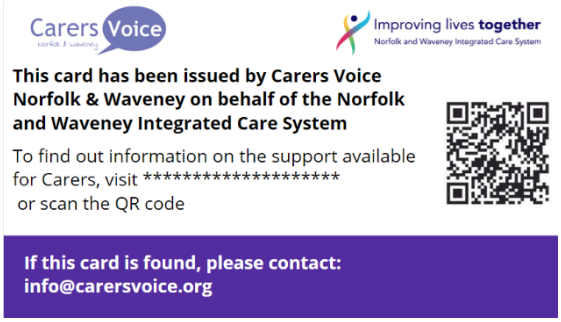
D. Launch of our Carers Identity Passport

Many people provide care, unpaid, to their relatives and friends. In Norfolk and Waveney, there are 108,000 carers, with one fifth (over 20,000) being young carers and young adult carers. Carers often know the needs and preferences of their family member or close friend even better than professionals do, and many carers become an expert in the condition of the person that they are caring for.

We are delighted that on Thursday, 24 November, our Carers Identity Passport will be launched. We heard at our ICB launch meeting in July how we could better support carers and families by involving them earlier when we are planning for a patient's discharge and listening to them about what would work best for the people they know and love. The launch of the passport is a good step forward in achieving this. Evidence shows carers passports can help staff, improve care and aid hospital discharge.

The passports will be issued by Carers Voice Norfolk and Waveney. To start with, the following organisations are supporting the scheme:

- East Coast Community Healthcare
- James Paget University Hospital
- Queen Elizabeth Hospital King's Lynn
- Norfolk and Norwich University Hospital
- Norfolk and Suffolk Foundation Trust
- Norfolk Community Health and Care Trust



There will be a virtual launch event for anyone who wants to find out more about the new Carers Identity Passports. It will be hosted online via Zoom on Carers Rights Day, which is Thursday, 24 November, from 2-3pm. To register to attend the event please email: info@carersvoice.org. Carers can register for a passport by completing a short form available at www.carersvoice.org.

E. Our Green Plan for achieving net zero by 2045

Climate change presents a profound and growing threat to people's health. Taking action to reduce harmful carbon emissions will save lives and improve health now, and for future generations. As one of the top ten largest employers in the world, contributing almost 5% of UK carbon emissions, the NHS has a real opportunity, responsibility and interest in tackling this threat head on.

Our recently published Green Plan outlines the aims and actions that partners in Norfolk and Waveney will take to meet the NHS's ambition to reach Net Zero by 2045. The plan sets out how we will reduce carbon emissions in areas such as:

- Medicines, medical equipment and other areas of the supply chain such as construction and freight, as well as food and catering.
- The carbon footprint from our buildings and materials.
- Personal travel (including patient and staff travel, as well as visitors).

F. Visits

We wanted to highlight some the meetings we've attended and visits we've made to interesting local organisations. These have included:

As Chair, meetings and visits have included:

- With Tracey, a visit to the Green Light Trust, an environmental education charity working in Suffolk and Norfolk to promote access to nature, thereby enhancing people's physical and mental health.
- I attended a development session of the Board of the Queen Elizabeth Hospital and a workshop of the Board of the James Paget Hospital, where I was also given an extremely interesting tour of the Emergency Department and other parts of the hospital. I attended a virtual meeting of the Board of Norfolk and Suffolk NHS Foundation Trust and I will be attending a meeting of the Board of the Norfolk and Norwich University Hospital in December.
- I attended meetings of both the Suffolk Health and Wellbeing Board, and the Norfolk Health and Wellbeing Board / Integrated Care Partnership.
- I also gave evidence to the House of Commons Health and Social Care Committee, which is undertaking an enquiry into Integrated Care Systems.

As Chief Executive, meetings and visits have included:

- I attended the ICB Review Meeting with NHS England, which was an opportunity to discuss the challenges we're facing in Norfolk and Waveney, as well as the actions we're taking as a system.
- I attended the launch of the Wellbeing on Wheels bus, which is an initiative with Voluntary Norfolk to reach communities who are seldom heard and underserved, who often struggle to access health services in the traditional way. The bus began its journey in October 2020 giving covid vaccinations to our homeless community – it is still offering vaccinations along with some tests, health advice and signposting to services.
- I have had some interesting and useful discussions about end of life care, including a visit to Tapping House Hospice in King's Lynn and a discussion with Marie Curie.

- I met with Active Norfolk to discuss how physical activity can support people's health and wellbeing, and I observed a bit of 'All To Play For', which is a weekly socially inclusive drop-in football programme for men struggling with poor mental health.
- I also attended and spoke at the HSJ Integrated Care Summit.

G. Delegation and joint exercise of statutory functions

On 28 September, NHS England published statutory guidance outlining options for how NHS organisations can exercise some of their statutory functions via delegation or via joint working arrangements under the Health and Care Act 2022. The guidance is welcome and introduces some flexibilities that will enable health and care organisations, including NHS England, the ICB and NHS trusts and foundation trusts, to work together more closely.

The guidance recognises the new delegation arrangements are not straightforward. Given the complexities of the new arrangements, NHS England recommends that, generally, systems do not seek opportunities to make use of these new powers in 2022/23. The new arrangements offer a good opportunity to work differently as our system working matures, so together we are starting to consider what the guidance means for us and how we work together. The ICB Board and system partners will be kept informed and involved as these discussions progress.

H. Change to Accountable Emergency Officer

When the Board met in July 2022, our Medical Director, Dr Frankie Swords, was approved as the ICB's Accountable Emergency Officer. The Accountable Emergency Officer is supported by the Principal Resilience Officer in ensuring that the ICB discharges its duties relating to Emergency Preparedness, Resilience and Response. Following further consideration of the portfolios of our Executive Management Team, it is proposed that our Director of Finance, Steven Course, is appointed as the ICB's Accountable Emergency Officer and the Board is asked to approve this change.

I. Appointments

The Board should note that the recruitment of the ICB's Executive Management Team is now complete. We have recently welcomed Ema Ojiako as our Director of People and Ian Riley as Director of Digital and Data. We also recently interviewed a very strong shortlist of candidates for the Board's fourth non-executive member who will chair both the Patients and Communities Committee and the Quality and Safety Committee; the interview panel has made a unanimous recommendation and an announcement will be made as soon as the usual checks are completed.

Recommendation to the Board:

The ICB Board is asked to agree:

- The Director of Finance is appointed as the ICB's Accountable Emergency Officer.

Key Risks	
Clinical and Quality:	The Accountable Emergency Officer plays an important role in our Emergency Preparedness, Resilience and Response, helping to protect and support clinical services in the event of an emergency, so it is important that the ICB appoints someone to this role who has the requisite experience, seniority and capacity.
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	N/A
Legal:	The ICB is required to appoint an Accountable Emergency Officer.
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Norfolk and Waveney
Integrated Care Board

Agenda item: 08

Subject:	**Transitional and combined Integrated Care Strategy and Joint Health and Wellbeing Strategy**
Presented by:	**James Bullion, Executive Director, Adult Social Services, NCC** **Debbie Bartlett, Director of Strategy and Transformation, Adult Social Services, NCC**
Prepared by:	**Debbie Bartlett, Director of Strategy and Transformation, Adult Social Services, NCC**
Submitted to:	**ICB Board**
Date:	**22 November 2022**

Purpose of paper:

To update the Integrated Care Board on the transitional Integrated Care Strategy for Norfolk and Waveney.

Executive Summary:

The Norfolk and Waveney Integrated Care Partnership (ICP) agreed its system wide Integrated Care Strategy at its meeting on 9th November 2022. (The Strategy is attached). The sign off of this transitional strategy follows a process over the last nine months to develop a high level framework which brings together existing themes from both the Norfolk and Suffolk Health and Wellbeing strategies.

The Integrated Care Strategy is needed to effectively influence all strategies in our system, including the ICB 5-year Joint Forward Plan as well as Place Boards and Health and Wellbeing Partnership strategies. It is centered on the four previously agreed themes of driving integration, prioritising prevention, addressing inequalities, and enabling resilient communities. Further Guidance is still awaited -and for this reason, it remains a transitional strategy which will be kept live and updated.

At the ICP meeting, on 9 November 2022, members agreed to the following recommendations:

1. Agreed to the transitional Integrated Care Strategy for Norfolk and Waveney and Joint Health and Wellbeing Strategy for Norfolk.
2. Agreed that all partners will take the transitional strategy through their own Governance arrangements, and feedback the actions their organisations will be taking in the coming year to deliver against the Integrated Care Strategy's key challenges and priority actions at the next ICP, in March 2023.
3. Agreed that this is a transitional and active document which will be kept updated and progressed.

Report

1. Background

1.1. Over the last six months, the Partnership has been advising and agreeing the shape and direction of the developing Integrated Care Strategy.

1.2. Early in this process, it was agreed that the foundation of the Integrated Care Strategy should be the four themes which made up the Norfolk Health and Wellbeing Strategy and the Suffolk Health and Wellbeing Strategy – driving integration, prioritising prevention, addressing inequalities, and enabling resilient communities – and that it will be high level to cover the whole system.

1.3. Over the course of discussions, including with district health partnerships, we considered identifying specific objectives under each of those themes, but on balance the Partnership agreed that at this stage in the development of the ICS, the four themes provided the strategic intent and direction under which all partners could collaborate.

2. Content

2.1. Based on the above evidence-led scoping, the strategy outlines our System structure and sets the scene within Norfolk and Waveney based on who we are, where and how we live, and how we end our life. This leads to the four priorities, our challenges as a System, and the priority actions for addressing them.

2.2. The highlights are:

Driving integration	
Our key challenges are	**Our priority actions are**
• Increasing demand on health and care services and post-covid challenges, puts the focus on operational pressures ahead of cultural changes, behaviours, and partnership development. • Reducing and levelling budgets within a stretched system. • Recruitment and retention issues with high number of vacancies across health and care. • Lack of joined up records and information across the system.	• To work as a single sustainable system in the delivery of people centred care, across a complex organisational and service delivery landscape. • Shift in focus and investment to community-based support so that people stay healthier for longer in their own homes and communities. • Use and share evidence and data intelligently, lived experience and evidence from service users, to help us keep our Strategy and System Plans on track and understand their impact. • Use partners' existing plans – building on the priorities partners are already working hard to address, identifying the added value that collaboration through this strategy can bring. • Develop mechanisms such as the sharing of information, pooling of resources and budgets (including Section 75 arrangements), to target health and care where it is needed most. • Create a joint workforce strategy and long-term plan to include recruitment and retention of health and care staff across Norfolk and Waveney.

Prioritising prevention

Our key challenges are	Our priority actions are
• Prevention and Early Help are seen as difficult to do and not everybody's priority. • Prevention support doesn't always show immediate results. • Stretched services due to lack of investment and provision in prevention awareness and intervention at an early stage. • Residents across various age and demographic groups are sometimes unclear what services might be available to help them stay healthy and well. • The current costs of ill health, providing health and social care and anticipated demographic changes in the next 20 years means it is not sustainable to continue to work as we currently do.	• Review historic practices to develop, in partnership, the opportunities for a systematic approach to preventing ill health from birth through early years to older age and end of life, starting with those areas that need it most • Funding of prevention services alongside existing services, to shift the system focus to helping people lead healthier lives at the earliest opportunity especially at a younger age. • Embed prevention and early help across all system and organisational strategies, plans and policies and shift focus to community provision. • Have joint accountability so that as a system we are preventing, reducing, and delaying need and associated costs. • Prevent people from becoming ill through promoting healthy lifestyles and mental wellbeing and healthy communities.

Addressing inequalities

Our key challenges are	Our priority actions are
• Deprivation, poverty, and multiple overlapping risk factors for poor health outcomes are found throughout Norfolk and Waveney and are more concentrated in some areas. • Seldom heard communities, the most vulnerable and those that are socially excluded experience additional difficulties accessing services. • Not everyone has a positive experience when accessing and using our services. • We have pockets of inadequate and poor housing, as well as inappropriate living conditions which are linked to poor health outcomes • There are differences between some of our rural and urban communities in their levels of need and the support available to them.	• Provide, share, and use the evidence to address needs and inequalities. • Identify and target collaborative interventions, services and resources to those communities and areas that have more need. • Plan for the future by joining up development planning and working with those with planning responsibilities. • Consult and engage with residents, including those from seldom heard and excluded communities, to design and input into our services. This should include a variety of engagement methods and technologies. • Ensure our services are easily accessible to all and improving accessibility to our services for those who need more support • Build confidence and trust in everyone who engages with our services and learn from those with lived experience • Reduce the impact of injuries, accidents, and crime in our most deprived areas.

Enabling resilient communities	
Our key challenges are	**Our priority actions are**
• Gaps in support services to enable people to live independent healthy lives in their communities for as long as possible. • Inconsistencies in our communities with accessing help and support through a variety of means • Loneliness and social isolation, especially for those with caring responsibilities. • People and communities including those with lived experience are often not involved in planning and developing their environments and care, as well as shaping the redesign of services and support.	• Support people to live independent healthy lives in their communities for as long as possible, through promotion of self-care, early intervention, and digital technology where appropriate. • Enable local resources, skills, and expertise to help people, families, and communities to thrive by accessing local support through the use of community assets such as green spaces, village halls, leisure centres etc. • Build capacity in our voluntary, community and social enterprise, faith groups and third sector. • Create healthy environments so healthy choices are the easiest choices. • Improve access and encourage people to use our natural and cultural landscapes to benefit their physical, mental, and emotional wellbeing. • Identify investment and funding opportunities from a variety of sources to develop new initiatives e.g., to combat loneliness and isolation.

2.3. Appendix 1 shows the final version of the transitional Integrated Care Strategy for Norfolk and Waveney/Joint Health and Wellbeing Strategy for Norfolk, which was agreed by partners at the ICP meeting, on 9th November 2022.

3. Next Steps

3.1. This transitional strategy provides continuity and high-level direction in our key challenges and priority actions that will enable ICS partners and individual organisations to start to address our system challenges in their planning and direction, and meet the deadline set by the Department of Health and Social Care, whilst setting an initial pathway and structure for the ICS. This strategy will drive the development of the ICB 5 -year Joint Forward Plan, and the strategies currently being worked on at a place-level by the Place Boards and Health and Wellbeing Partnerships.

3.2. Publication of this transitional Strategy ahead of the December 2022 deadline facilitates and supports the JFP development. The ICB Board has been supportive of the two pieces of work being developed in parallel, with the co-ordination being undertaken via the ICB's Transformation Board.

3.3. There is an expectation that all partners will take the transitional strategy through their own Governance arrangements and feedback to the ICP their own organisations actions that they will be taking in the coming year to deliver against the Integrated Care Strategy's key challenges and priority actions.

3.4. It is important to note that this will be a live and active document which will be updated and progressed as we garner increased insight and further develop our Integrated Care System.

*'2022 to 2023 will be **a transition period**. We expect that integrated care partnerships will want to **refresh and develop their integrated care strategy as they grow and mature**. In order to influence the first 5-year joint forward plans which are to be published before the*

next financial year, ***the integrated care partnership would have to publish an initial strategy by December 2022****.'*

The guidance for the preparation for Integrated Care Strategies can be found on the Gov.uk website.

3.5. The strategy will be available to all partners, internal and external stakeholders, and communities across Norfolk and Waveney by being published on the ICS website.

Recommendation to the Board:

The ICB is asked to:

1. Endorse the transitional joint Norfolk and Waveney Integrated Care strategy and Health and Wellbeing strategy
2. Agree to have regard to the Norfolk and Waveney Integrated Care Strategy when carrying out its functions.
3. Agree to support the system and partners in delivering against its key challenges and priority actions.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	
Legal:	Yes
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	Audit Committee for information.

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

Transitional Integrated Care Strategy and Joint Health and Wellbeing Strategy

Setting the agenda for our new Integrated Care System across Norfolk and Waveney

2022-23

Welcome

Every local area must have a Joint Health and Wellbeing Strategy setting out priorities, identified in the Joint Strategic Needs Assessment (JSNA), that partners will deliver together to improve health and wellbeing outcomes. The Health and Wellbeing Boards for Norfolk and Suffolk have their own strategies aimed at highlighting the need for collective responsibility for health and wellbeing. The Boards have a proven history of holding partners to account and enhancing everyone's responsibility to improve the health and care of their counties.

The recent changes under the Health Act 2022, has created a new Integrated Care System (ICS) which has formally brought together a wide range of organisations and stakeholders to improve services and provide more joined-up health and care for our residents. Our ICS is comprised of Norfolk with the addition of Waveney.

It also created an Integrated Care Partnership which key organisations – including health, care, local authority, Healthwatch, and voluntary sector from across Norfolk and Waveney – are part of. This partnership must produce an Integrated Care Strategy which is the key document for all ICS partners to develop their strategies and plans from, and sets out the challenges and opportunities we face that can only be addressed by partnership working and joint approaches.

As there is a clear cross-over between an Integrated Care Strategy and a Health and Wellbeing Strategy, this creates an opportunity to work together as a collective ICS around shared high-level health and wellbeing priorities. We have already achieved a lot by working in partnership, this has been strengthened through our collaborative response to the COVID-19 pandemic. The past three years have seen unprecedented challenges, but also incredible stories of communities and providers working together to ensure the people of Norfolk and Waveney have the support and care they need.

We want to build on the learnings from the pandemic to enhance our integrated working within the new Integrated Care System structure, but this will take time to do.

This Strategy builds on that collaborative mandate – our vision is working as a single sustainable system that enables us to achieve our overarching mission to **help the people of Norfolk and Waveney to live longer, healthier, and happier lives.** To do this, we are evolving our longer-term priorities from our previous Joint Health and Wellbeing Strategy to help us face the challenges of the future.

Prevention and early intervention are critical to the long- term sustainability of our health and wellbeing system – stopping ill health and care needs happening in the first place and targeting high risk groups, as well as preventing things from getting worse through systematic planning and proactive management.

For us to achieve our goals, we have developed these priorities which are reliant on everyone taking a collective and collaborative approach:

Rather than duplicate and replicate work being undertaken at place-level, it makes sense to coordinate an integrated approach for the whole System. This document acts as a transitional strategy which encompasses both the Integrated Care Strategy for Norfolk and Waveney and the Joint Health and Wellbeing Strategy for Norfolk.

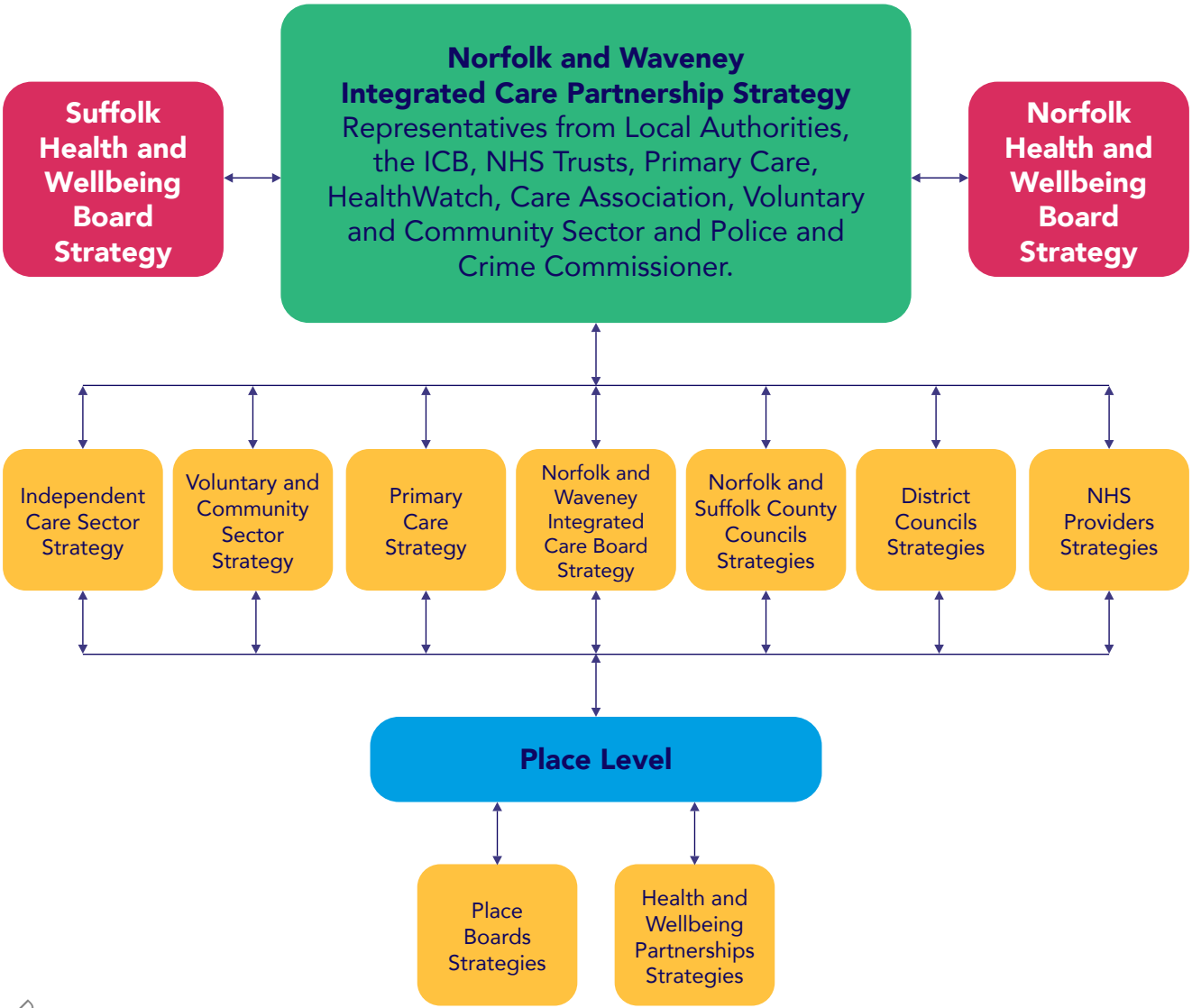
Over the course of 2023, we will be engaging with people, communities, and partners across our System to find out how our Integrated Care Strategy can work for us all. This engagement will be targeted and accessible to ensure those with quieter and overlooked voices are heard and listened to. We will engage with a wide range of communities, including those who are harder to reach and more rural.

This transitional period will allow time for emerging partnerships within the new ICS to establish themselves, for partners to assess the latest information from the JSNA and the impact the coronavirus pandemic has had on our communities, as well as allow time for meaningful engagement to take place. It is a 'living' document that will change and grow as our new collaborative system develops.

Councillor Bill Borrett
Chair of Norfolk Health and Wellbeing Board and
Chair of Norfolk and Waveney Integrated Care Partnership.

System and strategy

A key strength of our system is that it is built from the ground-up, meaning that District, City and Borough Councils, grass-roots voluntary and community organisations, NHS partners, providers, and most importantly the communities and people we provide services for all have input. This includes ensuring that strategies and plans across the system work cohesively and collaboratively. The diagram below shows the working relationship between the transitional Integrated Care Strategy and other boards and committee strategies across the ICS, and how we all work together in partnership.

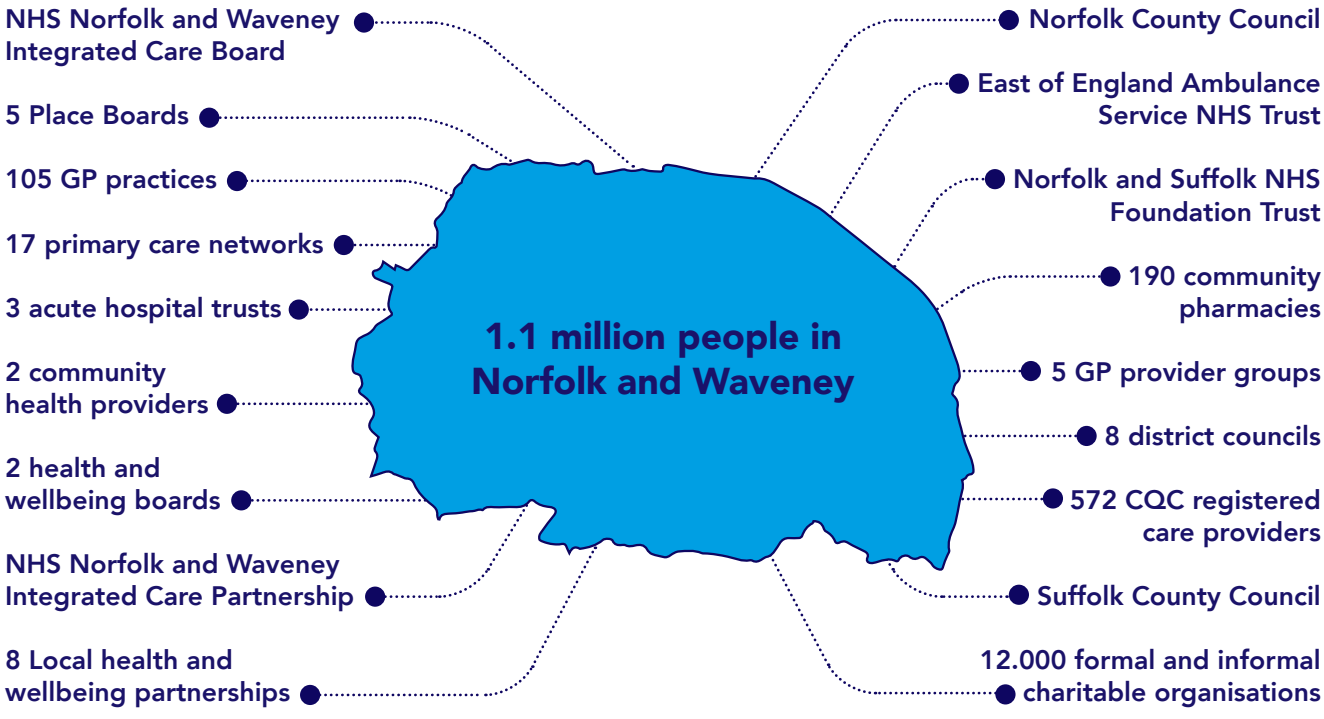


Setting the scene for our system

Norfolk and Waveney consists of over a million residents living in eight districts across rural, urban and coastal geographies. These include Breckland, Broadland, Great Yarmouth, King's Lynn and West Norfolk, North Norfolk, Norwich, South Norfolk, and Waveney.

Our health and wellbeing system is complex and made up of lots of different organisations under the umbrella of the Norfolk and Waveney Integrated Care System, which came into being on 1 July 2022. While we have been working closely together for many years, the new Health and Care Act 2022 will make it easier to bring partners together and push forward collaborative working and a single sustainable system. It offers us the unique opportunity to build on what we already have and take the steps towards a truly integrated model which delivers for everyone across the area.

The map below shows everybody involved in our System supporting health and care for the people who live in Norfolk and Waveney.



Our system mission

As an Integrated Care System, we have developed an overarching mission to **help the people of Norfolk and Waveney to live longer, healthier, and happier lives.**

To fulfil our mission we have three goals, these are:

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

To make sure that you only tell your story once
Too often people have to explain to different health and care professionals what has happened in their lives, why they need help, the health conditions they have, which medication they are on. Services have to work better together.

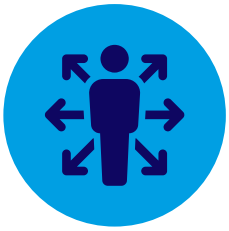
To make Norfolk and Waveney the best place to work in health and care
Having the best staff and supporting them to work well together will improve the working lives of our staff and means you will get high quality personalised and compassionate care.

From these system-wide goals and overarching purpose, we have developed shared guiding principles for the Norfolk and Waveney Integrated Care Partnership. These are designed to drive the cultures and behaviours of the Integrated Care System at a more local level, and to enable everyone to work together to make improvements and address challenges.

Our Integrated Care Partnership Principles are:

Partnership of equals

To find consensus and make decisions including working though difficult issues, where appropriate.



Collective model of accountability

As system leaders, taking collective responsibility for the whole system and partners hold each other mutually accountable for shared and individual organisational contributions to health and wellbeing objectives.

Improving outcomes for communities

Including improving health and wellbeing, supporting people to live more independent lives, reducing health inequalities, and tackling the underlying social determinants. Listening to the public and being transparent about our strategies across all organisations.

Collaboration and integration

Under the umbrella of the Integrated care Partnership and the Health and Wellbeing Board foster a culture of broad collaborations and integration at every level of the system to improve outcomes and reduce duplication and inefficiency. A commitment to joint commissioning and simpler contracting and payment mechanisms.

Co-production and inclusivity

Create a learning system which makes decisions based on evidence and insight. Using data, including the Joint Strategic Needs Assessment to target our work where it can make the most difference - making evidence-based decisions to improve health and wellbeing outcomes.

For us to achieve our mission and goals as a partnership, we have developed these priorities which are reliant on everyone taking a collective and collaborative approach:

Driving integration

Collaborating in the delivery of people-centred care to make sure services are joined-up, consistent and make sense to those who use them.

Prioritising prevention

A shared commitment to supporting people to be healthy, independent, and resilient throughout life. Offering our help early to prevent and reduce demand for specialist services.

Addressing inequalities

Providing support for those who are most vulnerable using resources and assets to address wider factors that impact on health and wellbeing.

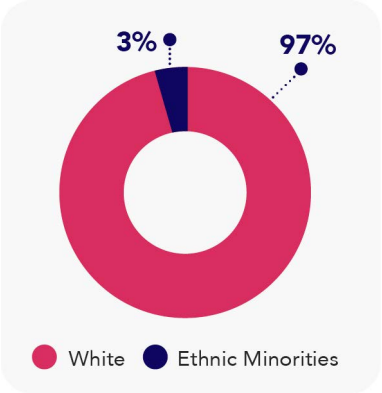
Enabling resilient communities

Supporting people to remain independent whenever possible, through promotion of self-care, early prevention, and digital technology where appropriate.

Living in Norfolk and Waveney: Who we are, and where and how we live

The population in Norfolk and Waveney is generally **older** than the England population. **1 in 4 are over 65.**

Norfolk and Waveney population is expected to **grow** by about **116,500** people between 2020 and 2040, the **largest growth** is expected in the older age groups, with those aged 65+ increasing by **95,000**. This is likely to put extra pressure on the working age population and potentially the availability of staff to deliver services.

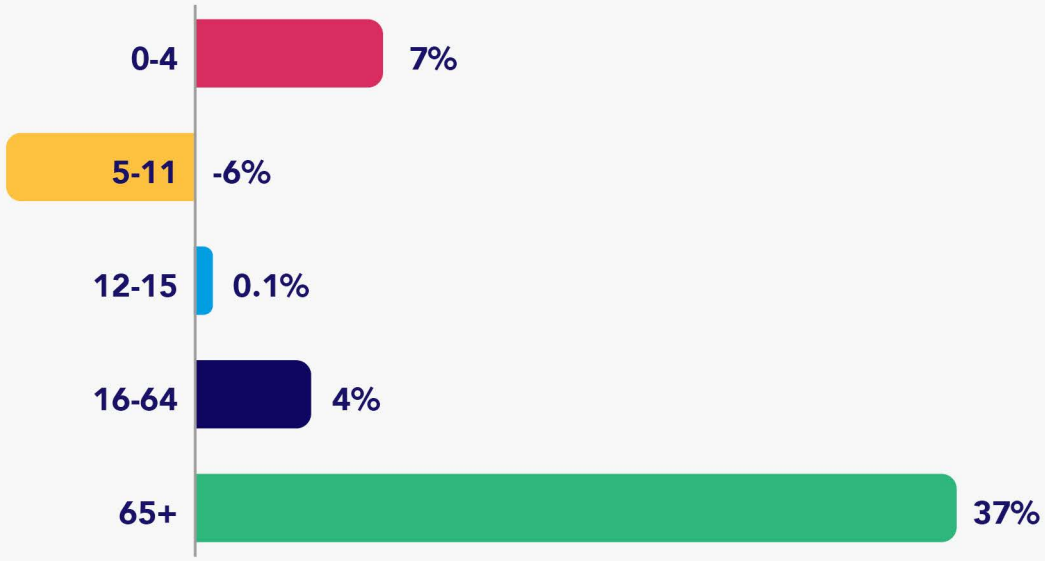


The Norfolk and Waveney population is less ethnically diverse than average in England. The most diverse areas across Norfolk and Waveney are Norwich, Great Yarmouth and Breckland.

There are around **160 languages** spoken in Norfolk & Waveney. English is not the first language of around **12,400** school children.

1.2% of people in Norfolk and Waveney have a disability.

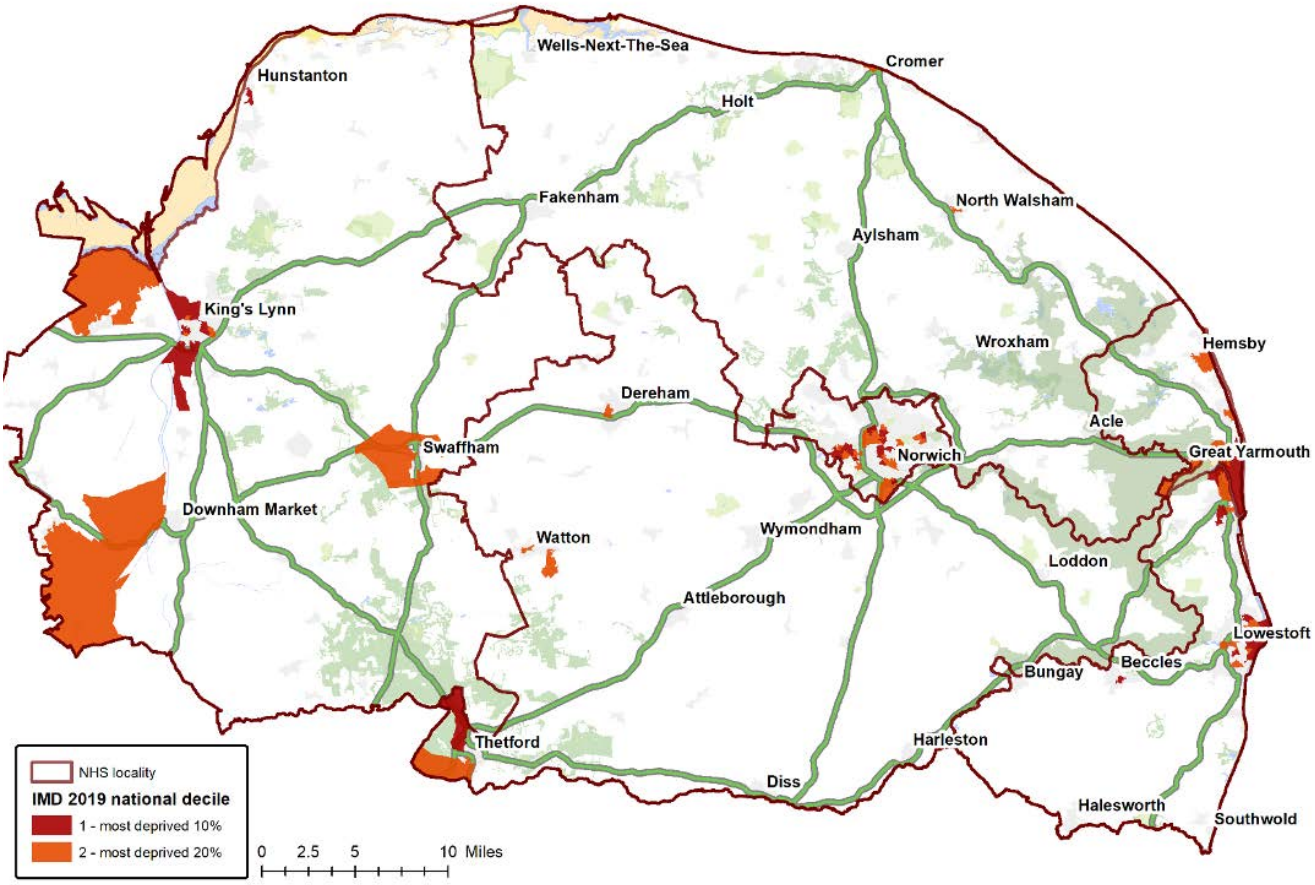
Percentage increase in each of the age groups between 2020 and 2040



Where we live

There are 42 communities across Norfolk and Waveney where almost 164,000 people live in the 20% of the most deprived areas in England. However, none of these communities are in Broadland or South Norfolk.

The map below shows the most deprived communities are mainly in our urban areas of Great Yarmouth, King's Lynn, Lowestoft, Norwich, and Thetford but there are smaller areas of deprivation in rural areas too. 40% of the populations of Great Yarmouth and Norwich live in the most deprived 20% of areas in England compared to 16% for Norfolk and Waveney as a whole.



15% of children live in low-income families

13% of households experience fuel poverty

The built and natural environment is inextricably linked to health across our lifetime. Populations in more deprived areas are more likely to have worse health outcomes, are more likely to be admitted to hospital in an emergency and are more likely to die early.

The design of neighbourhoods can influence physical activity levels, travel patterns, social connectivity, mental and physical health, and wellbeing outcomes. There is a higher occurrence of behavioural risk factors in the more deprived areas in England.

The connection between inappropriate or inadequate housing and poor health, effects everyone from childhood through to the elderly.

In Norfolk and Waveney, we have populations which have historically been excluded or have found our services hard to access. This includes refugees and asylum seekers, those experiencing homelessness or substance misuse, prisoners, sex workers, and those from Roma or traveller communities.

This results in missed opportunities for preventive interventions and further exacerbates existing inequalities. We need to breakdown the difficulties and barriers in engaging with our services to enable better outcomes for those with seldom heard and excluded voices. Our system should provide services that are available to everyone. This will require us to work differently, to include and involve better. By working together our system can bring expertise in hearing the voices of those excluded.

**comparison between the most and least deprived 20% of the population in Norfolk and Waveney.*

How we live

Births in Norfolk and Waveney are declining.

The rate of births to mothers aged 15-44 is lower compared to the rest of England.

1 in 20 children are under 5

9,100 births in 2019

Both Norfolk and Waveney have higher prevalence of smoking at time of delivery compared to the rest of England.

Early years to age 25

Overall health outcomes for children and young people in Norfolk and Waveney are similar to those for the rest of England. There are, however, differences in health outcomes based on where children live and in some groups of children, such as children with Special Educational Needs and Disabilities (SEND) and children in care.

5-11 year olds represent **8%** of our total population

The past couple of years have seen more children and young people accessing our services due to emotional wellbeing and mental health needs and gaps in learning following the pandemic.

More than 2 in 5 children in Year 6 (10-11yrs old) are overweight or obese

Further work is needed across Norfolk and Waveney for children and young people in the areas of prevention, early help, and health inequalities to promote healthier lifestyles and emotional wellbeing.

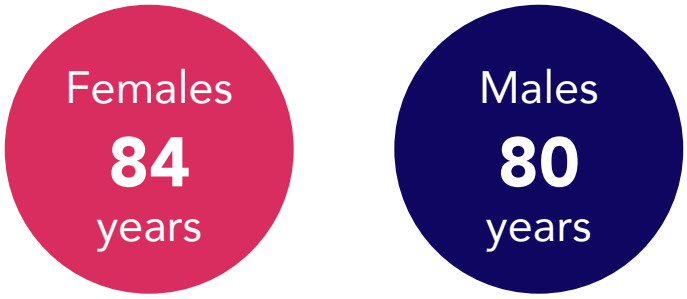
Across Norfolk and Waveney, we already have in place some strategies and operational plans to provide improved outcomes for our early years, children, and young people. Flourishing in Norfolk: A Children and Young People Partnership Strategy, which can be found by visiting the Norfolk County Council website. and, in the Family 2020 Strategy for Waveney which can be found by visiting Suffolk County Council website. The Family 2020 Strategy is currently in the process of being updated.

Life expectancy

Life expectancy is a person's estimated length of life based on age, gender and where they live.

Life expectancy in Norfolk and Waveney has consistently been higher than the national average for both men and women.

A person born in Norfolk and Waveney can expect to live:



Deaths from **circulatory diseases, cancer and respiratory diseases** contribute to most of this life expectancy gap.

Healthy Life expectancy is the average years somebody is expected to live in good health. In Norfolk and Waveney healthy life expectancy is about **63 years for males** and **64 years for females**, lower than England and has decreased over the last few years. This means that the time people spend in ill health is getting longer and is **17 years for males and 20 years for females.**

Inequalities exist from birth to older age (e.g. smoking in pregnancy, obesity, educational outcomes, lifestyle, unemployment). These contribute to a gap in peoples life expectancy of 9 years for men and 7 years for women between the least wealthy and most wealthy areas in Norfolk and Waveney. The life expectancy gap between these communities is mainly due to more people dying at an earlier age of circulatory, cancer and respiratory diseases.

Alcohol consumption is the biggest risk factor of ill health, premature death, and disability for younger adults (aged 15-49 years) in Norfolk and Waveney.

Lifestyle factors

These are the things that have an impact on our life expectancy in Norfolk and Waveney.

1 in 7 adults smoke. That's **100,000+** smokers

1 in 4 adults drink more than 14 units per week. **180,000+** adults drink too much.

3 in 5 adults carry excess weight. That's **475,000** adults that are overweight or obese

1 in 5 adults are inactive. **140,000** adults do not exercise

3 in 5 adults eat the recommended '5-a-day'. **280,000+** adults could eat better

Mental health

As a group of conditions, mental health disorders are a leading cause of ill health. This reflects the fact that most mental health conditions start early in life, some of them are very common (e.g. depression and anxiety) and many have a major impact on quality of life. People with long-term conditions, including diabetes and heart disease, are two to three times more likely to have depression.

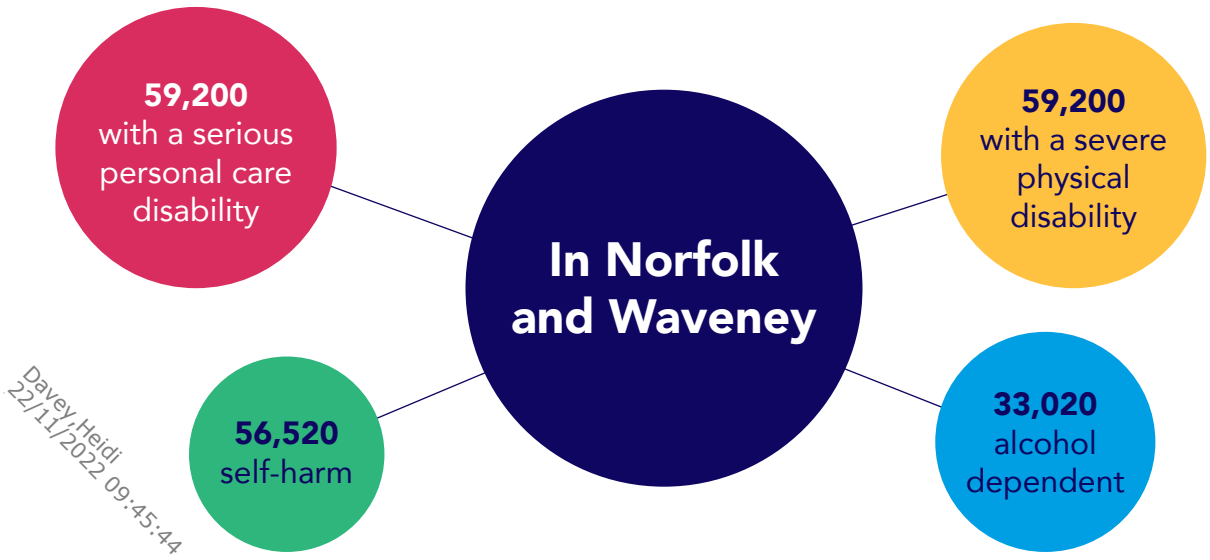
In Norfolk and Waveney, **143,430** people live with a common mental disorder. Suicide rates are higher than the England average, with suicide more common in men, those living in deprived areas, are unemployed, and who live alone.
We have seen an increase in people wanting to access mental health services, especially children and young people.

Care and Carers

A carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support. Around **1 in 8 people are carers**, that's 6.5 million people in the UK. According to the 2011 census, there are over 108,000 carers in the Norfolk and Waveney Integrated Care System with a fifth of these being young carers and young adult carers.

Carers UK report "Alone and caring" reveal 8 out of 10 carers have felt lonely or isolated as a result of their caring responsibilities. 57% had lost touch with friends and family, and 38% of carers in full time employment have felt isolated from other people at work.

The health and wellbeing of carers is also reported to be affected by the levels of caring, with carers who care for someone for more than 50 hours a week twice as likely to be in poor health as non-carers.



Safeguarding, its everyday business

Every child, young person and adult has a right to live their life free from abuse and harm. When safeguarding is done well it permeates through every part of our workforce, across our communities and through our voluntary & social enterprise sector. Safeguarding isn't just everyone's business, it's everyday business.

From the start of your career to the end, from frontline to board, in every conversation, in our working lives to our leisure time, we are all responsible. When done effectively we can 'feel' it in all contacts we have an organisation and its people. This feeling is outwardly demonstrated because raising a safeguarding concern is done with total ease and confidence.

We all have a role to play. We are all accountable.

Impact of Covid-19

The impacts of the pandemic are likely to be both short- and long-term, and the ongoing impacts on services and changes to healthy behaviour will have a negative impact on health outcomes for future generations.

Norfolk and Waveney and all district, city and borough areas had death rates lower than the East of England and England averages.

Unequal impacts of Covid-19

Populations in more deprived areas are more likely to have more pre-existing health conditions, which means that reduction in service use during the pandemic will have disproportionately impacted those groups.

The 20% most deprived areas had the highest case rates, the lowest vaccination uptake and the highest death rates once age was taken into consideration.

There were more cases in the female population, but national research shows that males are at a higher risk of dying.

Highest case rates were shown in older children and working-age adults compared to other age groups.

Ethnicity and Covid-19

Highest case rates were seen in:

Long Covid-19

Long Covid is defined as symptoms reported by individuals themselves that last for more than four weeks after a suspected Covid-19 infection. The most common symptoms reported were fatigue, shortness of breath and loss of smell.

Nationally, around 1 in 40 people experience Long Covid. That would mean around **26,000 in Norfolk and Waveney.**

14,000
would have moderate impacts

4,000
would have more severe impacts

Highest rates are in women, people **aged 35-49 and those living in more deprived areas.**

How we end our life

There were about **12,700 deaths** in 2020. All-cause mortality rates are **lower** than England.

Generally, as the population in Norfolk and Waveney increases and ages, the actual number of people dying each year is increasing. Most deaths are in older people, with very few deaths in younger age bands. The increasing age at death means more need for our health and care services.

The leading causes of **death for males and females are:**

- **Dementia and Alzheimers**
- **Covid-19**
- **Heart disease**
- **Stroke and lung cancer**

So, what does this information mean?

Looking at the Norfolk and Waveney picture we have developed these four priorities which are key to achieving our system-wide mission to **support the people of Norfolk and Waveney to live longer, healthier, and happier lives:**

Driving integration

Collaborating in the delivery of people-centred care to make sure services are joined-up, consistent and make sense to those who use them.

Prioritising prevention

A shared commitment to supporting people to be healthy, independent, and resilient throughout life. Offering our help early to prevent and reduce demand for specialist services.

Addressing inequalities

Providing support for those who are most vulnerable using resources and assets to address wider factors that impact on health and wellbeing.

Enabling resilient communities

Supporting people to remain independent whenever possible, through promotion of self-care, early prevention, and digital technology where appropriate.

Driving integration: What's important strategically?

Norfolk and Waveney have an annual budget in excess of £2bn for health and social care services. However, as a system we are seeing increasing demand resulting in budget pressures. Needs are becoming increasingly complex and so our service improvements must be more co-ordinated and effective for the service user and their carer. Services are improved where there is a coordinated, effective, and seamless response.

Interviews with members of Norfolk Health and Wellbeing Board emphasised the collaborative and innovative working during the pandemic. This involved breaking down some of the organisational barriers to support one another and moving resources accordingly. Health and Wellbeing Board members are keen for these changes to continue with collective resources used to their best effect, and duties and responsibilities shared to better support communities.

Our key challenges are:

- Increasing demand on health and care services and post-covid challenges, puts the focus on operational pressures ahead of cultural changes, behaviours, and partnership development.
- Reducing and levelling budgets within a stretched system.
- Recruitment and retention issues with high number of vacancies across health and care.
- Lack of joined up records and information across the system.

Our priority actions are:

- To work as a single sustainable system in the delivery of people centred care, across a complex organisational and service delivery landscape.
- Shift in focus and investment to community based support so that people stay healthier for longer in their own homes and communities.
- Use and share evidence and data intelligently, lived experience and evidence from service users, to help us keep our Strategy and System Plans on track and understand their impact.
- Use partners' existing plans – building on the priorities partners are already working hard to address, identifying the added value that collaboration through this strategy can bring.
- Develop mechanisms such as the sharing of information, pooling of resources and budgets (including Section 75 arrangements), to target health and care where it is needed most.
- Create a joint workforce strategy and long-term plan to include recruitment and retention of health and care staff across Norfolk and Waveney.

We know we will have achieved this when:

- We are all working together as a single system and sharing thinking, planning, funding, opportunities, and challenges – to inform new ways of working and the required transformation.
- We are effectively engaging with, and listening to, staff, residents, and communities to inform our understanding and planning for the future.
- Investment and funding has shifted focus to community provision.
- Someone only has to tell their story once when accessing multiple health and care services.
- We have a resilient and sustainable workforce to meet system need.

Prioritising prevention: What's important strategically?

There is strong evidence that interventions focussed on prevention are both effective and more affordable than just focussing on providing reactive emergency treatment and care. Although the language of prevention is not spontaneously used by people, the concept itself is well understood.

To build a financially sustainable system means we must promote healthy living across a life course, seek to minimise the impact of illness through early intervention, and support recovery, enablement, and independence. This starts with early years and childhood and throughout the life course.

Our research shows primary responsibility for health and wellbeing is seen to fall to individuals, with personal responsibility heightened by the pandemic for most. Despite agreement that health and care partners have some role to play in supporting residents to be healthy and well, there is a lack of understanding of what this role looks like in practice.

Our key challenges are:

- Prevention and Early Help are seen as difficult to do and not everybody's priority.
- Prevention support doesn't always show immediate results.
- Stretched services due to lack of investment and provision in prevention awareness and intervention at an early stage.
- Residents across various age and demographic groups are sometimes unclear what services might be available to help them stay healthy and well.
- The current costs of ill health, providing health and social care and anticipated demographic changes in the next 20 years means it is not sustainable to continue to work as we currently do.

Our priority actions are:

- Review historic practices to develop, in partnership, the opportunities for a systematic approach to preventing ill health from birth through early years to older age and end of life, starting with those areas that need it most
- Funding of prevention services alongside existing services, to shift the system focus to helping people lead healthier lives at the earliest opportunity especially at a younger age.
- Embed prevention and early help across all system and organisational strategies, plans and policies and shift focus to community provision.
- Have joint accountability so that as a system we are preventing, reducing, and delaying need and associated costs.
- Prevent people from becoming ill through promoting healthy lifestyles and mental wellbeing and healthy communities.

We know we will have achieved this when:

- System strategies, budgets, plans and policies reflect a focus on prevention and early help and future proofing for our changing demographics.
- All partners are prioritising prevention and early help both at a policy level and in decision-making that resonates with our communities.
- People and communities are able to independently access prevention help and advice, and activities, with the support of partners if needed.
- A reduction in the gap between life expectancy and years spent in poor health by better outcomes for everybody.

Case study: Age Healthy Norwich

Age Healthy Norwich

About

This project is aimed at 50-65 year olds with high blood pressure and weight concerns, to help prevent further deterioration in their health and wellbeing.

Age Healthy Norwich is a collaboration of VSCE providers who specialise in supporting people aged 50+ with their physical and mental health. The team consists of qualified staff from Age UK Norwich, Exercising People in Communities, Norwich Theatre, and Norwich Door-to-Door.

Two GP surgeries from OneNorwich PCN were involved in a pilot programme, which started in February 2022. 50 individuals from each surgery took part.

Approach

Participants could choose from a diverse range of over 30 activities which were a mixture of one-to-one or group-based and delivered within the home or garden, surgery, parks, community buildings or online.

Everyone received weekly one-to-one coaching sessions over a six-month period. This supported behavioural changes, helped to identify wider determinants of health (such as smoking cessation and healthy diets), accredited advice, hardship and transport subsidies as required.

Results

After six months, a variety of tools were used to evaluate participant goals and progress. These showed frequency of activity remained consistent over the six-months with a positive shift to more vigorous activity and walking. Time spent on physical activity increased from 4 hours-per-week to 5hrs 20 mins-per week, with time spent on vigorous activity trebling in duration.

Participants rated the quality of the service **10/10**

Across all types of feedback, people reported improvements in sleep, anxiety, nutrition, and levels of physical activity – all factors that can impact high blood pressure and overall wellbeing. There was also positive improvement across the majority of factors, including life satisfaction, happiness, physical health, and life purpose, and a significant improvement in mobility and ability to perform activities of daily living.

Although participants received one-to-one coaching in their home, 50% of people were supported to connect to community clubs for ongoing self-care, increasing their levels of social connection, support, and friendships.

Age Healthy Norwich will be continuing this model into 2023. You can find out more by visiting their website at AgeHealthyNorfolk.org.uk.

Addressing inequalities: What's important strategically?

Those living in our most deprived communities experience more difficulties and poorer health outcomes. Health and Wellbeing Board members told us that this was magnified during the pandemic and gaps between communities widened.

We recognise that together, we need to deliver effective interventions, to break the cycle, mobilise communities and ensure the most vulnerable children and adults are protected. To be effective in delivering good population outcomes we need to most help those in most need and intervene by working together at system, place, and community levels to tackle issues reflecting whole system priorities as well as specific concerns at the right scale. Reducing inequalities in health and wellbeing will involve addressing wider issues that affect health, including housing, employment, and crime, with community-based approaches. These need to be driven by partnerships at a place level involving councils, health services, the voluntary sector, police, public sector employers and businesses.

Our key challenges are:

- Deprivation, poverty, and multiple overlapping risk factors for poor health outcomes are found throughout Norfolk and Waveney, and are more concentrated in some areas.
- Seldom heard communities, the most vulnerable and those that are socially excluded experience additional difficulties accessing services.
- Not everyone has a positive experience when accessing and using our services.
- We have pockets of inadequate and poor housing, as well as inappropriate living conditions which are linked to poor health outcomes
- There are differences between some of our rural and urban communities in their levels of need and the support available to them.

Our priority actions are:

- Provide, share, and use the evidence to address needs and inequalities.
- Identify and target collaborative interventions, services and resources to those communities and areas that have more need.
- Plan for the future by joining up development planning and working with those with planning responsibilities.
- Consult and engage with residents, including those from seldom heard and excluded communities, to design and input into our services. This should include a variety of engagement methods and technologies.
- Ensure our services are easily accessible to all and improving accessibility to our services for those who need more support
- Build confidence and trust in everyone who engages with our services and learn from those with lived experience
- Reduce the impact of injuries, accidents and crime in our most deprived areas

We know we will have achieved this when:

- Populations in areas of most need show better health outcomes.
- There is an increase in availability of services in deprived and rural communities.
- We are consistently able to engage and support those in seldom heard communities and those who have previously experienced difficulties in accessing services.
- Our services are shaped by feedback from those with lived experience and everyone can access our services with confidence
- There is a reduction of injuries, accidents, and crime in our most deprived areas.

Case Study: Tricky Friends

Friendships are important and valuable to everyone and have a major impact on our health and wellbeing. Friendships are as important as healthy eating and exercise and support a sense of belonging. Belonging fulfils an important emotional health need and helps decrease feelings of depression and hopelessness.

It is important that people with learning disabilities and autism, those who have cognitive difficulties, and also children and young adults, have positive opportunities to make and maintain friendships. However not everyone who says they are your friend is genuine and some people can be exploited and abused by so called friends.

Over the last few years, Norfolk Safeguarding Adults Board (NSAB) have had discussions with groups and organisations in Norfolk who support people with learning disabilities and autism, about how to raise awareness of issues like exploitation, county lines, cuckooing.

We wanted to help them to do this, to reduce the risk of harm and exploitation in groups who may be less able to recognise the intentions of others. So, working with adults with learning disabilities and autism we have produced a short 3 minute animation called Tricky Friends.

This video can be used with or by anyone - carers, family, organisations, groups, to start conversations about what good friendships look like and what to look out for if something is not right.

Tricky Friends has been adapted for children and young people, and there's now a version in Ukrainian for those working with refugee families and vulnerable adults.

NSAB has shared this resource nationally and now over 35 safeguarding adults boards and other organisations are using it

Enabling resilient communities: What's important strategically?

District, City and Borough Councils work hard with partners to identify areas of increasing concern, poverty and inequality across Norfolk and Waveney. Health and Wellbeing Board Members told us that, through the pandemic, local resilience arrangements were key to providing clear messages and communication with communities, partners, and members.

Communities have the knowledge, assets, skills, and ability to help their residents flourish. Communities and individuals that are able to meet their own needs have better outcomes. It is important that our services support those living in our communities to look after themselves and live an independent life for as long as possible.

Our key challenges are:

- Gaps in support services to enable people to live independent healthy lives in their communities for as long as possible.
- Inconsistencies in our communities with accessing help and support through a variety of means
- Loneliness and social isolation, especially for those with caring responsibilities.
- People and communities including those with lived experience are often not involved in planning and developing their environments and care, as well as shaping the redesign of services and support.

Our priority actions are:

- Support people to live independent healthy lives in their communities for as long as possible, through promotion of self-care, early intervention, and digital technology where appropriate.
- Enable local resources, skills, and expertise to help people, families, and communities to thrive by accessing local support through the use of community assets such as green spaces, village halls, leisure centres etc.
- Build capacity in our voluntary, community and social enterprise, faith groups and third sector.
- Create healthy environments so healthy choices are the easiest choices.
- Improve access and encourage people to use our natural and cultural landscapes to benefit their physical, mental and emotional wellbeing.
- Identify investment and funding opportunities from a variety of sources to develop new initiatives e.g. to combat loneliness and isolation.

We know we will have achieved this when:

- There is increased partnership working and engagement of local authorities, parish councils, the voluntary, community, faith groups and third sector offering.
- There are better health outcomes such as decrease in admissions because of early interventions and more support services in the community.
- More people are independently able to access the support they need by using a variety of methods such as digital tools, apps and websites.
- Personalised advice is helping people to navigate our services and the use of self-directed support, such as new technologies and innovative models of care, are engrained in people's experiences.
- Healthy living environments are created at a local level through good holistic Planning design.

Case study: Lowestoft Rising - The Power of Collaboration

Lowestoft Rising is a multi-agency place partnership set up to take a holistic and asset-based approach to tackling the challenges faced in the town. Just over £500,000 of investment by the Lowestoft Rising funding partners over seven years has generated more than £4m of funding for the town. The funding partners are East Suffolk Council, Suffolk County Council, Great Yarmouth and Waveney ICB and Suffolk Police/Police and Crime Commissioner, but Lowestoft Rising is so much more than funding.

A few of our key achievements include our Mental Health Ambassador role and Positive Mental Health Manifesto, the Lowestoft Interventions process – where we work together to triage and support the most vulnerable, enabling Lowestoft Solutions (the first social prescribing project in Suffolk), our schools mentoring programme, high impact Cultural Education Partnership, work around homelessness and street drinking and our innovative 'Collaboration Academy' to inspire current and future leaders to work across organisational boundaries.

Current priorities are supporting vulnerable people (including financial and food poverty, substance misuse), mental health and wellbeing, and aspiration and achievement in young people. Our emphasis is on maximising the benefits of integration and partnership working for Lowestoft (including through the new Place Board, Waveney Health and Wellbeing Partnership and Waveney Health and Wellbeing Network, as well as the existing Lowestoft and Northern parishes Community Partnership), and inspiring individuals and families to believe in a better future.

Social Prescribing

- Operating in all GP surgeries across the town where patients with long-term conditions can access a holistic package of care within the community, through Solutions Lowestoft.
- Delivered by Citizens Advice North East Suffolk and funded by Better Care Fund, East Suffolk Partnership and the Suffolk Transformation Challenge Fund (plus Kirkley Mill) to March 2021.
- There was an approximately 40% reduction in GP appointments in the six months after support compared to the six months before but, more importantly, much better life outcomes for individuals.

"I am so pleased to have seen the adviser at Solutions because I know they are professional and they aren't going to scam me. I am being taken seriously because they are in the surgery so I know I can trust them".

"After visiting Solutions I feel like everyone is coming together to help me and I am going to be able to sort everything out now. For so long I have been getting bits of advice from 'here and there' and have never resolved anything".

"I felt the appointment with Solutions was really good, the adviser listened to me and took lots of notes. She is going to get some information to send to me so it was 45 minutes well spent".

Food Bank response

- Signpost East-led Food Bank collapsed in November 2017. An interim solution was quickly deployed by Access Community Trust to maintain food bank service across most sites – with 22 tons of food moved by volunteers to a new storage site.
- Lowestoft Community Church launched a new Food Bank in February 2018, with college and church volunteers working together. This provides six-day coverage across Lowestoft, plus an outreach service.
- There is a Free Period Scheme (sanitary products) in schools, colleges, and the library, which is now funded by national government.
- Special homeless persons Food Parcels are allocated by MEAM workers.
- 2 Year celebration event held for the 70+ volunteers who help keep the food bank running and helping to provide on average 750 parcels per month.

How can we make a change?

Working together is an opportunity to achieve joint outcomes, as a partnership we commit to:

- **Identifying the actions** that each Integrated Care and Health and Wellbeing Board partner will take in delivering our strategy, either through their existing plans or new initiatives.
- **Developing a joint system plan** so we can focus on the important things we have agreed to do together.
- **Holding ourselves to account** and be an accountable public forum for the delivery of our priorities.
- **Monitoring our progress** by reviewing data and information that tells us if we are making an impact.
- Reporting on our progress to the Integrated Care Partnership and/or Health and Wellbeing Board and **challenging ourselves** on areas where improvements are needed and supporting action to **bring about change.**
- **Recognise that social exclusion** impacts health outcomes, experiences, and access, and will require us to work different to include and involve better.
- **Developing and promoting a culture** within our system that actively addresses the **prevention of abuse and neglect** across all ages.
- **Keeping our Strategy live** and reflecting the changes as we work together towards a single sustainable system.

Plans for the transitional strategy going forward

The guidance from the Department for Health and Social Care outlines various areas where the Integrated Care Strategy must or should develop to be comprehensively support the health and care of our communities. As this document is a transitional strategy, which encompasses both the Joint Health and Wellbeing Strategy for Norfolk and the Integrated Care Strategy for Norfolk and Waveney, we plan to build on what is here to ensure we meet those requirements.

Over the coming months we will:

- Meaningfully engage with people, services and staff across Norfolk and Waveney.
- Identify areas of unwarranted variation and disparities in health and care outcomes.
- Identify gaps in our knowledge and research.
- Consider whether the needs outlined in the transitional strategy could be more effectively met with an arrangement under section 75 of the NHS Act 2006.
- Continue to work with partners in children and young people's services to highlight the safety and development of early years and transition into adulthood.

Improving lives **together**

Norfolk and Waveney Integrated Care System

Norfolk and Waveney
Integrated Care Board

Agenda item: 09

Subject:	**Norfolk and Waveney Integrated Winter Plan**
Presented by:	**Mark Burgis, Director of Patients and Communities**
Prepared by:	**Rachael Peacock, Head of System Resilience**
Submitted to:	**ICB Board**
Date:	**22 November 2022**

Purpose of paper:

This paper has been prepared to update Integrated Care Board (ICB) members of work being undertaken to support and create a resilient system, so we are more able to face the impact of the colder months and the rise in demand that is traditionally placed on our health and care system over the winter period. This report also notes that the historical 'lull' in pressure during the summer months once again did not happen during 2022, placing increasing pressure on all staff and providers within our system.

Executive Summary:

This report sets out a Winter Framework of key activity planned across Adult Social Care and NHS partners, to further improve and enhance system resilience over the coming months to meet the needs of the population of Norfolk and Waveney. The framework supports our organisations at system and place level, to maintain high quality and safe service provision in a climate of increasing pressure as we continue as an Integrated Care System to recover from the COVID-19 pandemic and prepare to face the additional strain that winter and cold weather inevitably bring.

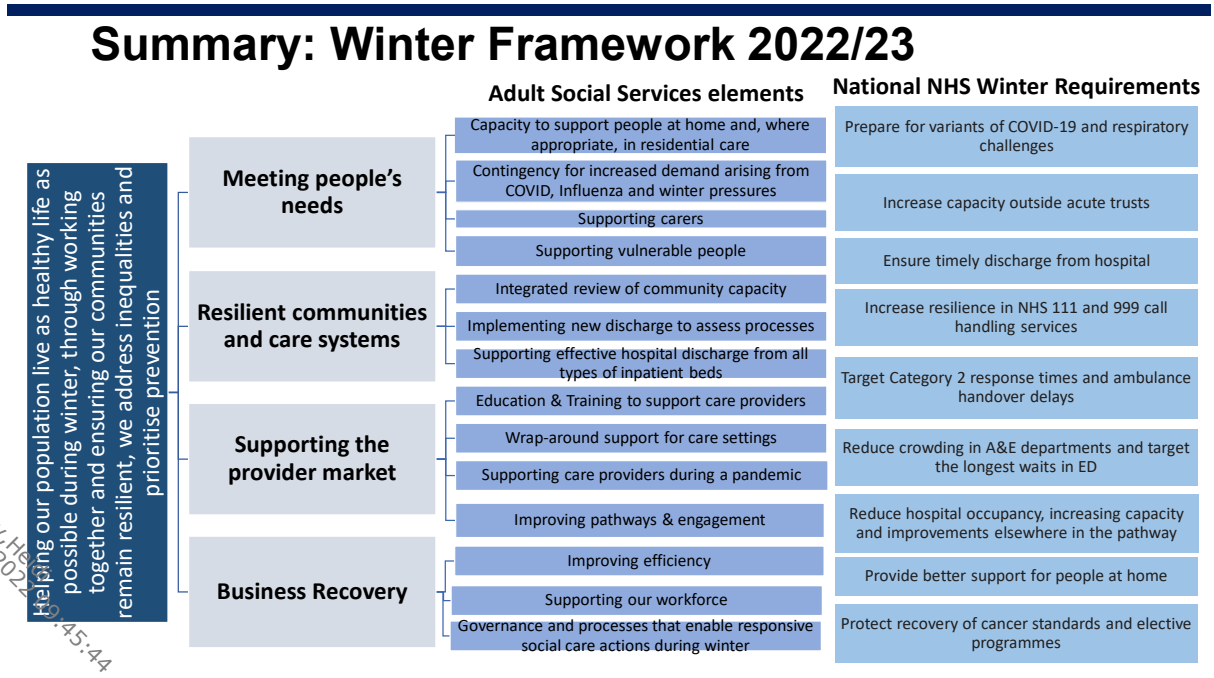
The Care Quality Commission (CQC) State of Care Report published on 21 October 2022 stated that our national health and care system is in gridlock, having a 'huge negative impact on people's experiences of care', (Go to Summary - Care Quality Commission (cqc.org.uk). Our Norfolk and Waveney ICS is no exception. We are seeing ambulance response times much longer than we would like, longer stays in hospital, and even more demand for access to care in the community., We also face a a backdrop of staff shortages and recruitment issues across the whole of the system. The COVID-19 pandemic has also taken a toll on our workforce, with some staff choosing to leave the health and care sectors which is impacting on resilience and capacity.

These pressures on our health and care system have remained in place all through the summer and we now face a challenging winter with uncertainty regarding flu activity, an increase in respiratory issues, and of potential further outbreaks of COVID-19 or the emergence of new variations, as people are facing increasing cost of living expenses and hardship. Again, Norfolk and Waveney is not alone here, these challenges and demands are being seen across England. Imperial College London modelling for the World Health Organisation (WHO) suggests planning for a winter with a similar number of emergency admissions as the previous two years. Emergency admissions have reduced due to lockdowns / other restrictions and have fallen below the expected baseline up to summer 2022 but we may see a particularly acute resurgence if flu and covid admissions peak at the same time.

Initiatives will help our population live as health life as possible during winter through working together to help support communities to remain resilient, address inequalities and prioritise prevention. Activity is grouped under 4 key strategic areas; Meeting people's needs, Resilient community and care systems, Supporting the provider market and Business Recovery.

Whilst there is no national Social Care Winter Plan to deliver against this year, NHSE have set out 8 core objectives designed to increase capacity and operational resilience in Urgent and Emergency Care (UEC) ahead of Winter. Our Integrated Care System (ICS) has received a funding allocation of £11m from NHS England to; increase "bed" and / or "bed equivalent" capacity in people's homes or in the community, to improve discharge for individuals, maintain the elective recovery programme and cancer care pathways and accommodate surges in demand in urgent and emergency care that are anticipated this winter.

The ICB has appointed a Winter Director and in line with national requirements, an integrated System Control Centre will be established to monitor operational activity and provide a point of coordination for system escalation. This will build on the existing collaborative resilience working within the ICS and provide the level of 'grip and control' required to manage the combined pressures of winter.



1. Background

Adult Social Care and Norfolk and Waveney Clinical Commissioning Group (now ICB) presented an integrated winter report to the Norfolk Health and Well Being Board on 1 December 2021, this was well received and endorsed by the Board.

As with last year, the system has not experienced a summer where pressures have abated. Therefore, although winter is not an emergency or considered an unusual event, it is traditionally recognised as a period of increased pressure due to demand both in the complexity of people's needs and the capacity demands on resources within social care and the wider system. As a result, it is anticipated that this winter will present greater challenges than in previous years.

The framework provides structure for a detailed and dynamic winter plan, where activity will adapt and change to respond to developing needs and policies.
The rising cost of living further disadvantage vulnerable communities and many households will be at greater risk of both hardship and reduced opportunity, health, and well-being.

The framework focusses on adult social care and health initiatives that include better support for people at home, children and young people, adult mental health services, we have also given an overview of place-based initiatives being delivered at Health and Wellbeing Partnership and Place Board levels.

The plan sets out initiatives in the community; primary care, hospitals, ambulance services, NHS 111 and 999 services, preparations for respiratory challenges including variants of COVID-19.

2. Winter Plan initiatives

2.1 The COVID-19 pandemic has placed strain on Norfolk and Waveney's social care and health system, and a risk remains of further outbreaks during winter. In addition, winter often brings with it untoward events such as widespread infectious diseases including pandemic flu which can affect our residents and staff alike. This has also taken a toll on our workforce, with staff leaving the health and care sectors impacting on resilience and capacity.

2.2 Meeting the needs of our staff, people and communities.

2.2.1 Norfolk County Council's Tactical Home Care Improvement Plan:
A number of key deliverables are in progress to ensure winter readiness. They include; commissioning additional block provision, opening up the home care framework and working with new providers, an enhanced home care discharge rate, additional double up capacity and targeted work to reduce the Interim Care list to give customers a longer term solution. Provider support is a vital component of the work with a collaborative approach being developed

with place-based commissioners to be able to respond swiftly to increasing demand. A collaborative prevention model is being developed to ensure an early detection triage process for referring people to community and VCSE support where their needs could be best met rather than a formal care package. Circa 2500 additional home care hours are being commissioned to further support people in their own homes. Assistive Technology Practitioners are reviewing patient discharge pathways and offer GPS pendants and telephone support to social workers.

2.2.2 Hospital Discharge: Adult social care, ICB and community health colleagues have been working together to stand up intermediate care beds as a key part of the system's increase in 'beds or bed equivalents' to support hospital discharge. At the start of the month, we had approximately 600 people in our hospitals that do not have a criteria to reside. This figure is slowly declining, with the latest number totalling approximately 550. Wrap around support from community health services is being commissioned to provide reablement and ongoing recovery support.

Improving discharge flow includes ensuring that discharge processes are robust and sustained with all three HomeFirst Hubs (multi-disciplinary teams working to support hospital discharge) being funded to year end. Substantive funding options are being developed to support recruitment and secure the workforce in this key area.

Work is ongoing to quantify ongoing care capacity requirements to support and sustain hospital discharge pathways after the winter surges. Matching of demand and capacity is an essential requirement to enable the Norfolk and Waveney system to exit winter pressures next year.

2.2.3 Waveney: Key activity in Waveney includes encouraging oversees recruitment to support Home Care Capacity and commissioning of a 'provider of last resort' to pick up care packages from HomeFirst in order to free up reablement capacity to support with hospital discharges. An increased Home Care rate is being offered to providers for new care delivered in the rural areas where it is most difficult for providers to cover. Additional block beds have been commissioned until April 2023, providing solutions for individuals with a range of care complexity.

2.2.4 Community Step Down model – Housing with Care Flats: A model has been developed between Norfolk County Council, Housing Providers (Broadland and Saffron Housing) and the ICB to make use of Housing with Care flats, as part of a Community Step Down model. In November we expect the first flats to be made available for people who are awaiting a care package to return home but are currently in an Intermediate Care bed. This is an opportunity to support people in an Independent Living environment but with access to 24/7 support, whilst their longer-term care package is being sourced. In addition to this, one of the other primary benefits of this model is to free up Intermediate Care beds that in turn will be used to support people who need to be discharged from the three acute hospitals.

2.2.5 Infection Prevention and Control (IPAC): Protocols are in place to manage and contain outbreaks of flu and Covid-19, pre-discharge testing for patients discharged to care settings and supporting and monitoring the care market to ensure a consistent IPAC approach. Care home capacity with wraparound care to support reablement and onward progression has been commissioned in Norwich and South Norfolk. Additionally, virtual wards are being scaled up to include community access pathways including frailty support.

2.2.6 Mental Health: There are a number of operational schemes to support seasonal pressures for people with mental health needs in 5 key areas; Admission avoidance, decreasing ambulance conveyance, reducing the pressures on emergency departments, decreasing length of hospital stay and improving support for successful hospital discharge. District Direct is now supporting people with Mental Health issues being discharged from hospital, reducing barriers to housing.

2.2.7 Children & Young People (CYP): NHSE initiatives focus on providing an alternative to A&E for CYP in a crisis supported by the voluntary sector, providing alternative respiratory pathways to reduce the pressure on Emergency Departments as well as additional support for discharge across the 3 acutes. Improved targeted support has been introduced at the front door for families signposting to the range of health and wellbeing resources that can be accessed via Just One Norfolk.

2.2.8 Primary Care: The majority of urgent 'on the day' care is delivered in general practice (80%). Norfolk and Waveney practices offer on average 74% of appointments face to face, compared to 68% nationally (September 2022). In September alone, more than 575,000 people accessed an appointment across general practice, that's half of our total population across Norfolk and Waveney. Following consultation with patients and from October, our Primary Care Networks have expanded their enhanced access offer with additional appointments in the evenings and on Saturdays to improve access for patients.

NHS N&W ICB has invested £142k of resilience funding into 14 GP practices to support strengthening resilience and we are continuing to work directly with the 6 of our 104 practices that were rated inadequate by the Care Quality Commission. We are sharing training and best practice on preparing for a CQC inspection with all practices.

We have commissioned a proactive healthcare service which enables practices to put in place interventions designed to reduce impact on the rest of the system. All 105 practices have signed up to the scheme. Examples are the Norwich home visiting service, discharge support and admission avoidance schemes. The direct care workforce has increased (e.g., pharmacists, physios and healthcare assistants). In August there were 798 staff providing 579 whole time equivalents. This compares to 740/530 a year ago.

NHSE funding has been used to increase the number of Social Prescribers with new posts at each of the acute hospitals supporting patients in the Emergency Departments and at discharge including promotion of Personal Health Budgets. 2 Social Prescribers have been allocated to the ambulance service and will be based in the control centre providing advice to crews on scene where signposting and community intervention may avoid the need for conveyance to hospital.

2.2.9 Carers: The Carers Matter Norfolk and Family Carers Suffolk services, offer Information advice, assessment and support, carers breaks, access to a health and wellbeing fund and Welfare advice. Over the winter more resource will go in to providing advice focussing on enabling carers to access additional financial support to cope with cost-of-living concerns such as heating and food resources. The service is working to raise the profile of carers with other agencies, so that carers can be identified, and the most appropriate support can be offered.

2.2.10 Resilient communities and care systems: Expansion of support from VCSE providers features as a key element of the winter plan supporting a range of service areas. Voluntary Norfolk have recruited volunteers to support residents recently discharged from hospital and will be able to assist with non-CQC regulated tasks. Age UK Norwich have been commissioned to offer additional health coaching and support in the community for those struggling with complex issues. A number of cost-of-living support schemes are being promoted to ensure people that needs support can find help when needed. Self-directed support and use of Direct Payments is being promoted to give access to untapped support in the community.

2.2.11 Keep Warm and Well Norfolk and Waveney winter campaign: The system wide prevention campaign ahead of winter launched on 1 November 2022 to support people to keep well in the coming months. A communications and marketing campaign will run until March 2023 asking residents whether they are 'winter ready?'. Resources encourage and support residents to stay warm and well as well as helping friends and family to do the same. Winter wellness tips and advice to look after your mental health will form part of the campaign with further advice on hardship and fuel poverty support. To find out more go to Warm and Well - Norfolk & Waveney Integrated Care System (ICS) (improvinglivesnw.org.uk). The campaign has been co-designed with all partner organisations across the ICS. Messages have also been tested with a number of patient and expert by experience groups to ensure they resonate as well as possible with people and communities across Norfolk and Waveney.

2.2.12 Increase Resilience in NHS 111 and 999 Services: The East of England Ambulance Service Trust (EEAST) Winter Plan includes recruitment of additional call handlers to improve call answer times. NHS 111 service development at a regional level includes mobilisation of a centralised call centre function to provide improved call answering times, thereby reducing delays, improving patient experience and improved redirection of ambulance resource.

A number of other initiatives are in train to support integrated working across health and social care providers this winter in relation to falls services, EEAST transfer of low acuity 999 calls to alternative providers and improving our urgent community response provision.

Work to improve hospital discharge will improve overall hospital flow and decompress Emergency Departments reducing ambulance waiting times so that they are able to attend to emergency calls in the community within the required response times.

2.3 **Supporting the provider market** Our Home Care Contingency Framework will help manage provider and place level resilience and risk. E-Brokerage is freeing up time and enabling more direct work to support providers. There has been an expansion of Norfolk Care Academies offering free training based on the Care Certificate, to encourage new care workers into the sector. Training through the Enhanced Health and Wellbeing in Care programme is supporting providers to safely help individuals with a growing complexity of need exacerbated by winter conditions. There is joint working across health and social care to promote the Flu and COVID-19 vaccination programme for staff and residents. The Integrated Community Equipment Service will be increasing its provision to support providers with access to equipment. IC24 are providing additional care home support with 'virtual' ward rounds at the weekends, helping to increase capacity outside acute trusts.

2.3.1 **Workforce** Health and Social care have joined up to carry out a large-scale recruitment drive, coordinating activities across ICS organisations to improve recruitment, retention and well-being of our staff. The campaign utilises the Norfolk Care Careers website, with health also promoting the call up of reservists to support key areas of work such as the vaccination programme and ambulance handover delays.
Incentives for staff include increased fuel payments for home care workers and the Blue Light card for the social care workforce, to assist with the cost and living and retention of workers. Work to improve the welfare and resilience of senior managers across health and social care working in operational roles, is being developed, supported by a staff survey to inform actions. Targeted recruitment for specialist groups such as therapist to support with care home residents looking to move back to their homes, is also ongoing.

2.4 **Business Recovery**

2.4.1 **Adult Social Care** – Work continues on the recovery programme to reduce the effects of the pandemic. There are a number of workstreams focussed on managing the demand on social care, improving efficiency, adopting a 'trusted assessment' approach and speeding up processes to ensure individuals receive the right care at the right time.

2.4.2 **Elective Recovery and Cancer Care Pathways** – The three acute hospital Trusts are broadly on target to deliver recovery trajectories for both the

elective and cancer care pathways. There remains significant challenge to deliver the recovery programme alongside the ongoing issues with hospital flow and surges in demand from urgent and emergency care pathways over winter. Recovery of performance and delivery against trajectory is being overseen via the national/regional tiering process with support from the Elective Recovery Programme.

2.4.3 IT and Data sharing. Accessible and high-quality data to inform operational decision making is vital. The creation of a dashboard to support accessibility for staff, will be a key enabler for our system and is a priority area. System level work is underway to develop an improved understanding and a commonality across health and social care particularly in relation to hospital discharge.

3. Place Base Working – Health and Wellbeing Partnerships and Place Boards

Place Boards and Health and Wellbeing Partnerships are leading on wide ranging initiatives that support residents and communities. For Districts and the Housing Sector, the pressures of housing, benefit issues and debt are immense. Winter is categorised as hardship and cost of living pressure, all of which can lead to poor mental and physical health and well-being issues that increase demand for our health care system.

The Health and Wellbeing Partnerships have been able to utilise Public Health COVID-19 recovery funding and Better Care funding for projects, which will help build resilience in people and their communities. The themes of work across the partnerships and board include support for those waiting elective surgery to remain well at home reducing falls and deconditioning, help with mental health, access to Active Now exercise programmes, hardship support and referral pathways to practical support maximising the opportunities to link people in with support networks such as debt advice, benefit claims, fuel and food support. This is another key theme as part of the warm and well winter campaign.

4. Governance

Over winter, day-to-day patient flow issues will be monitored via a ‘System Control Centre’ (SCC) with operational monitoring, cross organisational coordination and clear escalation processes in place. The SCC will be led by a Winter Director and team of senior operational managers to identify areas of concern, support a timely response and ensure plans can be adapted and flexed according to need giving the level of ‘grip and control’ required to manage the combined pressures of winter.

There will be ICB level oversight of Winter Plans and system performance via the ICS Executive Management Team and the Transformation and Recovery supporting Board structure, including the UEC Board, Discharge Board and Elective Recovery Board.

The NCC Adult Care Winter Plan will be taken to Cabinet in December 2022. Activity will be monitored regularly at the Internal Capacity Meetings and reported to the Director Leadership Team.

The Adult Care Services Senior Management Team will have oversight and governance of the Waveney plan.

5. Finance

Additional funding has been allocated by NHSE to support the continuation of the elective recovery work and to respond to an anticipated 7.5% increase in emergency admissions to hospital. This funding is being utilised to commission an additional 240 beds or bed equivalents for the Norfolk and Waveney system over winter to respond to surge pressures by reducing or avoiding hospital admissions and supporting discharges.

Key for this winter, is the approach to seasonal planning that builds upon the collaborative approach and learning from previous winters. A number of reactive schemes have been implemented in order to support the anticipated pressure and COVID response, whilst balancing the elective recovery programme and maintaining focus on ambulance category 2 response times.

As an ICB, we will continue to utilise learning from this and previous years (locally, regionally and nationally), in order to effectively establish the future capacity and demand requirements for our system. This cyclical process should support impactful programmes of work, give greater focus for strategic deliverables and inform commissioning intentions for 2023 and beyond.

Recommendation to the Board:

The ICB is asked to: Endorse the plan and work being carried out across social care and health to support the system and residents of Norfolk and Waveney during the coming months, and for partners to commit to working collaboratively to promote and support the plan.

Key Risks	
Clinical and Quality:	Clinical risk associated with delayed ambulance handovers, delayed community response times pushes the ICS frequently into Critical Incident status. This is resource intensive for the ICB and delays delivery of transformational work programmes.
Finance and Performance:	Performance risks associated with meeting statutory targets i.e. 4-Hour Emergency Department target
Impact Assessment (environmental and equalities):	N/A

Reputation:	N/A
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	B1929 – Next Steps in Increasing Capacity and Operational Resilience in Urgent and Emergency Care ahead of Winter. BW2090 – Going Further on Our Winter Resilience Plans
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	BAF02

Governance

Process/Committee approval with date(s) (as appropriate)	Audit Committee for information.

NHS
Norfolk and Waveney
Integrated Care Board

Agenda item: 10

Subject:	Overview of the Report of the Independent Inquiry into maternity and neonatal services at East Kent Hospital University Trust (Kirkup 2022)
Presented by:	Tricia D'Orsi, Director of Nursing
Prepared by:	Nicola Lovett - Lead Midwife Local Maternity Neonatal System (LMNS)/Norfolk and Waveney Integrated Care Board Emma Wiskin-Better Birth Transformation Midwife (LMNS)
Submitted to:	**NHS Norfolk and Waveney Integrated Care Board**
Date:	**22 November 2022**

Purpose of paper:

This is a briefing for the Norfolk and Waveney ICB Board to have an overview of the content of the Report of the Independent Inquiry into maternity and neonatal services at East Kent Hospital University Trust (Kirkup 2022), an understanding of current position, and ambitions for the future.

Executive Summary:

The Report of the Independent Inquiry into maternity and neonatal services at East Kent Hospital University Trust (Kirkup 2022) identifies key issues that contributed to the cases of avoidable harm identified within the maternity services. Some of the findings were reflected in the recent Ockenden Reports (2022,2022) and other previous key inquiries.

The Kirkup report highlighted;

- Failures of teamworking.
- Failures in professionalism.
- Failures in compassion
- Failures to listen.
- Failures after safety incidents
- Failures in the Trust's response, including at Trust Board level.

These incidents happened against the backdrop of oversight and reporting by the local clinical commissioning group and regulatory bodies.

This paper covers the four key action areas of the report, the current Norfolk and waveney position and next steps for consideration.

Full report can be found here:
Reading the signals: maternity and neonatal services in East Kent, the report of the independent investigation (print ready) (publishing.service.gov.uk)

Recommendation to the Board:

The ICB Board is asked to note the findings and recommendations of the report and proposal to monitor actions through LMNS Safety and Quality Oversight Group (SQOG) and LMNS Board.

Key Risks	
Clinical and Quality:	The report challenge to Boards is to remain focused on delivering personalised safe maternity and neonatal care, and ensure that women babies, and families are listened to, understood, and responded to with respect, compassion and kindness. Every Board must examine culture with their organisations and understand how they listen and respond to staff. Leadership and culture across organisations must positively support the care and experience provided.
Finance and Performance:	The LMNS funding is not baselined. The maternity Voices Partnership funding is not allocated from Region.
Impact Assessment (environmental and equalities):	The LMNS works with Trusts to support the Equality and Equity agendas.
Reputation:	There is a reputational risk of not hearing the voices of families and delivering safe and personalised care.
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	Better Birth Maternity Transformation NHS Long Term Plan (2016) Ockenden Reports (2020/22) Perinatal Quality Surveillance Model (2020) Overview of the Report of the Independent Inquiry into maternity and neonatal services at East Kent Hospital University Trust (Kirkup 2022)
NHS Constitution:	Relates to NHS constitution 1. Comprehensive service 3. Higher standards of excellence and professionalism

	4. Patient will be at the heart of everything 5. Work across organisational boundaries 7. Accountable to the public communities and patients
Conflicts of Interest:	None identified
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	Quality and Safety Committee for information.

Report

1. Background and Context

1.1. The report following the investigation into East Kent maternity and neonatal services sets out the devastating consequences and failings suffered by families and the need to listen and really hear the experiences of women, babies and families. The report identifies that if care had been delivered to national standards of care, then "the outcome could have been different in 97, or 48%, of the 202 cases assessed by the Panel, and the outcome could have been different in 45 of the 65 baby deaths, or 69% of these cases"

1.2. The report identified that culture and behaviours were a feature in the poor outcomes identified. These included

- Failures of teamworking.
- Failures in professionalism.
- Failures in compassion
- Failures to listen.
- Failures after safety incidents
- Failures in the Trust's response, including at Trust Board level.

1.3. The report challenges Boards to remain focused on delivering personalised safe maternity and neonatal care, and ensure that women, babies, and families are listened to, understood, and responded to with respect, compassion and kindness. Every Board must examine culture within their organisations and understand how they listen and respond to staff. Leadership and culture across organisations must positively support the care and experience provided.

1.4. The expectation is that every Trust and ICB will review the findings of this report at its next public board meeting, and for boards to be clear about the action they will take, and understand how effective assurance mechanisms are at 'reading the signals.'

1.5. The report identified four widely applicable areas for action based on the findings of the investigation, with national, regional and local expectations to ensure greater oversight of poorly performing units, and meaningful outcome measures.

1.6. The Norfolk and Waveney LMNS Programme team have reviewed existing practice and programmes of work to establish current position as well as future next steps for consideration against the four key areas.

2. Key Action Area 1: To get better at identifying poorly performing units

2.1. For the Norfolk and Waveney system, monitoring of trust safety intelligence continues in line with the perinatal surveillance tool at the LMNS bimonthly Safety and Quality Oversight Group, the quarterly Serious Incident Surveillance Group and other safety meetings with escalation of issues through the monthly clinical report at the LMNS Board. The clinical report has developed measures which are captured into a dashboard that shows trends, themes and outliers.

2.2. Norfolk and Waveney LMNS are developing and implementing a new maternity dashboard with the ICB Business Intelligence (BI) team

2.3. As raised at ICB Public Board (Sept 2022) the immature digital systems across the provider trusts/LMNS remains on the LMNS risk register. It is a priority to the create an accessible Power BI Maternity dashboard in line with the national data set (awaiting national steer).

3. Key Action Area 2: Giving care with compassion and kindness. The importance of listening to patients must be re-established as a vital part of clinical practice

3.1. Work will continue with the national team on Core Competency Framework V2, ensuring that compassion, civility and human factors incorporated within competencies.

3.2. We will progress and recruit to the position of 'Senior Midwifery Advocate' following a successful expression of interest. This position will support women and birthing people along with their families in the aftermath of a safety incident.

3.3. Progress work with provider Trusts to identify and triangulate themes from the birth reflections services, Professional Midwifery Advocates (PMA), and the Maternity Voices Partnership (MVP) as well as the themes from the freedom to speak up guardians.

4. Key Action Area 3: Teamworking with a common purpose

4.1. The LMNS Programme Team will lead quarterly Local Learning Events (LLE) to promote and support teamworking. Multidisciplinary attendance at LLE will be encouraged. As serious incidents are reviewed across the System in MDT System-wide meetings they inform the themes for the events.

4.2. System wide, multidisciplinary, obstetric skills and drills training (PROMPT) will be developed as well as exploring higher education institute/pre-registration multidisciplinary opportunities.

5. Key Action Area 4: Responding to challenge with honesty

5.1. The quarterly Serious Incident Surveillance Group will continue with escalation of issues through the clinical report at the LMNS Board ensuring that the Maternity Voices Partnership is aware of trends and themes.

5.2. Reporting to the Regional Performance and Quality Oversight Group (RPQOG) will provide an opportunity to review system challenges and areas for improvement and shared learning

5.3. LMNS will work with ICB Safety and Quality team to ensure that the roll of Patient Safety Incident Response Framework (PSIRF) incorporates the voice of the service uses.

5. Conclusion and next steps

6.1. In 2023 a single delivery plan for maternity and neonatal care which will bring together action required following this report, the report into maternity services at Shrewsbury and Telford NHS Foundation Trust, and NHS Long-Term Plan and Maternity Transformation Programme deliverables.

6.2. Norfolk and Waveney LMNS will be continuing with the on-going monitoring of Trusts Safety and Quality performance, Ockenden action plans and oversight of maternity and neonatal services in our system. The LMNS will work towards the development digital system that supports the identification of poorly performing Units, working the Trusts and ICB Digital teams.

6.3. The LMNS will review its core functions, priorities, and terms of reference once the single delivery plan is launched in March 2023.

Recommendation to the Committee:
The committee are recommended to note the findings of the East Kent report, the actions taken and next steps in line with the publication of the single delivery plan March 2023.

Improving lives **together**

Norfolk and Waveney Integrated Care System

Digital Transformation Strategic Plan and Roadmap

Part of

ConnectNoW

Using technology to improve health and care in Norfolk and Waveney

Foreword

We are at the start of an exciting, but challenging, digital transformation journey.

Together, we are determined to transform the way we use technology to deliver better, more personalised and easy to access care for the people of Norfolk and Waveney. Following on from the engagement and work we did to create our clinical and digital strategies, we have developed this Digital Transformation Strategic Plan and Roadmap.

Digital transformation is required to help achieve our three ICS primary goals:

- To make sure that people can live as healthy a life as possible.
- To make sure you only have to tell your story once.
- To make Norfolk and Waveney the best place to work in health and care.

Our new strategic plan and roadmap sets out the steps we want to take on this journey which include:

- ✓ improving communication between different parts of our system so people only have to tell their story once;
- ✓ having a single Electronic Patient Record (EPR) across our three acute Trusts to save time;
- ✓ more virtual services so people can be cared for in their own home and prevent/shorten admissions; and
- ✓ improve how we store, see and use data to help plan services much more wisely, focusing on people who need the most help.

To make these digital promises a reality, we need to make wide-ranging and long-term changes across our health and care organisations. Probably the most important, and hardest change, will be to adjust our attitudes and cultures to embrace digital opportunities. This is why we will work together to adapt how we are organised (governance), look at leadership, improve digital skills training we provide to staff, and help people who haven't previously used digital technology to make sure that nobody is left behind.

Across Norfolk and Waveney we have digitally well-informed people and communities who deserve a health and care system which can keep up with them. This strategy will help us create a secure and safer system to deliver better care.

Dr Frankie Swords
Medical Director,
Norfolk and Waveney
Integrated Care Board (ICB)

Connect-NoW

ConnectNoW

Using technology to improve health and care in Norfolk and Waveney

Across Norfolk and Waveney, we are committed to investing in, and using technology, to improve care and people's experience of health services. **We have called this area of work 'Connect-NoW'.**

Our vision is to develop a fully integrated digital service across Norfolk and Waveney, making more effective use of the technical expertise we already have across the region and allow our digital abilities to develop in line with advances we're seeing globally.

By setting out and working to our new Digital Transformation Strategic Plan and Roadmap, we have three key ambitions for our people and communities:

1. **Improve people's safety and quality of care**
2. **Give staff more time to care for people**
3. **Empower people to manage their health and wellbeing better**

Our Integrated Care System (ICS)

Across Norfolk and Waveney, we have a growing population and the ICS is striving to meet the needs of our people.

There is an urgent need to transform how we deliver care and support better health outcomes to address health inequalities, differences in life expectancy, and preventable causes of death.

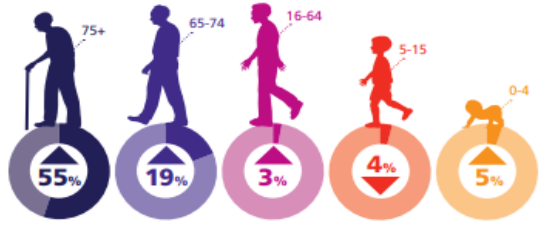
1.1 million population and growing

80-84 years average life expectancy

9% of the population is non-white British

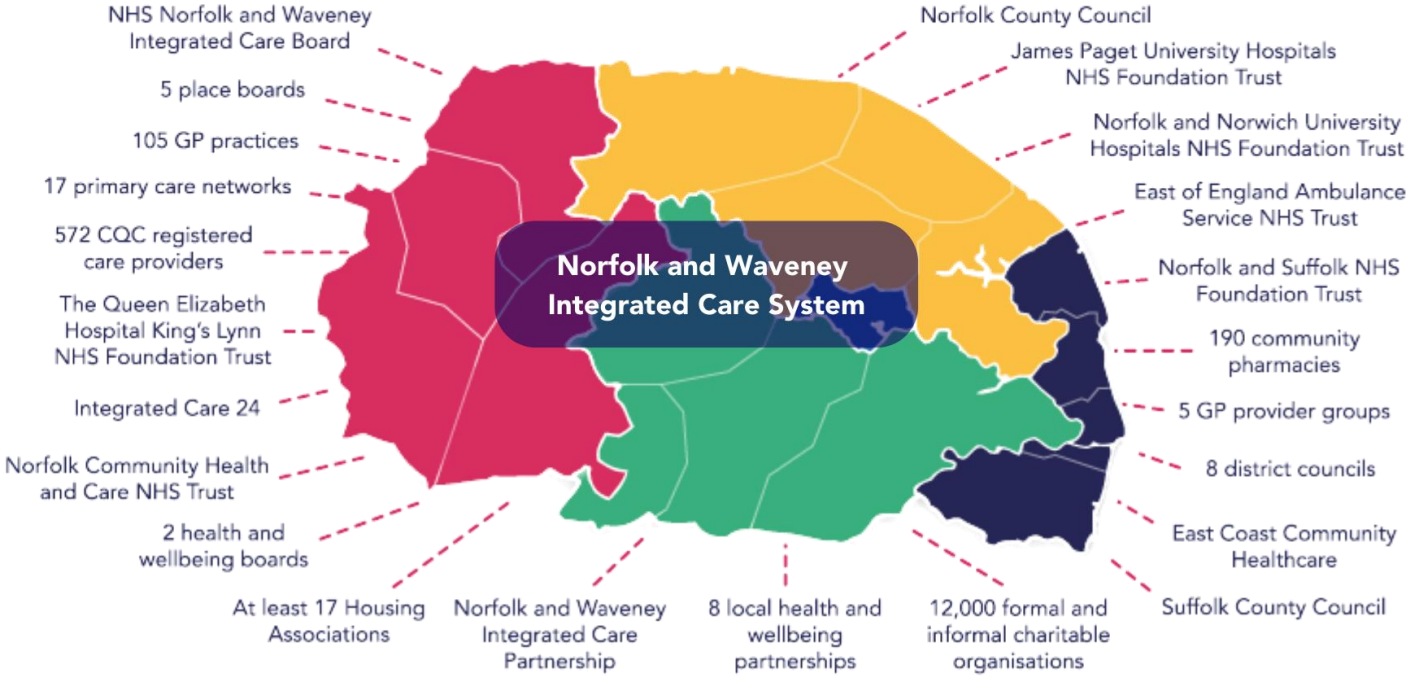
160 spoken languages

By 2040 our population is expected to **increase by over 110,000**, with older age groups growing faster than younger age groups.



280,000 adults could **eat better** and **100,000 smoke**.

143,430 adults estimated to have a **mental health condition**.



In 2019 more than 160,000 people in Norfolk and Waveney lived in some of the least wealthy areas of the country in both urban and rural places.

Inequalities exist from birth to older age (e.g. smoking in pregnancy, obesity, lifestyle, unemployment). These contribute to life expectancy inequality of 8.6 years for men and 6.8 years for women between the least wealthy and most wealthy areas in Norfolk and Waveney. **The life expectancy gap between these communities is mainly due to more people dying at an earlier age of circulatory, cancer and respiratory diseases.**

What people and communities said about digital

Throughout Summer 2022, we spoke to over 250 people at engagement events to find out what they want in digital health and care improvements. People said they want to see digital technology used for more reliable information sharing, improved access to services and more resources to support living well. They also said they'd like the ICS to ensure that information is kept confidential and shared securely, inequalities are not worsened, and the human element of care is preserved. The key themes were:

Reliable information sharing

"Real-time information sharing system-wide (not restricted to health). This could prevent delays in patients' treatment, e.g. patients seen by a specialist then referred back to GP for follow up but GP did not receive this info/referral."

Security of information

"Patients may not want their medical information to be accessible to the wider care system e.g. a disabled patient may not want their assessment shared due to the risk of their disability care needs not being met by another care service."

The 'human element' in care

"Information being accessible without counselling can distress or confuse patients e.g. test results shared online without explanation of results."
"Digital solutions need to add to existing services rather than replace them."

Access to resources to support living well

"Online information sharing of useful services for patients to self-manage their wellbeing without having to go to their GP. We need tailored and localised information shared about services. A virtual info hub that goes beyond health and signposts support e.g. energy grants."

Access to Services

"Many people have disabilities, long term conditions and fears regarding COVID-19 – virtual access enables easier access to services"
"Peer support and virtual communities for carers and patients."

Inaccessibility of digital services

"Online appointment booking can be difficult to access, particularly for individuals who lack digital skills or people with learning disabilities. It can also be challenging for people with complex needs and several appointments."

The feedback gathered helped develop our future vision for *"a digitally-enabled Norfolk and Waveney where access to information, services and support make it easy to deliver high quality health and care for and with our people".*

Why we're using digital to improve care

There is a need to digitise health and care services to support joined-up care, reduce inefficiencies and improve outcomes.

We know the impact using digital technology can have on our services and the level of care we can offer people in Norfolk and Waveney. Over the past few years, especially throughout the COVID-19 pandemic, technology helped us care for people in new ways as we adapted to innovative ways of working to keep people and our staff safe.

The Covid-Protect programme added 12,000 people to shielding lists using digital technology and population health management techniques and helped save lives. Using data from primary, secondary, ambulance and social care settings, the programme identified people susceptible to serious illness and hospitalisation and put them in regular contact with a virtual care team which prioritised and escalated their individual clinical and non-clinical needs.

This is just one example of digital innovation at work - there's more to do and we recognise that in order to continue our digital evolution, we need to invest more into this important area.

Investing in digital technologies can support our services to reduce inefficiencies, enhance safety and make people's confidential data more secure.

Benefits of digital transformation

Digital transformation will bring significant benefits for people and communities across our system by improving outcomes, reducing administrative processes, giving staff more time to care, and ensuring effective use of resources.

Improved outcomes and quality of care
through earlier detection and diagnosis, and reductions in errors

Reduced re-admissions / failed discharges
with patient tools to support self-management and accessible health information

Fewer A&E attendances
through preventative measures, enhanced triage processes, and improved care in community settings

Cost savings
with less printing, post, and merging of systems

A happier workforce
with improved staff satisfaction and more productive working years

Staff have more time to care
with automation and digitisation of administration

Proactive and preventative care
with better access to data to analyse trends

Reduced inequalities with improved access
As we can see the data of what health and care needs people have and can better target resources to help

Reduced waiting lists and length of stay
as technology improves and speeds up care freeing system capacity to help cope with demand

Reduced carbon emissions
With staff and people travelling less to health and care settings

Clinical objectives and digital ambitions

The Norfolk and Waveney clinical strategy objectives anchor our digital ambitions to ensure we are delivering services that are reliable, resilient, holistic, proactive and addresses health inequalities. Digital technology and innovation play a crucial role in helping us achieve these objectives and redesign health and care pathways.

Digital supports our dedicated workforce with the right tools and helps reduce administrative burden, releasing time to provide reliable services.

Preventative and proactive measures are vital to acting early in health and care. Digital tools improve predictive capabilities to support early intervention and treatment.

Digitisation of scheduling tools enables better management of clinical time. Technology can help reduce demand on services by directing people to the right place of care, freeing clinical time for those in need.

Better collection and analysis of data allows for a better understanding of our population so we can address inequalities in a more proactive and preventative way.

Technology allows information sharing across services and agencies which ensures people are cared for holistically.

Information sharing and collaborative working reduces duplication and helps us deliver safer, more efficient health and care services.

Our strategic objectives and guiding principles

The Digital Transformation Strategic Roadmap outlines five objectives that are underpinned by guiding principles which enable us to achieve our strategic vision.

Our five strategic objectives for the next three years are:

Strategic Objectives

Together
Use digital technology and skills to work more efficiently and collaboratively across standardised systems.

Connect
Provide effective and joined-up care through systems integration and streamlined information flows.

Activate
Empower people with greater visibility and control over their treatment and care journeys.

Understand
Use data to drive decisions and harness population health insights.

Innovate
Adopt a clear pathway for digital innovation and research to support the transformation agenda.

Our guiding principles were co-developed with clinical and digital stakeholders within the ICS to guide the development and delivery of the Digital Strategic Plan and Roadmap. The principles guide how we will work together to achieve our vision as a truly integrated care system:

- Collaborative & Inclusive
- Person-focused
- Joined-up
- Data-driven
- Safe & Sustainable

Investing in Digital as an ICS

Investing in Digital Capabilities

To deliver our strategic objectives, we will build our core digital transformation capabilities and invest in technology which will improve lives. Some of these investments include digitised patient records which will be securely accessible across the health and care system to provide one true record of information. We're looking to increase the quality of technology by improving connectivity, investing in more digital tools which will help collaborative working, give people more self-management equipment, and increase virtual offers to speed up access to treatments and personalised care. We're also investing in data solutions so we can understand the health and care needs of people and communities, which will help us tailor resources and support people better.

Investing in our System Enablers

Delivering our digital and data capabilities will require a set of underpinning system-wide enablers that span leadership, digital skills and inclusion, culture, governance, innovation and working as a unified digital team across the ICS. These are:

Leadership and Decision Making
We will align our priorities and continue to enhance our digital leadership skills.

Digital and Data Skills and Inclusion
We will upskill all our staff, people and communities to use digital and data confidently.

Governance
We will optimise governance structures for transparent and efficient decision making.

Innovation and Partnerships
We will encourage partnerships to innovate services and embrace digitisation.

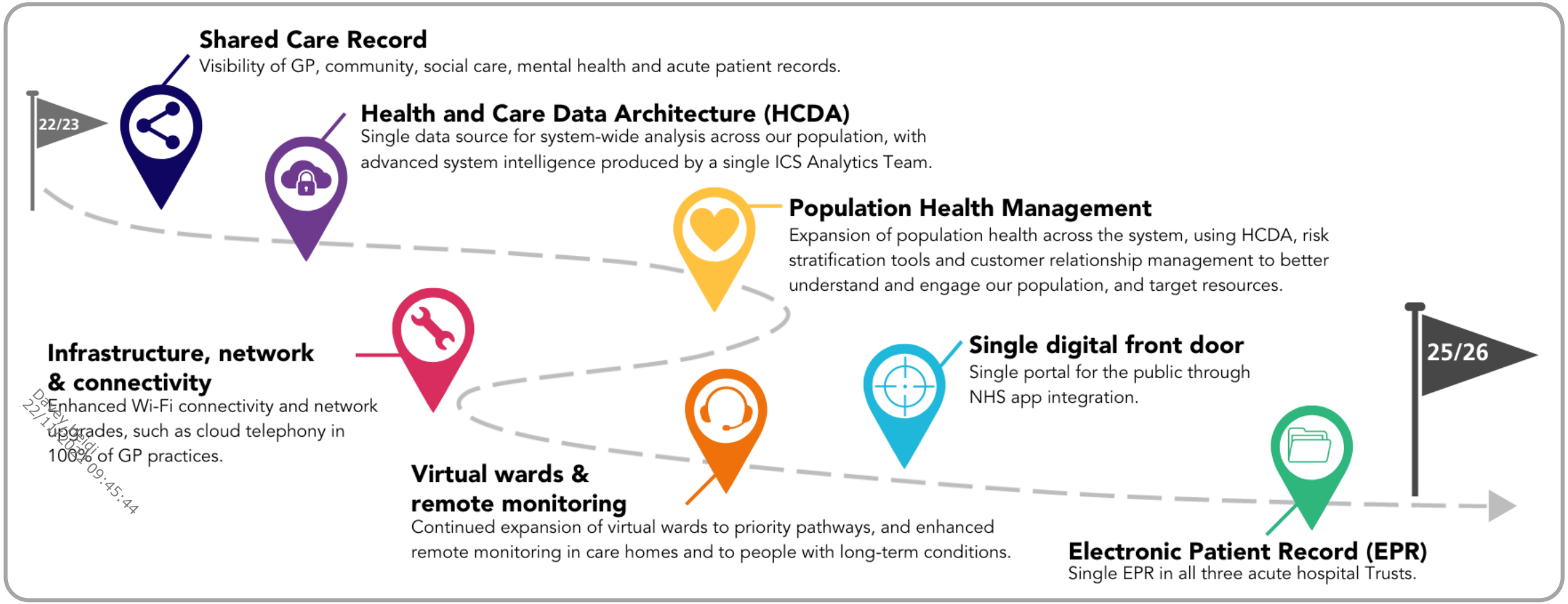
Transformation and Culture Change
We will nurture a 'digital first' culture and embed digital within system transformation.

Unified Digital Team
We will bring together key digital transformation skills to enhance collaboration across the system.

Digital Transformation Strategic Roadmap

Between now and the year 2026, we will achieve key milestones on our digital transformation strategic roadmap as we work together to improve the health and wellbeing of people living across Norfolk and Waveney.

Digital will enable transformation across all care settings, including outpatients.



Next Steps

This Digital Strategic Plan and Roadmap provides a direction of travel and a delivery roadmap for digital health and care over the next 3 years. Our priority actions for the ICS Digital Transformation Strategic Roadmap and Investment Plan are to:

- Agree and **commence appointment** of key digital transformation roles
- **Share the financial plan** with Chief Finance Officers across the ICS
- **Further develop plans and investment cases** for digital projects
- **Regularly review achievements against our goals** addressing new priorities as the clinical strategy evolves.

Thank you

Thank you to the people of Norfolk and Waveney, as well as clinical, operational and digital stakeholders from the ICS and partner organisations who supported the co-development of this Digital Transformation Strategic Plan and Roadmap.

If you have any questions or feedback please email:
nwicb.digitalstrategyfeedback@nhs.net

DRAFT for DISCUSSION

Improving lives together
Norfolk and Waveney Integrated Care System

Part of ConnectNoW
Using technology to improve health and care in Norfolk and Waveney

Norfolk and Waveney Integrated Care System

Digital Transformation Strategic Plan and Roadmap

Foreword

Frankie Swords
Medical Director, ICB

We are at the start of an incredibly exciting, but incredibly challenging, digital transformation journey.

Together, we are determined to transform the way we use technology to deliver better, more personalised and easy to access care for the people of Norfolk and Waveney.

Following the release of our ICS clinical and digital strategies, we have developed this digital transformation strategic plan and roadmap. Building on recent digital successes, this strategy aims to sharpen our focus on how we use the digital and technology capabilities to achieve the goals of our ICB: *to ensure that the people of Norfolk and Waveney only have to tell their story once, to help them to live as healthy a life as possible, and to make our ICS the best place to work in health and care.*

Engaging over 250 staff and patients to develop this strategic roadmap from June to September 2022, we have heard about current experience and expectations from digital for the future. I want to thank everyone involved for the time and attention they have given to develop our vision of *"a digitally-enabled Norfolk and Waveney where access to information, services and support make it easy to deliver high quality health and care for and with our citizens".*

Our new strategic plan and roadmap sets out the steps we want to take on this journey, including:

- *improving our communication between different parts of our system so that people only have to tell their story once;*
- *delivering a single Electronic Patient Record (EPR) across all three of our acute Trusts so staff can access the same information about patients whenever they attend one of our hospitals cutting out so much wasted time;*
- *expanding our virtual services, so that people can be cared for in their own home, using the latest technology to monitor their progress remotely, and even prevent or shorten hospital admissions; and*
- *expanding how we store, interpret and use data to help us plan services much more wisely, focusing on the people who need the most help.*

This is a massive opportunity and an incredibly challenging prospect. To make these digital promises a reality, we will need to make wide-ranging and long-term changes across our health and care organisations. Probably the most important and hardest change will be to change our attitudes and culture to embrace digital opportunities. That is why we will also work together to adapt how we are organised (governance), our leadership, the training we provide to staff in digital skills, and crucially work to help our citizens who haven't previously used much digital technology to make sure that nobody is left behind.

Thank you for all your help getting us this far and for taking the time to read about our future plans for digital tools to improve the care we provide for the people of Norfolk and Waveney.

Contents

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Improving lives together
Norfolk and Waveney Integrated Care System

Executive Summary

There is a need to digitise health and care services across Norfolk and Waveney to support joined-up care, reduce inefficiencies, and improve patient outcomes.

In Norfolk and Waveney, we are setting out on an ambitious journey of transformation. Our current care models rely on a mixed economy of predominantly legacy disparate systems and paper, which fall short of delivering the best care experience for our patients and staff. The inefficiencies that surround these models of care are ***costly and unsustainable,*** posing clinical and quality risks.

Investing in digital is essential to supporting collaborative working, truly joined-up care, improved outcomes, and a reduction in health inequalities across our region. Digital holds the potential to ***empower our population*** to take an active role in their own health through personalised care journeys and choice over where and how they receive care. Digital plays a key role in ***supporting our staff*** to work efficiently as one workforce across the system, reducing duplication and making the best use of their time. Digital also sets the foundation for operational, finance and estates transformation to ensure we make best use of resources.

Building on our Strategic Transformation Partnership (STP) Digital Strategy developed in 2018, the **Norfolk and Waveney ICS Digital Transformation Strategic Plan and Roadmap,** takes into account the shifts in digital thinking since the COVID-19 pandemic and establishes updated shared priorities for digital investment. It sets out the direction of travel for delivering digital solutions across the ICS. Our transformation journey is rooted in key ***national guidance*** such as the NHS Long Term Plan and the NHSX What Good Looks Like framework, as well as the Digital Health and Social Care Plan.

Our Digital Transformation Strategic Plan and Roadmap has been developed collaboratively with our people and reflects the perspectives of our citizens, patients, front-line clinicians and staff across Norfolk and Waveney. They have helped shape our vision of a ***digitally enabled Norfolk and Waveney where access to information, services and support make it easy to deliver high quality health and care for and with our citizens.***

Our Plan is brought to life through the journeys of five fictional people, shown below, which demonstrate how digital capabilities will ***deliver better outcomes and experiences*** for citizens and staff.





Executive Summary

Improving lives together
Norfolk and Waveney Integrated Care System

The Digital Transformation plan outlines five strategic objectives that are underpinned by our guiding principles that enable us to achieve our strategic vision.

VISION: our overarching aim

A digitally-enabled Norfolk and Waveney where access to information, services and support make it easy to deliver high quality health and care for and with our citizens.

To realise our strategic vision, we have developed five strategic objectives for the next three years.

Together
Use digital technology and skills to work more efficiently and collaboratively across standardised systems.

Connect
Provide effective and joined-up care through systems integration and streamlined information flows.

Activate
Empower citizens with greater visibility and control over treatment and care journeys.

Understand
Use data to drive decisions and harness population health insights.

Innovate
Adopt a clear pathway for digital innovation and research to support the transformation agenda.

Our strategic objectives are underpinned by our guiding principles.

Our guiding principles were co-developed with clinical and digital stakeholders within the ICS to guide the development and delivery of the Digital Strategic Plan and Roadmap. The principles guide the capabilities we implement to ensure we achieve our vision and ensure we work together as a truly integrated care system.

Collaborative & Inclusive

Person-focused

Joined-up

Data-driven

Safe & Sustainable

Executive Summary

To realise our digital ambition and deliver on our strategic objectives, we have established our core digital transformation capabilities.

To achieve our strategic objectives, we will invest in ***key digital and data capabilities:***

Digitised Patient Record, which will include a single Electronic Patient Record (EPR) across the acute Trusts, a Digital Social Care Record and also a Digitised Mental Health Record (EPR).

Shared Information, which will include the Shared Care Record (ShCR) roll-out and enhancements for information visibility across care settings.

Data and Analytics, including the development of the Health and Care Data Architecture (HCDA) and advanced business intelligence insight for consolidated and richer data analytics.

Population Health Management, developing the tools to understand our population and use data-driven insights to better engage with our citizens, system partners and tailor system resources to deliver maximum impact.

Citizen and Patient Tools, which will offer a single digital front door for streamlined access and greater self-care.

Virtual Health and Care, including the scaling-up of remote monitoring and virtual wards.

Infrastructure and Connectivity, enhancements and upgrades including cloud telephony, enhanced connectivity and information security, and optimised ICT infrastructure.

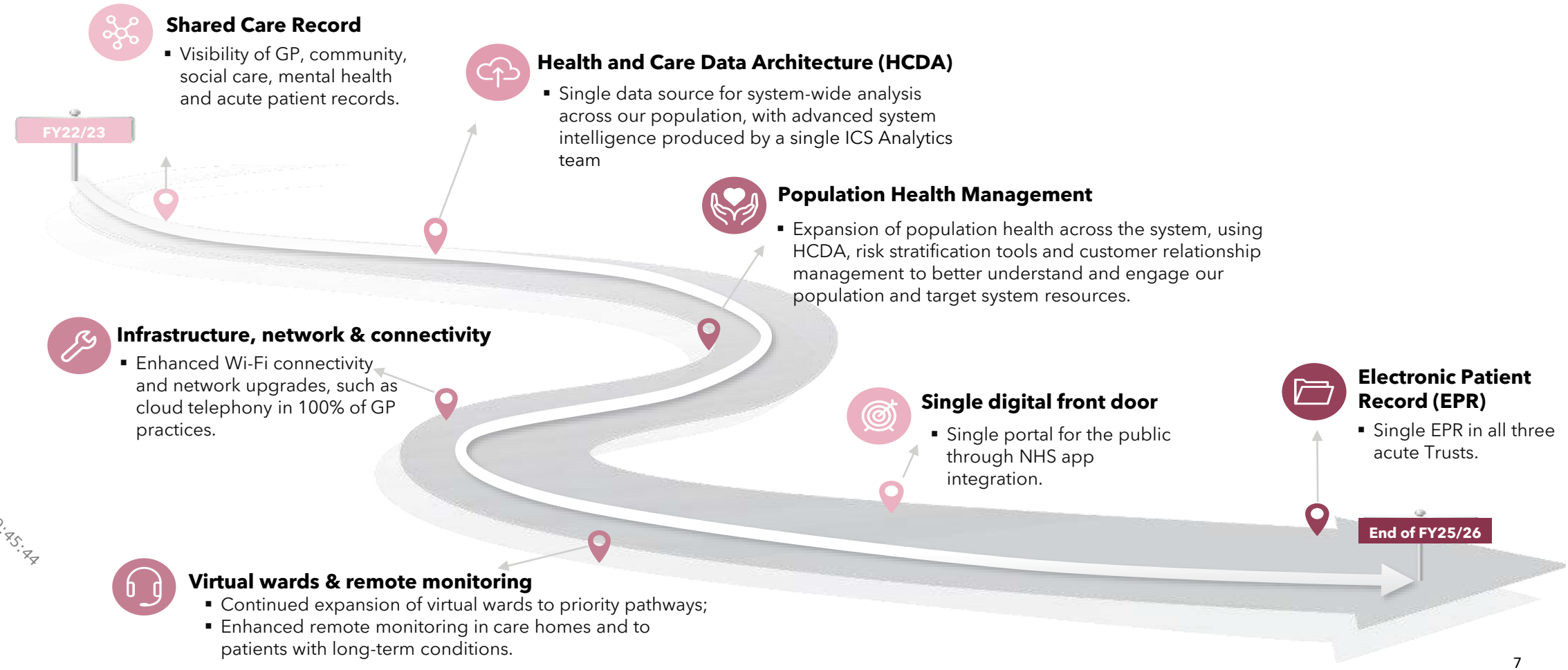
Digital Workforce Tools, which will support system-wide workforce planning and will include integrated learning management systems for staff, as well as a virtual careers office.

Executive Summary

Over the next few years, we will achieve key milestones on our digital transformation strategic roadmap as we work together to improve the health and wellbeing of people living across Norfolk and Waveney.

Digital Transformation Strategic Roadmap

Digital will enable transformation across all care settings, including outpatients.



Executive Summary

Delivering our digital and data capabilities requires a set of underpinning system-wide enablers.

Digital innovation plays a crucial role in enabling progress towards our clinical objectives, improving quality and productivity and addressing the needs of patients, clinicians and our staff. Digital transformation will require ***sustained cultural change within our system***. This includes changes to the way we work, develop, and govern as an integrated system.

Alongside our core digital initiatives, we will implement a set of ***underpinning system-wide enablers*** that span ***leadership and decision-making***, ***governance***, ***digital and data skills and inclusion***, ***transformation and culture change***, and ***innovation and partnerships***. We will also set out a model and next steps around working as a ***unified digital team across the ICS.***

These are our commitments around key digital enablers. We will:

- *Engage **system leaders** to champion the digital transformation strategy objectives at all levels, supporting their teams to work differently, and collaboratively agreeing system priorities.*
- *Embed **a transparent governance structure** around digital, including ensuring streamlined processes, information governance, cyber security and clinical safety.*
- *Develop a culture that embraces digital and data and **embed a 'digital first' approach** as part of wider transformation efforts.*
- ***Upskill all our staff, patients and citizens** to use digital and data confidently and to encourage inclusion and digital adoption.*
- ***Leverage partnerships and opportunities to innovate** our services and embrace the potential of digitisation.*
- ***Bring together key digital transformation skills** to enhance collaboration across the system.*

Executive Summary

DRAFT for DISCUSSION

Improving lives together
Norfolk and Waveney Integrated Care System

Delivering our digital and data capabilities and enablers will require significant investment.

In order to ***transform and truly integrate***, investment in capabilities beyond our current funding commitments is required. The investment for each digital capability is described in the diagram on the right.

£236m

Investment required to implement our digital ambitions in full across the ***FY22/23 – FY25/26 strategy period*.***

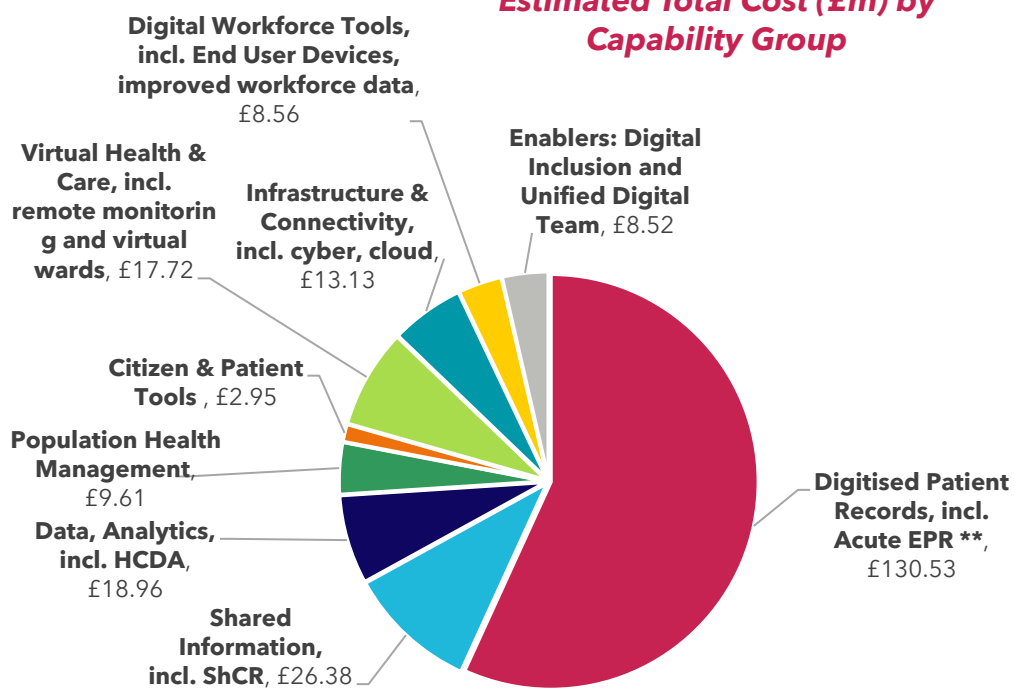
£132m

Funding identified to deliver our digital ambitions.

£105m

Additional funding required to deliver on Norfolk and Waveney's digital and data transformation beyond the sources already identified.

Estimated Total Cost (£m) by Capability Group



National guidance recommends that Trusts spend 5% of expenditure on technology.*** Our current spend on digital as a proportion of overall spend on health and care is approximately 1.6% (FY21/22). ***Investment in digital transformation will increase the proportion of health and care spend on digital to between 2.5 and 3.4% during the strategy period, bringing us closer to national guidance.***

The investments we are committed to and have secured funding for will ensure we can deliver some of the work packages we have committed to, however without further investment we will fail to realise the full outcomes that we wish to deliver. To fill this funding gap, we will work to secure additional regional and national funding. We will also consider, as a system, how to best increase our digital transformation budgets.

**Investment includes both capital and revenue. No optimism bias has been applied. 10% contingency has been applied to all costs and 8% inflation p.a from FY23/24.*
***Digitised Patient Records includes the Acute EPR programme costs for the strategy period (FY22/23 – FY25/26), as well as costs for digitising mental health records and optimising our primary care EPR.*
****Source: Lord Darzi and Institute for Public Policy Research, Better health and care for all, June 2018, referenced in the NAO Digital transformation in the NHS May 2020 report, Digital transformation in the NHS - National Audit Office (NAO) Report*

Executive Summary

DRAFT for DISCUSSION

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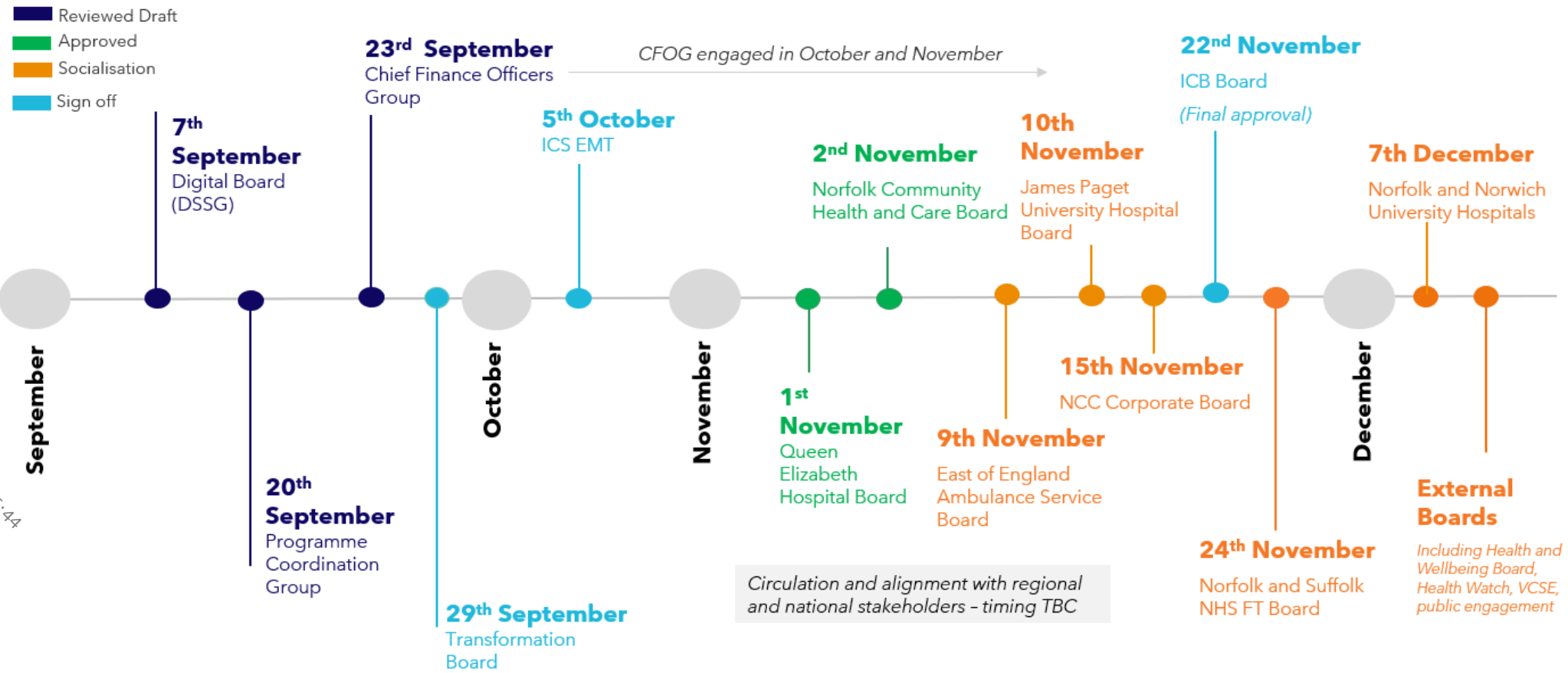
Norfolk and Waveney Integrated Care System

Supporting our digital transformation journey will require leadership and buy-in, achieved through socialisation and agreement to the plan.

This Digital Strategic Plan and Roadmap provides ***a direction of travel*** and a delivery roadmap for digital health and care over the next ***3 years***.

A critical path has been established for review and approval of this document. The path enables representative agreement and ownership with all organisations across the ICS. Once approved, we will seek to review achievements against our goals and objectives at ***annual intervals***, addressing new priorities and adjusting our direction of travel as required.

The current approval timeline for this document is outlined below with final ICB Board approval expected on ***22nd November 2022***.



Introduction and Strategic Context

Our Integrated Care System

DRAFT for DISCUSSION

Improving lives together
Norfolk and Waveney Integrated Care System

Across Norfolk and Waveney, we have a growing population and our Integrated Care System is striving to meet the needs of our citizens.

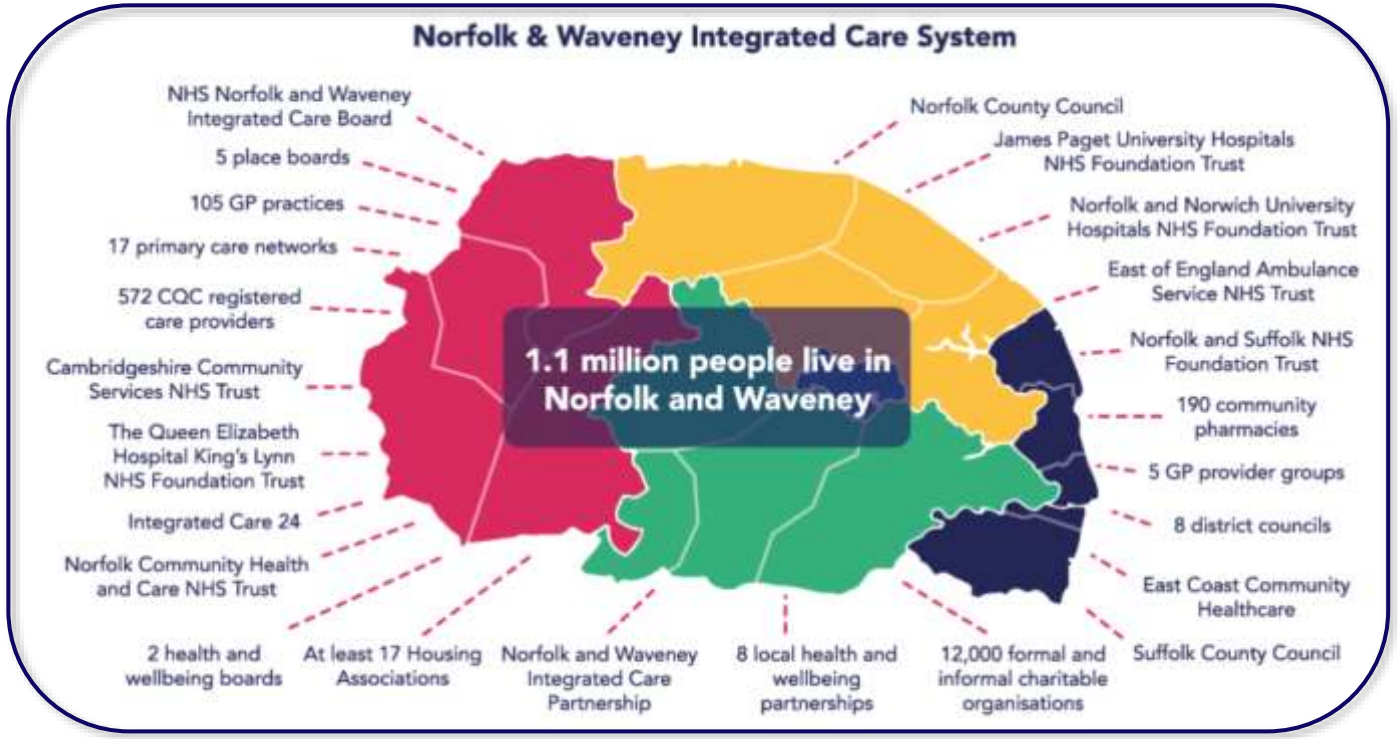
Norfolk and Waveney:

1.1 million citizens and growing*

80-84 years average life expectancy

3.3% of the population is minority ethnic

160 spoken languages



** A 110,000 increase is expected by 2040, with **74% of this being in the over-65s category,** larger than any other age group.*

Sources - https://www.norfolkinsight.org.uk/wp-content/uploads/2022/01/Norfolk_and_Waveney_Population_Overview_December_2021_accessible.pdf
In Good Health - Demand and Capacity Review (norfolkandwaveneypartnership.org.uk)

Our population's health and wellbeing

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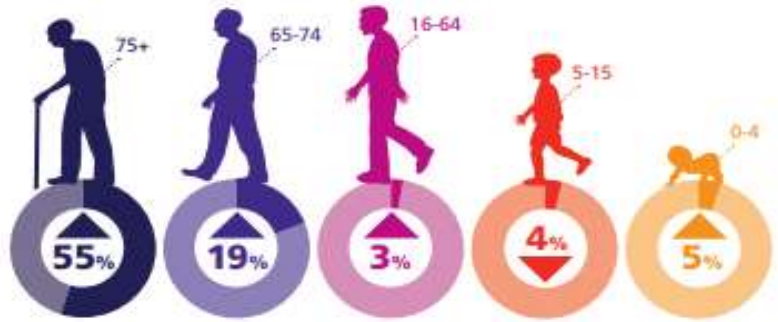
There is an urgent need to transform how we deliver care and support better health outcomes in order to address health inequalities, differences in life expectancy, and preventable causes of death.

By 2040 our population is expected to increase by over 110,000, with older age groups growing faster than younger age groups.



280,000 adults could eat better and 100,000 smoke.

143,430 adults estimated to have a mental health condition.

In 2019 more than 160,000 people in Norfolk and Waveney lived in areas categorised as the least wealthy 20% in England. While these are mainly located in urban areas, there are also pockets of rural deprivation.

Inequalities exist from birth to older age (e.g. smoking in pregnancy, obesity, educational outcomes, lifestyle, unemployment). These contribute to life expectancy inequality of 8.6 years for men and 6.8 years for women between the least wealthy and most wealthy areas in Norfolk and Waveney. The life expectancy gap between these communities is mainly due to more people dying at an earlier age of circulatory, cancer and respiratory diseases.

Sources - https://www.norfolkinsight.org.uk/wp-content/uploads/2022/01/Norfolk_and_Waveney_Population_Overview_December_2021_accessible.pdf
In Good Health - Demand and Capacity Review (norfolkandwaveneypartnership.org.uk)
02 NW Clinical Strategy 2022.2027 (1).pdf

Our need to embrace digital

Maximising the opportunities enabled by digital is required to achieve our goals for citizens and staff. There is a need to digitise health and care services across Norfolk and Waveney to support joined-up care, reduce inefficiencies and improve patient outcomes.

Since the establishment of Norfolk and Waveney ICS, efforts have progressed in digitising the provision of health and care in the system. According to NHS Improvement figures (2018), Norfolk and Waveney STP was significantly less digitally mature than other systems in the country at that time, with examples of innovation existing in many areas such as primary care.

The level of digital maturity in our organisations has significant implications for the health of our population and sustainability of the system. The criticality of embracing digital in the health and care setting is renowned. ***Digital can support systems to reduce inefficiencies, enhance clinical safety and promote significant cost savings.***

Digital transformation is required to meet the needs of our citizens and our staff and help achieve our three primary goals:

- To make sure that people can live as healthy a life as possible.
- To make sure you only have to tell your story once.
- To make Norfolk and Waveney the best place to work in health and care.

The lack of digital maturity in the system has resulted from many years of under-investment in digital technologies. For example, our three acute Trusts are reliant on ageing Patient Administration Systems. Such digital immaturity results in significant issues for the many dedicated people who work in our NHS services, including ***time wasted finding patient information***, switching between the ***multitude of legacy systems and paper*** in use, and ***clinical safety concerns***.

To enable people to live as healthy a life as possible, to only tell their story once and to make Norfolk and Waveney the best place to work in health and care, we have to take advantage of digital to ensure our staff has ***the right skills and tools to provide safe and equitable health and care.***

Our clinical objectives drive our digital ambitions

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Norfolk and Waveney Integrated Care System

The Norfolk and Waveney clinical strategy objectives anchor our digital ambitions to ensure we are delivering a service that is reliable, resilient, holistic, proactive, and addressing health inequalities.

Digital plays a crucial role in enabling progress towards our clinical objectives and in helping to redesign health and care pathways.

Digital supports the dedicated workforce with the right tools and capacity to reduce administrative burden and release time to provide reliable services.

Preventative and proactive measures are vital to acting early in health and care provision. Digital tools enhance predictive capabilities to support early intervention and treatment.

Digitisation of scheduling tools enables better management of clinical time. In addition to this, general efficiencies enabled by digital reduces the demand on services by directing people to the right place of care, freeing clinical time for those in need.

Better collection and analysis of data allows for a better understanding of our populations to address inequalities in a more proactive and preventative health and care model.

Digital enables information sharing across services and agencies which ensures the patient or citizen is cared for holistically.

Information sharing to enable integrated care pathways and collaborative working reduces duplication and enables safer, more efficient joined-up health and care service.

Our clinical objectives are critical in shaping our digital ambitions and portfolio. The improved outcomes and experience that digital will enable for our patients is illustrated in the following section describing example future patient journeys.

Our Engagement: What We Heard From Our Patients, Citizens and Staff

How will digital transform care for our patients?

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Norfolk and Waveney Integrated Care System

Future patient journeys, co-developed with clinical and social care leads from across the ICS, bring to life our vision for how digital will transform care models and improve experiences for illustrative patients like Jake, Bruna, Maciej, Faiza and Arthur.

	 JAKE	 BRUNA	 MACIEJ	 FAIZA	 ARTHUR
Workshop Dates	28th July, 12-1pm	29th July, 12-1pm	2nd August, 4-5pm	3rd August, 12-1pm	4th August, 4-5pm
	Jake is 14 years old. He lives with his mother who has recently split up with an abusive partner. He is prone to anxiety and has been diagnosed with ADHD and also has a learning disability. As a result, he doesn't enjoy school and sometimes misses his classes.	**Bruna** is 26 years old and pregnant for the third time. She lives in Great Yarmouth and has recently arrived from Guinea-Bissau. She is overweight and is a heavy smoker. She is suffering from chronic fatigue following long Covid which has left her unable to hold down a full time job. She is entering her third trimester when she is diagnosed with placenta accreta.	**Maciej** is 55 years old and moved to the UK from Poland six years ago and speaks limited English. He has experienced bouts of homelessness and suffers from depression. He has been admitted to A&E in the past for alcohol and drug dependency issues. He presents to A&E after an overdose, receives treatment and is referred to urology.	**Faiza** is 75 years old, retired and lives with her husband. Both her and her husband are physically inactive and have been for many years. Faiza speaks limited English and has poor digital literacy. Faiza suffers from diabetes and is overweight. She has been recently diagnosed with stage 2 breast cancer.	**Arthur** is 86 years old and lives in a care home where he requires around the clock care. He has dementia and is more prone to falls and accidents due to his limited mobility and loss of peripheral sensation. He recently had a fall trying to get out of bed and has been transported to A&E.

Our future patient journeys (1/2)

Population health management, virtual support, and digitised records will enable joined-up care and more targeted interventions for people most in need.

Our ambition for

JAKE

Male
14 years old

King's Lynn

English

Diagnosed learning disability and ADHD, suffers from anxiety

Using ***population health and advanced analytics,*** Jake is proactively assessed and referred to CAMHS and other support services. Jake's treatment is managed holistically by multiple agencies who have access to his ***digital record***. Jake and his mother are supported and digitally signposted via a ***portal*** to virtual and community resources tailored to their needs.

Our ambition for

BRUNA

Female
26 years old

Great Yarmouth

Mixed heritage

Pregnant for third time. Overweight, heavy smoker

Bruna self-refers to maternity services and digitally books her first appointment. All appropriate care professionals have access to her ***EPR***. She is able to easily flag the support she requires and is ***digitally signposted to weight management and smoking cessation services***. In her third trimester she is diagnosed with placenta accreta and scheduled for c-section. She undergoes delivery at week 36, and 7 days later her and her baby are discharged for ***remote virtual care.***

Our ambition for

MACIEJ

Male
55 years old

Norwich

Polish

Drug/alcohol dependency, depression. Bouts of homelessness

Maciej is assessed by paramedics when found unwell by a member of the public. The paramedics use a ***mobile translation app*** and update his ***digital record***, and notify A&E of his incoming. Maciej is treated but diagnosed with pyrexia of unknown origin and diagnosed with renal stones. He undergoes a fluoroscopy and lithotripsy procedure (after watching a ***preparatory procedure video***). After recovering he is discharged for community support, and has ***virtual follow ups***. He uses ***apps for self-management*** and is signposted to support networks.

Our future patient journeys (2/2)

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Innovative ways to remotely monitor people living across Norfolk and Waveney will also improve outcomes and experiences.

Our ambition for
FAIZA

Feale
75 years old

Breckland

South Asian heritage

Diabetic
Stage 2 Brest Cancer

Faiza visits her GP due to a concerning lump. She is referred to NNUH and diagnosed with stage 2 breast cancer. She is signposted to the local library to upskill and use virtual services as part of a community programme e.g. ***patient portal***. Faiza's blood glucose is ***remotely monitored***, the data automatically feeds into her ***EPR*** which informs her treatment plan. MDT agree her treatment plan and use ***Virtual Reality*** to show her what to expect. She prepares for surgery with ***digital prehabilitation***. After recovery, she is discharged.

Our ambition for
ARTHUR

Male
86 years old

Norwich

English

Dementia
Prone to falls

Movement sensors and ***remote monitoring*** in use in Arthur's care home have supported him in avoiding previous hospital admissions. However, one morning, he falls out of bed and requires an ambulance. Paramedics complete a ***digital assessment*** and conduct an x-ray (***portable x-ray***). During a ***video triage,*** the ED consultant advises that Arthur attend the hospital. His ***digital shared care plan*** is accessible to all agencies. He is assessed and discharged with agreement from his family and ***remotely monitored*** during his end of life care.

Jake's future journey is described on the next pages to exemplify the capabilities required in the future.

The full version of the other future patient journeys may be found in Appendix B.

Jake's Journey

JAKE'S BACKGROUND

Male | 14 years old

King's Lynn

English

Diagnosed learning disability and ADHD, suffers from anxiety

Jake lives in **King's Lynn** with his mother who is in the process of leaving an abusive partner that has lived with them on and off for several years.

Jake has been diagnosed with **ADHD** and suffers from **anxiety**. He doesn't enjoy school and has a diagnosed **learning disability**. His most recent experience with acute anxiety has prompted a referral to **CAMHS** where he is **prescribed medication** for his anxiety and ADHD.

During a particularly difficult month, he **starts missing school** and confides in a schoolteacher about **troubles at home**.

Jake's Journey

Improving lives together
Norfolk and Waveney Integrated Care System

- **Male | 14 years old**
- **Learning disability and ADHD**
- **Anxiety**

Reimagining Care and Experiences: 2025 to 2030 Patient Journey

Referred to CAMHS → Prescribed medication → Safeguarding concerns raised → Social services & Police informed → Social Worker / Police visits Jake's home → Ongoing support for Jake and his mother

Jake receives support for his anxiety

Jake is struggling with his anxiety and begins missing school.

Jake's recent poor school attendance prompts a referral to CAMHS.

Jake's CAMHS referral is analysed and prioritised.

Jake's appointment is prioritised as his data is analysed with system insights pulling together all risk factors and calculating that he is high risk.

Prior to the appointment, the Psychology team review Jake's SEND plan notes.

The CAMHS team also review Jake's health and social care records, ensuring they are already aware of his story before he arrives to the appointment. Jake inputs his current concerns into the notes too.

During the appointment, Jake's patient record is updated, and he is prescribed medication for his anxiety and ADHD.

The Psychology team update Jake's SEND plan, noting his prescription. All relevant professionals have the appropriate access and visibility of Jake's care. Jake and his mum are also informed about self-help apps, support groups, crisis lines and virtual therapy available.

Following the appointment, Jake is able to access information about his treatment.

Jake and his mum have access to all appointments, his care plan and medication lists via the patient portal. Jake's medicines reconciliation is accessible to community pharmacies too. The portal allows Jake to input his progress and personalise his care plan. Jake also has visibility of parent/guardian access rights for his account.

Digital Capabilities

Process automation

Information sharing between all health, care and education partners

PHM Risk Stratification using HCDA (Health & Care Data Architecture)

Patient portal (with accessible content)

Jake's Journey

Improving lives together
Norfolk and Waveney Integrated Care System

- **Male | 14 years old**
- **Learning disability and ADHD**
- **Anxiety**

Reimagining Care and Experiences: 2025 to 2030 Patient Journey

Referred to CAMHS → Prescribed medication → **Safeguarding concerns raised** → **Social services & Police informed** → Social Worker / Police visits Jake's home → Ongoing support for Jake and his mother

Jake receives safeguarding support

Jake's anxiety worsens and it's not clear if he is taking his medication despite receiving digital reminders.

Jake uses electronic medication management technology which alerts his mother when he takes his medication. Jake also begins missing classes again and the school inform his mother.

Jake confides in a schoolteacher of troubles at home. Safeguarding concerns are raised by the school and social workers and police are informed.

A social worker guides Jake on how to interact with social media to avoid exploitation. The social worker and Jake work together to develop a support plan, which is updated on his record for parent and care professionals' visibility.

Jake is visited at home by the police and social services.

The police visit Jake's home and speak to his mother. Jake is assigned regular visits by social workers (who have access to his record). A way forward is agreed with Jake's mother and both her and Jake are offered online and community resources and support. Resolution documented and multiagency assessments shared with all appropriate care professionals.

Digital Capabilities


Personalised education and support (e.g., CBT app)


Electronic medication management technology


Electronic Patient Record (EPR)


Digital signposting to community resources

Jake's Journey

Improving lives together
Norfolk and Waveney Integrated Care System

- **Male | 14 years old**
- **Learning disability and ADHD**
- **Anxiety**

Reimagining Care and Experiences: 2025 to 2030 Patient Journey

Referred to CAMHS → Prescribed medication → Safeguarding concerns raised → Social services & Police informed → Social Worker / Police visits Jake's home → Ongoing support for Jake and his mother

Jake and his mother receive ongoing support

Jake receives ongoing support, and his SEND plan is regularly reviewed and updated on the EPR.	Jake is also working with a Child Wellbeing Practitioner (CWP) to support his CBT therapy.	Jake's mother is given ongoing support.	Jake manages his annual learning disability health check appointment on the patient portal.	Jake's data is analysed for future treatment improvement.
Jake's SEND plan is regularly updated by Jake, his mother, his GP, his social care worker(s) and educators via integrated sources that feed into the patient record. Jake records his personal preferences on this portal.	Jake's mother is informed of his progress on a regular basis via the patient portal. Jake's treatment plan is guided by decision support and outcome analytics.	Jake and his mother are signposted to support apps and resources.	His Social Worker reviews his SEND plan on his record and adds progress notes for all appropriate care professionals' visibility.	Aggregated data and advanced analytics are used to analyse Jake's initial presentation, treatment and progress overtime to enable continuous improvement.

Digital Capabilities


Advanced analytics to evaluate outcomes


Online accessible patient portal


Electronic Patient Record (EPR) (including SEND plan)


Seamless information sharing

We see from Jake's future journey that significant transformation, enabled by advanced digital and data capabilities is required. Our patients and citizens living across Norfolk and Waveney have echoed the aspirations reflected in Jake's future journey. Feedback received via our public forum is outlined on the following pages.

Improving lives together
Norfolk and Waveney Integrated Care System

What our patients and citizens want from digital transformation

We gathered feedback from patients and citizens in Norfolk and Waveney through a public forum*, to understand how they would want to use digital technology for more reliable information sharing, improved access to services, and access to resources to support living well.

*This feedback was gathered during the citizen / patient engagement forum held on 26 July 2022

Reliable information sharing

People told us that…

"Carers need to know all required information before the patient is discharged. The carer's identity and services provided should also be recorded"

"Alerts/flags capability to ensure acknowledgement of disabled patients to ensure appointment type/location is appropriate and accessible"

"Real-time information sharing system-wide (not restricted to health). This could prevent delays in patients' treatment, e.g. patients seen by a specialist then referred back to GP for follow up but GP did not receive this info/referral"

Service convenience

People told us that…

"Online appointment booking that is available 24/7 supports carers or people in employment who cannot ring a reception between 9-5. It also offers a quick way to manage your booking e.g. change or cancel"

"Many people have disabilities, long term conditions and fears regarding COVID-19 – virtual access enables easier access to services"

"Peer support and virtual communities for carers and patients"

Access to resources to support living well

People told us that…

"Online information sharing of useful services for patients to utilise to self-manage their wellbeing without having to go to their GP. We need tailored and localised information shared about services. A virtual info hub that goes beyond health and signposts support e.g. energy grants would be useful"

"Wellbeing content available online, e.g. tips and recipes or exercise guidance / physio videos available online for all service users would be very helpful"

Concerns our patients and citizens have about digital transformation

Improving lives together
Norfolk and Waveney Integrated Care System

Our patients and citizens have told us they would like the ICS to ensure that their information is kept confidential and shared securely, inequalities are not exacerbated, and the human element of care is preserved*.

*This feedback was gathered during the citizen / patient engagement forum held on 26 July 2022

Confidentiality and security of information shared

People told us that…

"Patients may not want their medical information to be accessible to the wider care system e.g. a disabled patient may not want their assessment shared due to the risk of their disability care needs not being met by another care service. "

"There's concerns around entering personal information onto a shared device, e.g. library computer and the data entered not being secure."

"Information shared with family can be a risk in cases of abuse or other concerning situations."

Inaccessibility of digital services

People told us that…

"Online appointment booking can be difficult to access, particularly for individuals who lack digital skills or people with learning disabilities. It can also be challenging for people with complex needs and several appointments."

"Any patient interface needs to cater for all levels of digital expertise and adjustments made for accessibility, e.g. patients who are visually impaired will not be able to use these services."

"Services across N&W should offer consistency in the use of digital and technology, or this could lead to inconsistencies across organisations and services, preventing equity."

Removing the human element in care

People told us that…

"Digital solutions need to add to existing services rather than replace them. There should be an option for human or digital services, so individuals choose what is best suited to them."

"Information being accessible to the patient without counselling can distress or confuse the patient e.g. test results shared online via a portal without explanation of these results."

"There are concerns of digital exclusion, particularly those with a learning disability who may feel more comfortable having a more personable approach of face to face."

What we heard from staff

Improving lives together
Norfolk and Waveney Integrated Care System

Over 250 ICS staff members shared their views in a staff survey on what they need from digital, including having leadership, infrastructure, and adoption support.

77% of staff are interested in being **more involved in digital.**

78% of staff state **digital improvement** is very important or moderately important relative to other priorities in their area.

35% of staff don't have the right **technology or data and information** to do their job.

54% of staff are either **unsure or state they're uncomfortable** with using **new digital tools and systems.**

65% of staff think their organisation **fully embraces digital** to support **transformation** and **quality improvement** work.

57% of staff think their **leaders embrace digital change** and **drive uptake** within their teams, and their organisational **culture encourages cooperation** across organisational boundaries.

The **top 4 digital technology investments** staff think can be used to improve the **health and wellbeing of people living** in Norfolk and Waveney are:

Shared Care Record (ShCR) - supporting health and social care workers to share and access information about patients and citizens, combining information from acute hospitals, general practice, community and mental health, and social care.

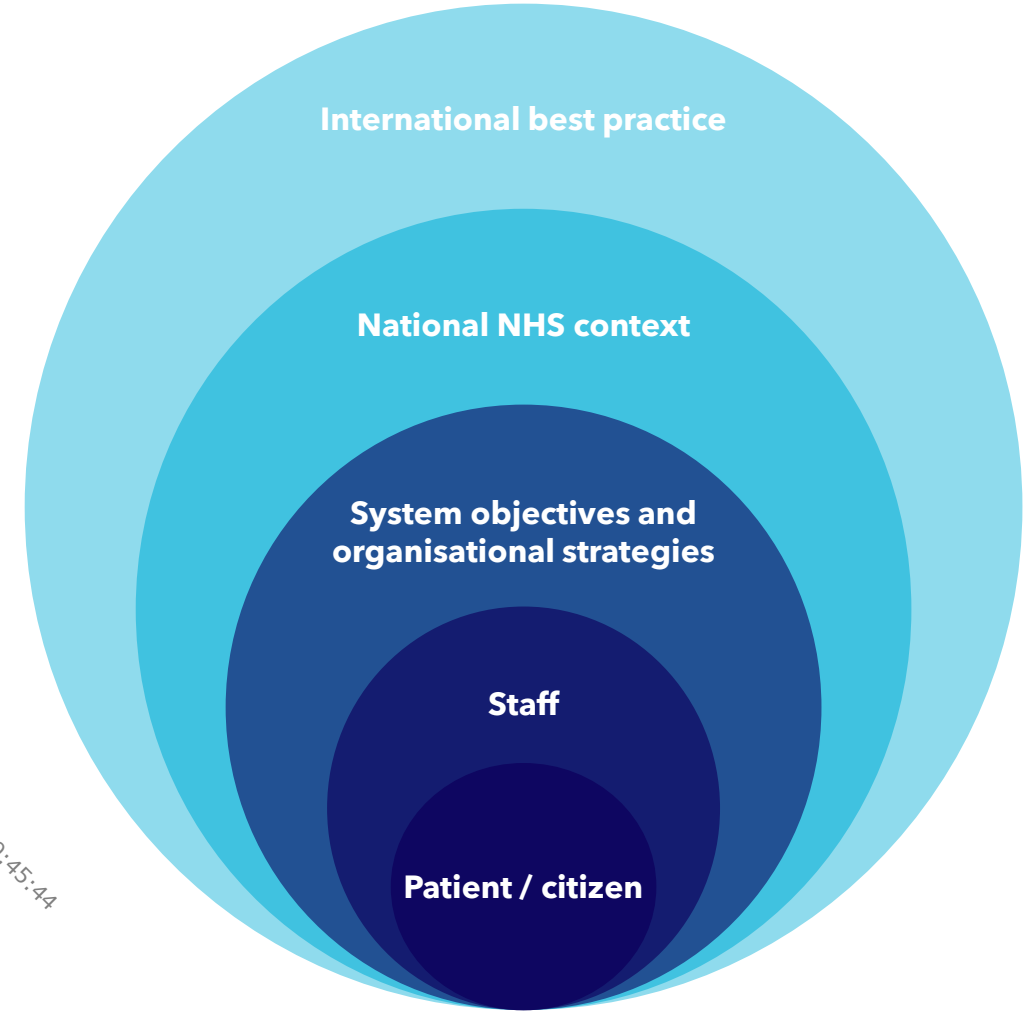
Electronic Patient Record (EPR) – an electronic patient record to replace many paper medical records, providing instant access to key clinical information such as the latest results, letters and notes.

Improved Connectivity - faster and more reliable Wi-Fi and network connectivity across sites and remote working from anywhere across the system.

Better, faster and more flexible data from across health and care to improve direct and secondary care, research, policy making, commissioning and management decisions.

Digital transformation opportunities

Overarching themes have emerged from input from our patients, citizens and staff, existing organisational strategies, NHS guidance, and international best practice*. We have developed the digital strategic roadmap with these core themes in mind.



Overarching digital transformation opportunities:

Patient empowerment
Providing patients with the tools to enable self-management of their health and care.

Collaborative care
Working collaboratively to provide joined-up care and share learnings to enable best practice.

Information sharing
Improved information sharing across and within health and care settings to allow for collaboration and holistic care.

Access to data
Better and quicker access to data and analytical tools to derive insight for population health management, improving outcomes and personalising health and care.

Alleviate burden on workforce
Reduced burden on administrative and duplicative tasks to release time to the workforce for care.

*Please see Appendix E for alignment of our digital transformation strategic roadmap and the NHSX 'What Good Looks Like' guidance.

Our Guiding Principles, Vision, and Strategic Objectives

Guiding principles

Principles have been designed with stakeholders to guide the development and delivery of the Digital Strategic Roadmap as a truly integrated care system.

Collaborative & Inclusive – Shared vision and jointly agreed priorities, co-ordinated at the system level and catering to local realities to improve health outcomes for the citizens of Norfolk and Waveney.

Person-focused – Citizens and patients at the core of everything that we do to deliver a seamless experience and best possible outcomes for citizens and patients across Norfolk and Waveney.

Joined-up – Connected pathways across health and care underpinned by joined-up systems, streamlined governance, and efficient data and information sharing.

Safe & Sustainable – Solutions that cater to the diverse needs of the Norfolk and Waveney population with quality, safety and sustainability at the heart of everything we deliver.

Data-driven – A culture that leverages data securely, in line with regulations and with individuals' consent, to drive insight for continuous improvement.

Vision and strategic objectives

DRAFT for DISCUSSION

Improving lives together
Norfolk and Waveney Integrated Care System

Anchored in the ICS vision, the Digital Transformation strategic roadmap outlines five strategic objectives that illustrate our ambition to work together, to provide joined-up care, to empower citizens, and to understand data and innovate.

VISION: our overarching aim

A digitally-enabled Norfolk and Waveney where access to information, services and support make it easy to deliver high quality health and care for and with our citizens.

STRATEGIC OBJECTIVES: the results we want to achieve

Together
Use digital technology and skills to work more efficiently and collaboratively across standardised systems.

Connect
Provide effective and joined-up care through systems integration and streamlined information flows.

Activate
Empower citizens with greater visibility and control over treatment and care journeys.

Understand
Use data to drive decisions and harness population health insights.

Innovate
Adopt a clear pathway for digital innovation and research to support the transformation agenda.

The following slides explore our vision and strategic objectives, describing our future vision and how we get there.

Improving lives together
Norfolk and Waveney Integrated Care System

Together

We will work in a more integrated and collaborative way as a system.

Strategic Objective

Use digital technology and skills to work more efficiently and collaboratively across standardised systems.

What this means

Staff working across standardised systems and the same data to enhance care delivery through advanced and joined-up digital solutions.

How we get there

We will:

- Work together to create a shared digital record and insights that support a single version of the truth and enables the best possible care for the citizens of Norfolk and Waveney;
- Work collaboratively across our system, support staff development and aligned ways of working, build relationships with key partners, national bodies, the voluntary sector and our citizens, and consolidate our technology systems.

Connect

We will create joined-up care experience with full visibility of health and care data.

Strategic Objective

Provide effective care through systems integration and streamlined information flows.

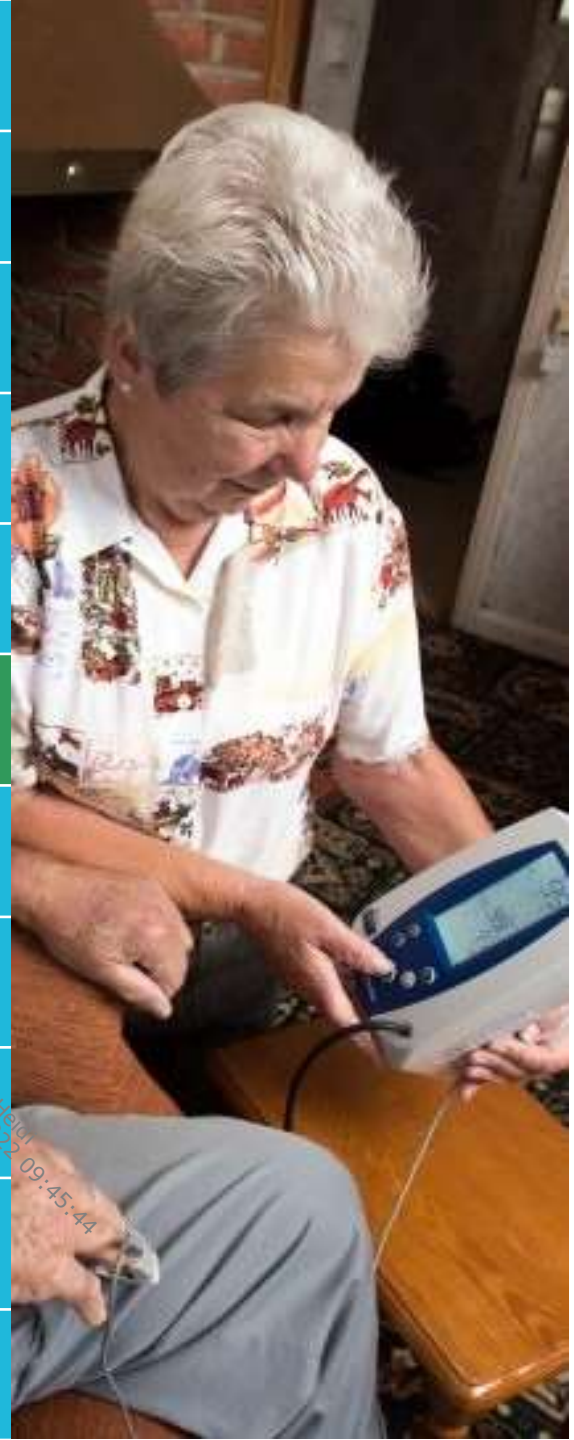
What this means

Delivering efficient and patient focused health and care regardless of service provider through simplified, consolidated, secure, and reliable infrastructure.

How we get there

We will:

- Join up care through consolidated IT infrastructure, information sharing, data governance and shared systems that provide a single version of the truth;
- Encourage a shift from the illness to wellness model by connecting our information and acting upon it more proactively with all our ICS partners, including VCSE, community, ambulance, and non-health and care services.



Improving lives together
Norfolk and Waveney Integrated Care System

Activate

We will give citizens greater control through personalised and tailored care.

Strategic Objective

Empower citizens with greater visibility and control over treatment and care journeys.

What this means

Citizens only need to tell their story once and be supported to drive the personalisation of their own care.

How we get there

We will:

- Enhance self-management through increased remote monitoring tools, streamlined access to applications and personal health and care records, and accessible information;
- Continue to build our inclusive digital literacy support programmes, benefiting our citizens, workforce and all ICS partners.

Improving lives together
Norfolk and Waveney Integrated Care System

Understand

We will leverage data for better health and care decisions.

Strategic Objective

Use data to drive decisions and harness population health insights.

What this means

Access to secure and timely data insights on demand, to support the best outcomes for individuals, our population, and the system.

How we get there

We will:

- Deliver population health management insights through whole population analysis using intelligence, data sharing, reporting, monitoring and evaluation;
- Improve accessibility and quality of data to drive better system decisions;
- Ensure robust information governance and data protection standards;
- Develop the Health and Care Data Architecture (HCDA) as a single source of comprehensive data, with advanced system intelligence produced by a single ICS Analytics team.

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Innovate

We will accelerate the adoption of innovative solutions to support our transformation.

Strategic Objective

Adopt a clear pathway for digital innovation and research to support the transformation agenda.

What this means

Become a centre for excellence, harnessing digital approaches to innovation and research.

How we get there

We will:

- Develop an agile approach that harnesses and builds upon local and regional examples of excellence;
- Support the identification, scaling and dissemination of innovation;
- Embed a culture of innovation across the system and expand collaboration with key partners.

Digital and Data Capabilities

Capabilities overview

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To realise our digital ambition and deliver on our strategic objectives, we will build our core digital transformation capabilities.

Digitised Patient Record
Digitising records across all health and care settings will provide streamlined access to a single source of truth.

Shared Information
Shared Information across health and care settings will optimise the way professionals interact and work together.

Data & Analytics
Data and analytics solutions will improve accessibility and quality of patient data and insights-driven decisions.

Digital Workforce Tools
Digital workforce tools will enhance care delivery though standardised systems and collaborative tools.

Citizen and patient tools
Citizen and patient tools will provide a joined-up care experience through enhanced self-management and innovative support.

Virtual Health and Care
Virtual health and care will improve referrals ensuring faster access to treatment and offer personalised care from home.

Population Health Management
Population Health Management will apply a holistic view to our population and use data-driven insights to tailor system resources to best engage and support our people.

Infrastructure & Connectivity
Integrated infrastructure and connectivity will improve working and collaboration amongst staff, ensure robust data protection standards and cyber security.

The following slides explore the capabilities, highlighting how we will build on our recent successes to positively impact patients and staff.
A summary view of our key milestones and a high-level implementation plan may be found in Appendix C.

Building on our digital foundations

Improvement in digital capabilities, evident prior to and throughout the pandemic, provides a firm foundation for our forward plan.

Primary Care

"We're the second highest area in the country for submission of online consultations. At two million forms submitted a year, this demonstrates excellent engagement in digital access by the public."

"We are also the first area in the country to move GP practices to cloud on a journey to provide them interoperability with ICS partners."

Associate Director of Digital, Norfolk and Waveney CCG

Chief Clinical Information Officer (CCIO), Norfolk and Suffolk Foundation Trust

Mental Health

"At NSFT we embedded an Electronic Prescribing and Medicines Administration (ePMA) across all in-patient units in less than nine months. This has transformed our safety with medication prescribing by reduction in errors. Thanks to close working with our amazing pharmacy team, it has reduced the time taken for many activities while improving decision support.
As this data is digital, we would love to share it with the Health and Care Data Architecture (HCDA) for population health improvements."

Social Care

"In Norfolk, we successfully made significant improvements in digital connectivity across the county. We connected c. 400 public sector buildings including schools and libraries to gigabit fibre, and improved access to Superfast or better connectivity to over 96% of Norfolk's properties."

Chief Digital Officer, Norfolk County Council

Acute Care

"NNUH were asked to set up a virtual ward by NHSE/I for Covid inpatients in January 2021. Since then, we have welcomed over 1,400 patients through the services, of which 98.2% reported 'very satisfied' with the service. This saved us over 11,000 bed days! We are keen to continue to expand this further to enable patients to receive care in the comfort of their own home."

Medical Director, Norfolk and Norwich University Hospitals

Chief Digital Information Officer, East of England Ambulance Service NHS Trust

Urgent and Emergency Care

"We have successfully deployed electronic patient records, removing paper from ambulances arriving at acute hospitals. Further increasing access to data and shared information will improve safety and reduce conveyances."

Community Care

"We share a common electronic patient record system with our community and primary care partners which has enabled us to access the same patient data, and join up the care we all provide. We've an established mobile working package used by over 1,100 community clinicians which enables them to enhance patient care by updating digital patient records during or straight after appointments."

Nursing Information Officer Norfolk Community Health and Care NHS Trust

Physiotherapist, Norfolk and Norwich University Hospitals NHS Foundation Trust

Podiatrist

Digitised patient record

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Digitising records across all health and care settings will provide streamlined access to a single source of truth improving communication and coordination between clinicians, staff, and teams.

What are our priorities?

- Acute Electronic Patient Record (EPR)
- Digital Social Care Record
- Digitised Mental Health Record (EPR)

What this means for our patients

- Only telling their story once as all appropriate clinicians and staff have access to a consolidated view of their record;
- Receiving reliable, high-quality care;
- Joined-up care as clinicians and staff have the same patient record information at their fingertips irrespective of location.

What this means for our staff

- Enhanced clinical safety with immediate access to critical patient information and functionality, e.g. Clinical Decision Support, embedded protocols;
- Time released to care, reduced duplication, and efficient ways of working due to consolidated view of information;
- Joined-up care and information accessible across providers, gives care professionals the full picture of the patient's story improving shared decision-making and outcomes.

Physiotherapist, Norfolk and Norwich University Hospitals NHS Foundation Trust

Podiatrist

Digitised patient record

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Digitised patient records will include the roll out of the acute Electronic Patient Record, the Digital Social Care Record, and the digitised Mental Health Record.

What we will deliver over time

FY22/23

- **Provide access to our Primary Care EPR (SystmOne)** for mental health nurses working in GP practices;
- **Digital Social Care Record in 60% of registered care home providers** by *March 2023 (and all CQC registered providers).*

FY23/24

- Optimise our Primary Care EPR (e.g., improved reporting capability);
- **Digital Social Care Record in 80% of registered care home providers** by March 2024 (and all CQC registered providers).

FY24/25

- **Commence Acute EPR implementation** to achieve a single, shared, integrated system across the three acute Trusts.

FY25/26

- **Implement a single EPR** in in all three acute Trusts (Trust A – April '25, Trusts B and C – June '25);
- **Fully digitise the Mental Health record.**

Shared Information

Improving lives together
Norfolk and Waveney Integrated Care System

Shared Information across health and care settings will optimise the way professionals interact and work together, including through paperless systems, and streamlined information flows.

What are our priorities?

- Shared Care Record (ShCR)
- Digital Histopathology
- Single Infection Prevention Control System
- Single waiting list
- Interoperable Radiology Information System (RIS)
- Vendor Neutral Archive (VNA)

What this means for our patients

- Only telling their story once with improved continuity of care across settings;
- Faster imaging results as imaging reporting backlogs are reduced and eliminated;
- Less time spent waiting for appointments and procedures;
- Better cancer outcomes due to improved turnaround times and earlier diagnoses of all cancer MDTs requiring a biopsy result.

What this means for our staff

- Improved quality, availability and reliability of information;
- Integrated systems that 'speak' to each other helping to keep information up to date and reduce duplication;
- Streamlined and faster referrals process with necessary information about a patient easily accessible to all relevant care providers;
- Reduced reporting backlogs and improved governance and reporting through digitised imaging.

Shared Information

Shared Information will include deployment of the Shared Care Record, digitised histopathology solution, a single acute waiting list, infection control system, vendor neutral archive, and the interoperable Radiology Information System.

What we will deliver over time

FY22/23

- **Deploy core Shared Care Records (MVS)** with read-only view of GP, community, social care, mental health and acute patient records;
- **Digitise histopathology** to streamline diagnostics and support remote working for staff;
- **Implement a single waiting list** across all three acute Trusts;
- **Implement a single Infection Prevention Control system** across all three acute Trusts.

FY23/24

- **Enhance the Shared Care Record** – with write/read functionality, expanding to Community Pharmacies, Care Homes, carers/third party providers and district councils for shared care plans and advanced treatment decisions;
- **Seamless image transfer and viewing amongst the acute Trusts** via the interoperable RIS Solutions enabling the Diagnostic Assessment Centre;
- **Deploy a Vendor Neutral Archive (VNA)** as a safer way to store clinical images easily accessible across organisations.

FY24/25

- **Further enhance the Shared Care Record;**
- **Continue to enable sharing and consuming of patient data from the ambulance service EPR to ensure safe care in the right time and at the place;**
- **Review and agree opportunities for further consolidation of digital systems** to streamline access and achieve financial benefits.

FY25/26

- **Single system wide RIS & PACS imaging** which is integrated with the Electronic Patient Record (EPR).

Healthcare Practitioner, Norfolk and Norwich University Hospitals NHS Foundation Trust

Reablement Support Worker, Norfolk County Council

Data and Analytics

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Improving lives together
Norfolk and Waveney Integrated Care System

Data and Analytics solutions and advancements will improve accessibility and quality of patient data, providing insights across end-to-end pathways.

What are our priorities?

- Health and Care Data Architecture (HCDA)
- Business Intelligence (BI)
- Advanced Analytics
- Robotic Process Automation (RPA)

What this means for our patients

- Improved and personalised care through advanced data insights;
- Targeted range of services to match population health needs of citizens reducing health inequalities and unwarranted variation in care;
- Improved experience of using healthcare services due to better planning;
- Access to new medical treatments through research and innovation data insights.

What this means for our staff

- Proactive care approach with interventions and resources targeted at those people and groups who need them;
- Planning and commissioning improvements for services that suit local needs, including areas that need support or improvement;
- Capacity and demand analysis, including for appraisal of safety risks and good practice;
- Workforce planning analysis and management in real-time;
- Richer data analytics to allow understanding of conditions and risk factors to support prevention;
- Clinical safety benefits from AI/machine learning tools.

Healthcare Practitioner, Norfolk and Norwich University Hospitals NHS Foundation Trust

Reablement Support Worker, Norfolk County Council

Data and Analytics

Improving lives together
Norfolk and Waveney Integrated Care System

Data and Analytics solutions will include the scaling of the Health and Care Data Architecture (HCDA), as well as BI and analytics capabilities.

What we will deliver over time

FY22/23

- **Stand up the HCDA** to enable system wide data collection, sharing and insights;
- **Establish a single ICS Analytics team;**
- **Create consistent system wide data and analytics reporting** to empower intelligent led decisions.

FY23/24

- **Integrate HCDA data and BI analytics** (e.g. whole population analysis including public health and ambulance data) for improved demand and capacity management across the system;
- **Integrate the PHM risk stratification tool with HCDA**, improving population health management insight from pilots;
- Deliver 'self-tooling' functionalities to allow staff to directly access data and analytics.

FY24/25

- **Deliver a longitudinal patient record** to consolidate disparate 'patient encounters' information into a single, patient centric record to support PHM and pathway analytics;
- **Introduce and utilise more advanced data concepts** such as AI to support clinicians and operational staff in their work.

FY25/26

- **Continuously enhance the HCDA** allowing better flow of information into the population health management capability to for improved system insight.


Healthcare Assistant, James Paget University Hospitals


Podiatrist

Population Health Management

Improving lives together
Norfolk and Waveney Integrated Care System

Population Health Management will apply a holistic view to our population, use data-driven insights to better engage with our citizens and system partners and tailors system resources to better support people.

What are our priorities?

- Population Health Management
- Risk Stratification
- Population Insights
- Personalised Care

What this means for our patients

- Personalised and proactive services that work together to better support people to manage their health and wellbeing;
- Expanded focus that goes beyond care and treatment to support people to stay healthy and better maintain health;
- Equitable access and support that reduces health inequalities across the population;
- Access to personal data to empower citizens to self-manage their needs.

What this means for our staff

- Enhanced population insights to improve our understanding and forecasting for the needs of our population as they evolve and allocate system resources accordingly;
- Shift from a reactive to a proactive delivery model for health and care services and actively address health inequalities;
- Wider reach and impact across our system partners and support adoption of consistent population health management approaches;
- Joined-up system approach that supports working together to improve access and support for all citizens, which also works to address sustainability across the system.

Healthcare Assistant, James Paget University Hospitals

Podiatrist

Population Health Management

Improving lives together
Norfolk and Waveney Integrated Care System

Widening and scaling our Population Health Management reach and impact across the system by enhancing and connecting our digital and data capabilities into a population health management programme for the ICS.

What we will deliver over time

FY22/23

- **Continue establishment of PHM Programme** building team capacity, standardising methodology and tools, developing enablers and requirements;
- **Continue expansion of Population Insights**, existing tools and capabilities, integration of existing data sets into Eclipse and Shared Care Records;
- **Agree priority use cases for risk stratification** using existing risk stratification insights, initiate 18-month procurement for risk stratification tool;
- **Expand Customer Relationship Management (CRM) capability** to enable personalisation approaches.

FY23/24

- **Continue development, enhancement and scaling of PHM Programme** (building robust insights to support monitoring and evaluation of existing pilots and initiatives);
- **Build PHM Platform** in HCDA including BI / reporting dashboards, continued integration of data flows to undertake/enhance whole population analysis;
- **Agree risk stratification tool** to scale across system, integrate tool into HCDA;
- **Continue to scale adoption of CRM tool**, linking into PHM programme pilots and initiatives.

FY24/25

- **Scale PHM capabilities to system partners**, with system partners using tools and analysis to inform clinical and operational decision making;
- **Develop ability to undertake large-scale population health analysis**, PHM platform is live and being used across the system, real-time pull of health and care data from HCDA;
- **Continue to expand risk stratification tool** capability drawing on HCDA expanded data.

FY25/26

- **Continue evolution and development of PHM programme** and capability (e.g. PHM platform / population insights, risk stratification tools with expanded data sets and personalisation approaches using CRM across the system).


Volunteer


Registered Manager, PCT Care Services LTD

Citizen and patient tools

DRAFT for DISCUSSION

Improving lives together
Norfolk and Waveney Integrated Care System

Citizen and patient tools will provide a joined-up, personalised care experience through enhanced self-management.

What are our priorities?

- Patient Portal and apps
- Digital Patient Triage
- Digital Social Prescribing
- Emerging Tools (e.g. Virtual Reality)
- eRedbook

What this means for our patients

- Better visibility of data, care plans, and resources to keep patients well informed;
- Improved access to services with easy appointment booking, results visibility, and consultation options;
- Streamlined access to tailored community resources, peer networks, and online support channels.

What this means for our staff

- Released administrative burden as patients take on tasks to manage their care;
- Reduced duplication of tasks, unnecessary activity, and DNAs, alleviating system capacity constraints;
- Improved patient outcomes and reduced number of failed discharges, frequent A&E attendances, and other avoidable admissions.


Volunteer


Registered Manager, PCT Care Services LTD

Citizen and patient tools

DRAFT for DISCUSSION

Improving lives together
Norfolk and Waveney Integrated Care System

Citizen and patient tools will include a single digital front door for the public, deployment of eRedbook, integrated patient portal and AI-enabled patient triage.

What we will deliver over time

FY22/23

- **Mental Health Integrated Front Door,** CYP and Adult websites and directory of operational services;
- **Single Triage Hub** for emergency care, 111 and 999 at proof-of-concept stage;
- **Deploy apps**, such as the colorectal cancer pre-habilitation app;
- **Continue to pilot home sensors** to support independent living.

FY23/24

- **Offer single digital front door** for the public by integrating existing patient portals with the NHS app across all health care settings; Streamline access to self-management apps;
- **Deploy eRedbook** solution to securely store information about mother and child from pregnancy to age 5;
- **Enhance digital social prescribing** to include a shared platform of community asset mapping and community resources accessible to all partner organisations;
- **Digital triage for Urgent and Emergency Care** with enhanced referral management in place.

FY24/25

- **Integrate patient portal** with social media and wellness apps for holistic support;
- **Implement AI-enabled triage** to reduce A&E attendances; and
- **Enhance the single digital front door** by integrating social care information to further streamline access.

FY25/26

- **Deploy Virtual Reality** solutions, for example in end-of-life care.

Reablement Support Worker, Norfolk County Council

Senior Healthcare Assistant, West Pottergate Medical Practice

Virtual health and care

DRAFT for DISCUSSION

Improving lives together
Norfolk and Waveney Integrated Care System

Virtual health and care will streamline referrals ensuring faster access to treatment, offer personalised care from home, improve digital referrals and pre-operative assessments, and enable outpatients transformation.

What are our priorities?

- Remote monitoring and virtual wards
- Improved E-referrals
- Digital pre-operative assessments

What this means for our patients

- Access to health and care services from home and optimised patient care prior to any procedure;
- Improved access for patients with disabilities, inability to travel, work/childcare commitments;
- Reduced time between referral and treatment improving quality of care;
- Reduced waiting times for procedures and appointments;
- Reduced hospital length of stay as well as avoidable A&E visits and hospital stays.

What this means for our staff

- More efficient consultations as time released to care;
- Reduced footfall in the care setting and supports prioritisation of procedures, addressing long waiting lists and back logs;
- Improved referrals and referral management,
- System-wide approach and efficient use of resources for remote monitoring and virtual wards;
- Easier coordination and communication between different settings of care.

Reablement Support Worker, Norfolk County Council

Senior Healthcare Assistant, West Pottergate Medical Practice

Virtual health and care

DRAFT for DISCUSSION

Improving lives together
Norfolk and Waveney Integrated Care System

Virtual health and care will include a system approach and scaling of remote monitoring and virtual wards, enhanced e-referrals, and digital pre-operative assessments.

What we will deliver over time

FY22/23

- **Deploy digital pre-operative assessments** across all three acute Trusts;
- **Enhance e-referral system** to enable more streamlined referrals;
- **Agree system approach for remote monitoring** with scaling of virtual wards;
- Enable personalised outpatient pathways, including patient-initiated follow-up (PIFU).

FY23/24

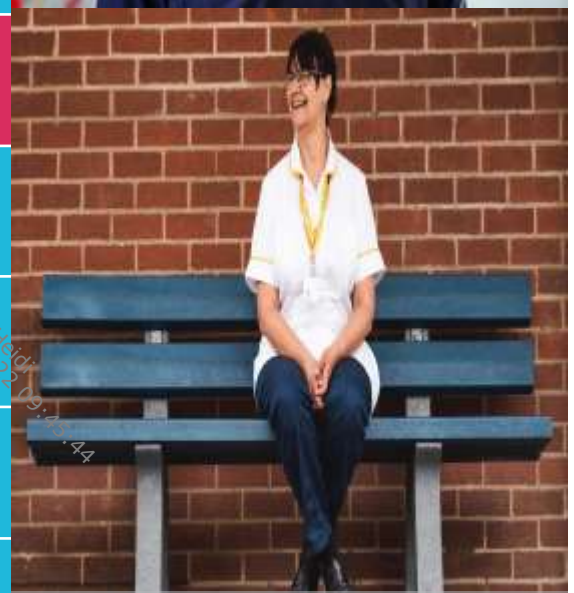
- 173 virtual ward beds effective in April 2023;
- **Continue to expand virtual wards** to priority pathways – 368 beds by January 2024;
- Expand use of assistive tech in care homes;
- **Scale remote monitoring to care homes** and to patients with long term conditions.

FY24/25

- Support increasing numbers of patients in virtual wards beds (450-550) co-ordinated via a central hub;
- **Deploy virtual A&E assessments** as part of virtual wards to ease pressure on ambulatory services and A&E.

FY25/26

- **Continue to enhance, scale, and innovate remote monitoring models** learning from previous roll-outs (1,000+ virtual ward beds).



Registered Nurse Associate, Norfolk Community Health and Care

Digital workforce tools

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Improving lives together
Norfolk and Waveney Integrated Care System

Digital workforce tools will enhance care delivery though advanced digital solutions across standardised systems to optimise collaboration and promote learning and development opportunities for staff.

What are our priorities?

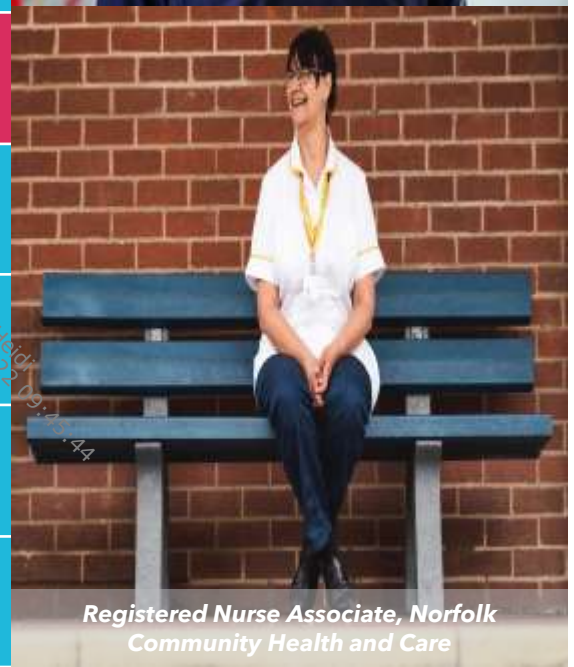
- Virtual Careers Office
- End User Devices
- Integrated Learning Management System
- Integrated Electronic Staff Record & Digital Staffing Bank
- Streamlined Learning Placements

What this means for our patients

- Patients supported by staff who have access to better systems and training, improving experiences;
- Greater consistency and quality of care received from staff who are better equipped to do their job.

What this means for our staff

- Staff are equipped with the tools they need to do their job regardless of location;
- Greater collaboration, reduced duplication and error, releasing staff time;
- Investment in staff to build digital skills to enable career progression and learning, including in their digital leadership skills;
- More effective workforce planning and rostering across the system to enable better use of resources;
- Smoother learning placement process and secondment opportunities to enable staff to work as a single workforce across the system.



Registered Nurse Associate, Norfolk Community Health and Care

Digital workforce tools

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Digital workforce tools will include user devices refresh, the standardisation of the Electronic Staff Record (ESR) systems including the e-roster, creation of the virtual careers office and an integrated Learning Management System (LMS).

What we will deliver over time

FY22/23

- **End user devices – IT refresh** to replace and upgrade 'out of warranty' devices;
- **Standardise use of Electronic Staff Record systems** for accessible and accurate workforce data;
- All nursing and AHP staff included on the e-roster;
- **Roll out the Carers Passport** to assist discussions around flexible working and support available to staff.

FY23/24

- **Establish a virtual careers office for staff** to enable joined-up ways to think about progression, scan job opportunities or talk to other professionals;
- Streamline the learning placement process across the ICS;
- Ensure all medical staff are added to the e-roster, enhancing and integrating the Electronic Staff Record (ESR);
- Improve workforce analytics enabling more efficient use of resources across the system.

FY24/25

- **Enhance digital training and courses**, including in digital leadership and management;
- Optimise workforce analytics;
- Develop the staff central bank – an integrated database of clinical, administrative and HCA staff to aid recruitment into posts across the system.

FY25/26

- **Implement an Integrated Learning Management System** enhancing consistency and improving e-learning across the ICS.

Fully integrated infrastructure and connectivity

Improving lives together
Norfolk and Waveney Integrated Care System

Fully integrated infrastructure and connectivity will improve ways of working and collaboration among staff and enable robust data protection and cyber security.

What are our priorities?

- Infrastructure & Connectivity upgrades
- Cloud First Infrastructure
- Enhanced Collaboration
- Cyber security and Compliant Standards

What this means for our patients

- More efficient and reliable care as clinicians and staff can access information required from anywhere and quickly;
- Improved clinical safety/outcome in urgent situations where patient information is required fast;
- Secured systems, where patient privacy and confidentiality are protected.

What this means for our staff

- Time released to care with optimal running solutions and increased connectivity;
- Less frustration waiting for load time and reduction in duplication of tasks;
- Improved accessibility to connectivity with compatible devices;
- Improved quality and performance of hardware and devices;
- Enhanced integrated working across the system.

Fully integrated infrastructure and connectivity

Improving lives together
Norfolk and Waveney Integrated Care System

Fully integrated infrastructure and connectivity will include a new cloud solution, cyber security solutions and enhanced Wi-Fi network and connectivity.

What we will deliver over time

FY22/23

- Deploy new cloud solution and cyber security solution;
- **Enhance Wi-Fi connectivity** across primary care and care homes;
- Implement WAN wide area network.

FY23/24

- **Implement Cloud telephony in 100% of GP practices**;
- Provide access to high-speed connectivity and devices for care providers;
- Enhance collaborative working via Office 365 upgrades and information sharing agreements across providers;
- Deploy Community Diagnostic Hubs infrastructure and connectivity requirements.

FY24/25

- Implement an information security management system;
- Continue to upgrade Wi-Fi, server, and network infrastructure across the acute Trusts in advance of the EPR implementation.

FY25/26

- **Improve and optimise ICT infrastructure** to evolve with market technology trends and needs.

Key Enablers

Enablers overview

Delivering our digital and data capabilities will require a set of underpinning system-wide enablers that span leadership, digital skills and inclusion, culture, governance, innovation and working as a unified digital team across the ICS.

Leadership and Decision Making
We will align our priorities and continue to enhance our digital leadership skills.

Governance
We will optimise governance structures for transparent and efficient decision making.

Transformation and Culture Change
We will nurture a 'digital first' culture and embed digital within system transformation.

Digital and Data Skills and Inclusion
We will upskill all our staff, patients, and citizens to use digital and data confidently.

Innovation and Partnerships
We will leverage partnerships and opportunities to innovate our services and embrace the potential of digitisation.

Unified Digital Team
We will expand our unified digital and analytics team, ensuring collaboration and system working.

The following slides explore the enablers identified above in more detail, describing recent progress and key milestones.

Building on our enablers

Recent progress across our system provide a robust basis and lessons learnt for our forward plan.

Chief Digital Officer, Norfolk County Council

Digital Inclusion in Social Care

"At Norfolk County Council, we created a strategic programme working with our NHS district and voluntary partners and delivered over 5,000 laptops and tablets to Norfolk's students and 1,400 to adults, along with various programme through our libraries network and video trials in care homes."

Clinical Digital Leadership

"We have come a long way as a Trust at Norfolk and Norwich University Hospitals. We have our C(x)IO network to collaborate as a system. We are clinically-led with our CCIO and CNIO roles, whereby clinicians are leading our change management and digital transformation."

Chief Digital Information Officer, Norfolk and Norwich University Hospitals

Nursing Information Officer Norfolk Community Health and Care NHS Trust

Responsive Care Provision

"Our talent and expertise in technical design and service delivery with the provision of responsive support for our frontline clinicians and corporate staff is award winning. We have a Chief Allied Health Professional and Nursing Information Officer within our digital team who champions the clinical and patient voice at the heart of all digital solutions. These things have all placed us at the forefront of digital maturity."

Digital and Data Skills and Inclusion

"We have a great library network that acts as a community hub which can reach the elderly population. It's used for teaching the community to use digital tools such as remote GP consultations."

Comms and Engagement Manager, Norfolk and Waveney ICS

Care Co-ordinator, PCT Care Services Ltd

Leadership and decision making

Improving lives together
Norfolk and Waveney Integrated Care System

Our leaders will champion a digital first culture, support their teams to work differently, and collaboratively agree system priorities.

What are our future aspirations?

We will engage system leaders to champion the digital transformation strategy objectives at all levels, seeking to develop collaborative ways of working and transparent governance around digital.

What we will deliver over time

FY22/23

- **Appoint ICS Digital Lead**;
- **Align system priorities**, ensuring leaders champion digital transformation strategy objectives;
- **Sign off digital investment priorities** and agree investment in digital;
- **Implement procurement convergence** and alignment across the system;
- Enhance our digital leadership community and integrate with clinical leaders, e.g. C(x)IO network.

FY23/24

- **Join up decision-making with a transparent funding approach** consistent with the annual business planning cycle and aligned to the strategic roadmap priorities;
- Establish the Digital Leadership development programme.

FY24/25

- Enhance and scale Digital Leadership development programme;
- **Ensure aligned decision-making and consolidation of digital systems**, leveraging buying power and enabling standardisation, inter-operability and cross-system working.

FY25/26

- Continuously ensure digital leadership is focused on delivering a shared vision and joint outcomes.

A&E Nurse, Queen Elizabeth Hospital

Improving lives together
Norfolk and Waveney Integrated Care System

Governance

Effective and efficient governance will form a key part of our transformation to ensure we are optimising the way we work across the ICS.

What are our future aspirations?

We will embed a transparent governance structure around digital, including ensuring streamlined process around digital, information governance, cyber security and clinical safety.

What we will deliver over time

FY22/23

- **Optimise governance processes** across the ICS (e.g. single ICS Digital Board);
- Streamline cyber security, IG process and standards across the ICS, ensuring consistent and standardised data sharing approaches;
- Streamline clinical safety processes across the ICS;
- Establish a Population Health Management Board.

FY23/24

- **Standardise policies and ways of working** (IG, Cyber, HR, remote working, etc.) to ensure streamlined adoption of digital and reduction in duplication across provider organisations.

FY24/25

- Establish robust and mature system-wide IG, cyber, clinical safety and security functions, building on previously undertaken work.

FY25/26

- Ongoing review to ensure efficient, effective governance structures embedded in the ICS.

Governance structures

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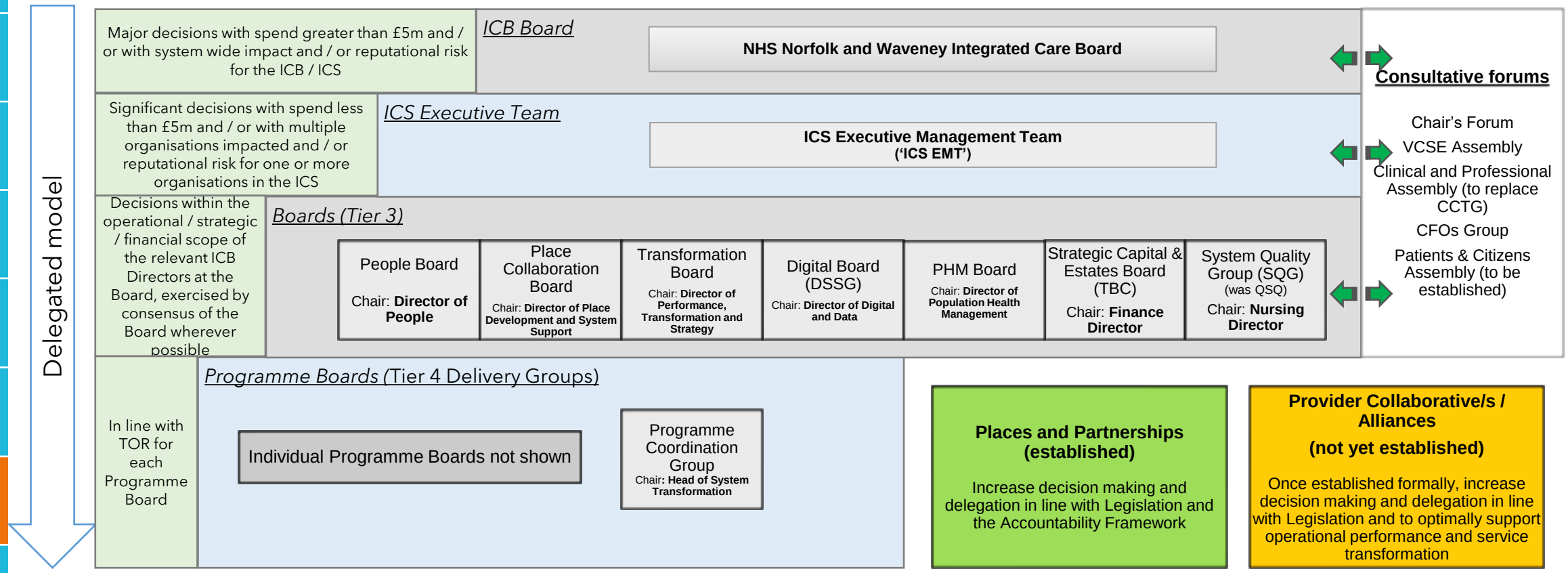
Digital leadership will be embedded throughout our ICS governance structures to ensure alignment and integrated system decision-making.



Our digital governance includes:

- Digital representation (Digital SRO) at the executive level (ICS EMT);
- Digital leadership embedded in our Tier 3 Boards, with digital representation at the Transformation, People, Strategic Capital & Estates, and PHM Boards;
- The Digital Board which will serve as the Digital Design Authority, driving system strategic thinking across digital and data, and aligning to a system-wide future state Enterprise Architecture; and
- A Digital PMO to ensure collaboration and alignment across all system-wide digital initiatives.

Transformation and culture change

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Transformation will be digitally-enabled, embedding key data and digital capabilities in pathway redesign and new models of care.

What are our future aspirations?

We will develop a culture that embraces digital and data and embed a 'digital first' approach as part of wider transformation efforts.

What we will deliver over time

FY22/23

- **Agree communications plan**, incorporating digital champions, dedicated digital communications staff, and OD;
- **Embed digital and change champions** amongst staff at all levels for 'digital first, data-driven' approaches;
- Deploy best practice, standardised approaches collaboratively across organisations.

FY23/24

- **Continue to build staff support through change champions**, including for frontline staff;
- Embed digital and data capabilities in pathway redesign and new models of care.

FY24/25

- **Improve monitoring and evaluation** to enable decision-making capability.

FY25/26

- Review ICS Strategic Transformation objectives and begin planning for future strategy delivery with digital and data capabilities embedded in transformation.

Infection Prevention and Control (IPAC) Nurse, Norfolk Community Health and Care

Digital and data skills and inclusion

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Our staff will be supported through training and development programmes, delivered with our community partners.

What are our future aspirations?

We will upskill all our staff, patients and citizens to use digital and data confidently and to encourage inclusion and digital adoption.

What we will deliver over time

FY22/23

- **Baseline digital skills amongst staff** and invest in training and resources to address gaps;
- Support access to devices and equipment through libraries and schools schemes;
- **Expand digital inclusion initiatives for citizens in partnership with community organisations** (e.g., libraries, outreach workers, religious groups);
- Establish a digital patient voice or citizens forum for continuous input.

FY23/24

- **Develop a digital skills competency framework**;
- Include digital skills in career pathways and future job training / jobs of the future;
- Support staff with digital and data apprenticeships and secondment opportunities;
- **Standardise digital inclusion programme for staff**, incorporating induction, training, recruitment and career progression; nominate digital champions.

FY24/25

- Maintain a pipeline of key digital roles that could work flexibly across the system;
- **Ensure continuous review of ICS-wide digital professional development opportunities**, peer support mechanisms and training.

FY25/26

- Expand targeted community engagement and support programmes, learning from past efforts and initiatives.

Innovation and partnerships

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Innovation will form a key part of our digital strategy to scale and spread best practice across our system.

What are our future aspirations?

We will leverage partnerships and opportunities to innovate our services and embrace the potential of digitisation.

What we will deliver over time

FY22/23

- **Promote learning and sharing of best practice through localised innovation** and sharing of good practice across the system;
- **Expand academic partnerships through the Evaluation Hub**, e.g. University of East Anglia and the Eastern Academic Health Science Network to develop a robust quality improvement / evaluation capability.

FY23/24

- **Develop 'Innovation Hub' capability** accessible across the ICS that acts as a repository for best practice, emerging technology, and access to innovation partners;
- **Expand networks and collaborations** with other NHS partners, academia and private industry partners to drive innovation;
- Establish formal innovation partner(s), e.g., a 'buddy ICS' or private sector partner.

FY24/25

- **Explore funding opportunities for the innovation hub**, mature partnership arrangements, begin running agile pilots to test initiatives;
- Maximise opportunities enabled by the Trusted Research Environment (built on the HCDA) to support innovation.

FY25/26

- Use innovation to address and support system challenges;
- **Mature the innovation hub** – run agile pilots and scale and spread initiatives.

ICS Unified Digital Team

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We will bring together and further invest in key skills to support existing digital programme teams, align as an ICS, and reduce duplication.

Our commitments include to:

- **Bring together a single EPR team to support the implementation of an integrated Electronic Patient Record system** across our three acute Trusts;
- **Establish an ICS Intelligence/Analytics team** to support system-wide data and analytics, including population health management, segmentation, and risk stratification;
- **Enhance capacity** by supporting and bolstering local teams around key digital skills;
- **Establish a central digital team** to own and manage the digital strategy, receive and disseminate information from regional/national bodies, support organisations in their funding bids for future projects providing the necessary guidance and support; and
- **Increase investment in and collaboration and co-operation** for key functions, including information governance, cyber security, clinical safety, transformation, communications, contract management, IT service management, software development, application, tech, and infrastructure services, PMO, workforce development and digital innovation.

Our model of working together based on the principles outlined above will be agreed in future based on the most effective and efficient outcome for our system. Model Health System productivity benchmarking demonstrated variation in digital spend amongst our provider organisations. By bringing our skills together more effectively as an integrated system, we will drive efficiencies and make best use of digital transformation investment.

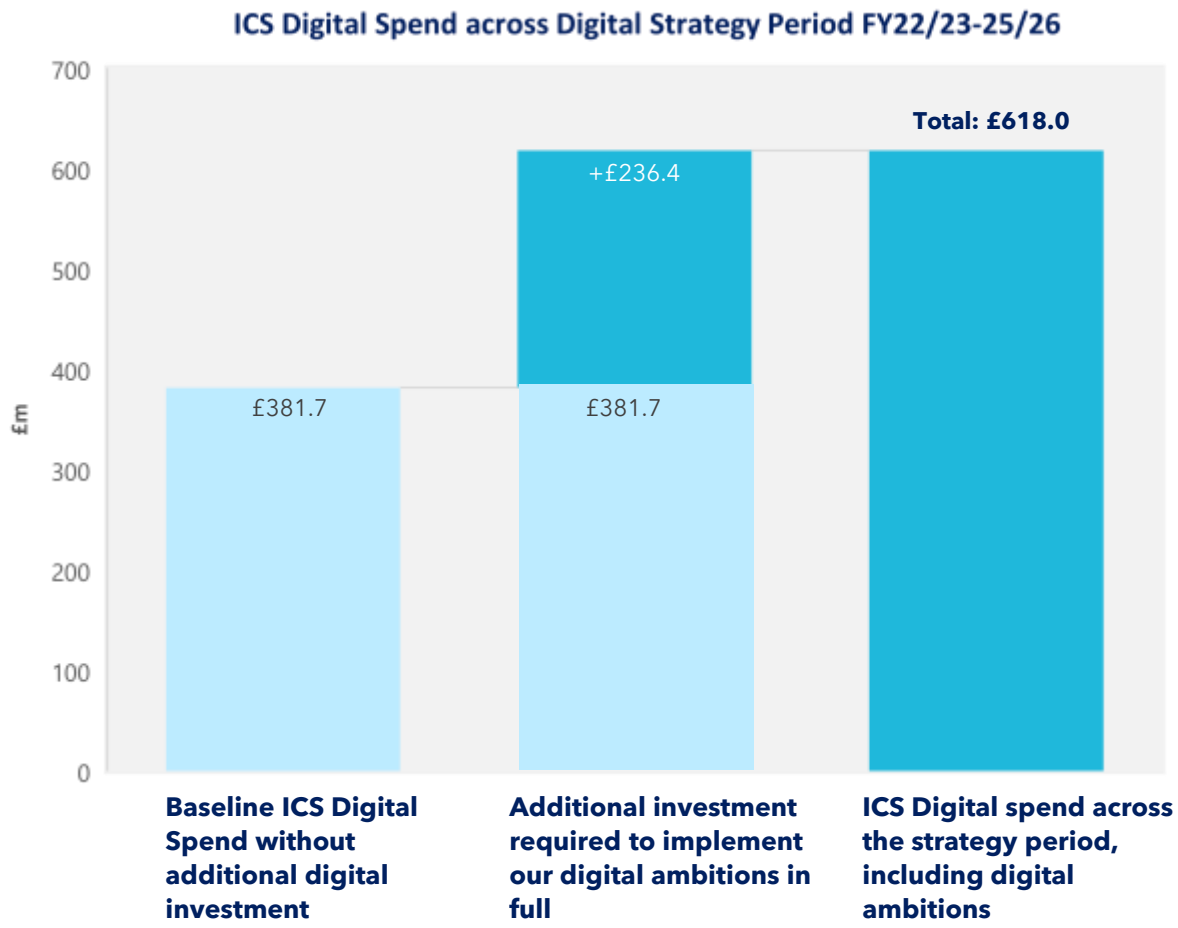
Investing in Digital Transformation

Investing in digitally-enabled transformation

In order to transform and truly integrate, investment in digital beyond our current funding commitments is required.

- National guidance recommends that Trusts spend ***5%*** of expenditure on technology.*
- In FY21/22, our annual spend on digital as a proportion of overall spend on health and care was approximately ***1.6%***, or £84.1m.
- The total estimated cost of the Digital Transformation Strategic Roadmap (FY22/23 – FY25/26) is ***£236m*****;
- Investment in digital transformation will increase the proportion of health and care spend on digital to between ***2.6 and 3.5%*** during the strategy period, bringing us closer to national guidance.

- **Due to the early stage at which some of the cost estimates and scope have been captured, a 10% contingency has been applied to all costs at programme level from FY22/23 to FY25/26. As scope for each programme is further defined, it is expected that specific levels of contingency and optimism bias will be applied. This will remove the need to apply a standard 10% contingency to all costs. A 5% contingency has been applied to EPR programme costings provided.
- An annual 8% inflation rate has been applied (from FY23/24). Though the published national tariff inflation rate is 5.2%, given the high proportion of non- pay costs, it was deemed appropriate to use a higher rate that was closer to 10% to reflect real costs/ current inflation rate.



The costed investment plan has been developed collaboratively with system digital and financial leads and will be further validated with system financial leads.

**Source: Lord Darzi and Institute for Public Policy Research, Better health and care for all, June 2018, referenced in the NAO Digital transformation in the NHS May 2020 report, Digital transformation in the NHS – National Audit Office (NAO) Report*
***Total estimated cost of £236m includes both Capital (£106.6m) and Revenue (£129.7m) costs.*

Funding required by digital capability

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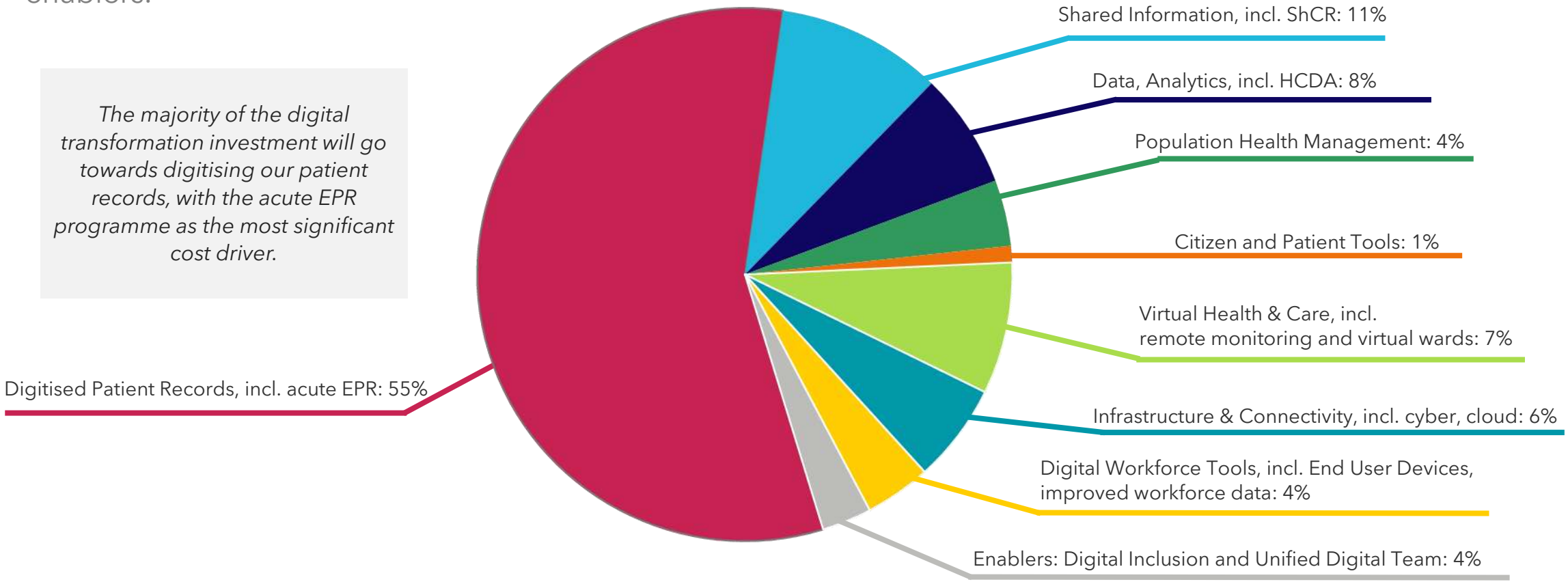
The Digital Transformation strategic roadmap will require significant investment to build our capabilities and enablers.

The majority of the digital transformation investment will go towards digitising our patient records, with the acute EPR programme as the most significant cost driver.



FUNDING REQUIRED FOR:

People	Hardware: Devices and Technology Kit	Tools and Systems	Integration, Sharing, Management of Data and Information

Additional funding sources required

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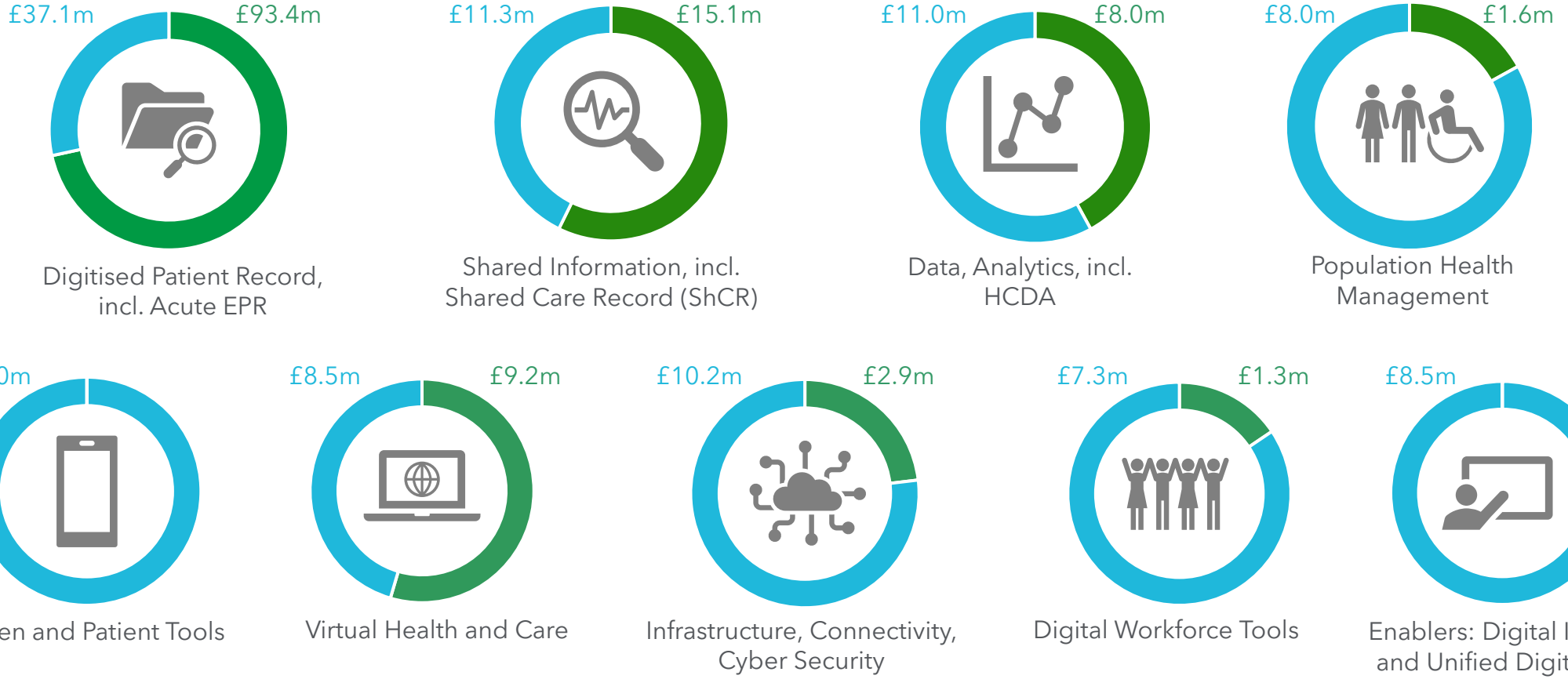
In order to maximise the opportunities enabled by digital, investment beyond our current funding commitments is required.

ADDITIONAL FUNDING REQUIRED BY DIGITAL CAPABILITY



Funding Identified or Secured | **Funding Gap**

Note: 'Funding identified' - Funding has been earmarked/requested for but not necessarily confirmed/allocated, 'Funding secured' - Funding that has been confirmed/allocated.

Costed plan

To deliver our digital transformation strategic roadmap, ~£236m of total investment is required, of which ~£105m requires additional funding.

Digital Capabilities	FY22/23 – 25/26 (Years 0-3)					
	Estimated Investment Required		Funding Identified or Secured		Estimated Funding Gap	
	Capital ('£000)	Revenue ('£000)	Capital ('£000)	Revenue ('£000)	Capital ('£000)	Revenue ('£000)
Digitised Patient Records, incl. Acute EPR	91,689	38,845	72,272	21,171	19,417	17,674
Shared Information, incl. ShCR	4,946	21,429	2,673	12,435	2,273	8,994
Data, Analytics, incl. HCDA	2	18,962	-	7,974	2	10,988
Population Health Management	-	9,606	-	1,631	-	7,975
Citizen & Patient Tools	1,582	1,371	-	-	1,582	1,371
Virtual Health & Care, incl. remote monitoring and virtual wards	3,703	14,015	2,115	7,085	1,588	6,930
Infrastructure & Connectivity, incl. cyber, cloud	1,362	11,769	863	2,043	499	9,726
Digital Workforce Tools, incl. End User Devices, improved workforce data	2,938	5,618	1,250	2	1,688	5,616
Enablers: Digital Inclusion and Unified Digital Team	413	8,104	-	-	413	8,104
Total ('£000)	**106,635**	**129,718**	**79,173**	**52,341**	**27,462**	**77,377**

To fill this funding gap, we will work to secure additional regional and national funding. We will also consider, as a system, how to best increase our digital transformation budgets, including agreement on a target percentage spend on digital.

Please see Appendix D for further details of the costed investment plan.

Implementing Our Strategy

Benefits of digital transformation

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Digital transformation will enable significant benefits across our system. Implementation of digital capabilities will improve patient outcomes, reduce administrative burden, release time to care, and ensure effective use of our resources.

Improved patient outcome and quality of care
through earlier detection and diagnosis and reduction in error and improved staff satisfaction

Reduced re-admissions / failed discharge
with tools to support self-management and accessible information

Fewer A&E attendances
through preventative measures, enhanced triage processes, and reduced conveyances

Cost savings
with reduced use of printing paper, and post, and consolidation of systems

Reduced attrition
with improved staff satisfaction and more productive working years

Time released to care
with automation and digitisation of administrative tasks

Proactive and preventative care
with better access to data to analyse trends

Reduced inequalities
with improved access knowledge of health disparities and therefore better targeting of resources

Reduced waiting lists and length of stay
as digital unlocks efficiency opportunities and improved system capacity to address rising demand

Reduced carbon emissions
with less patient and staff travel to health and care settings

We will ensure we implement a robust approach to evaluating and realising benefits, with a dedicated focus on change management.

Socialisation plan

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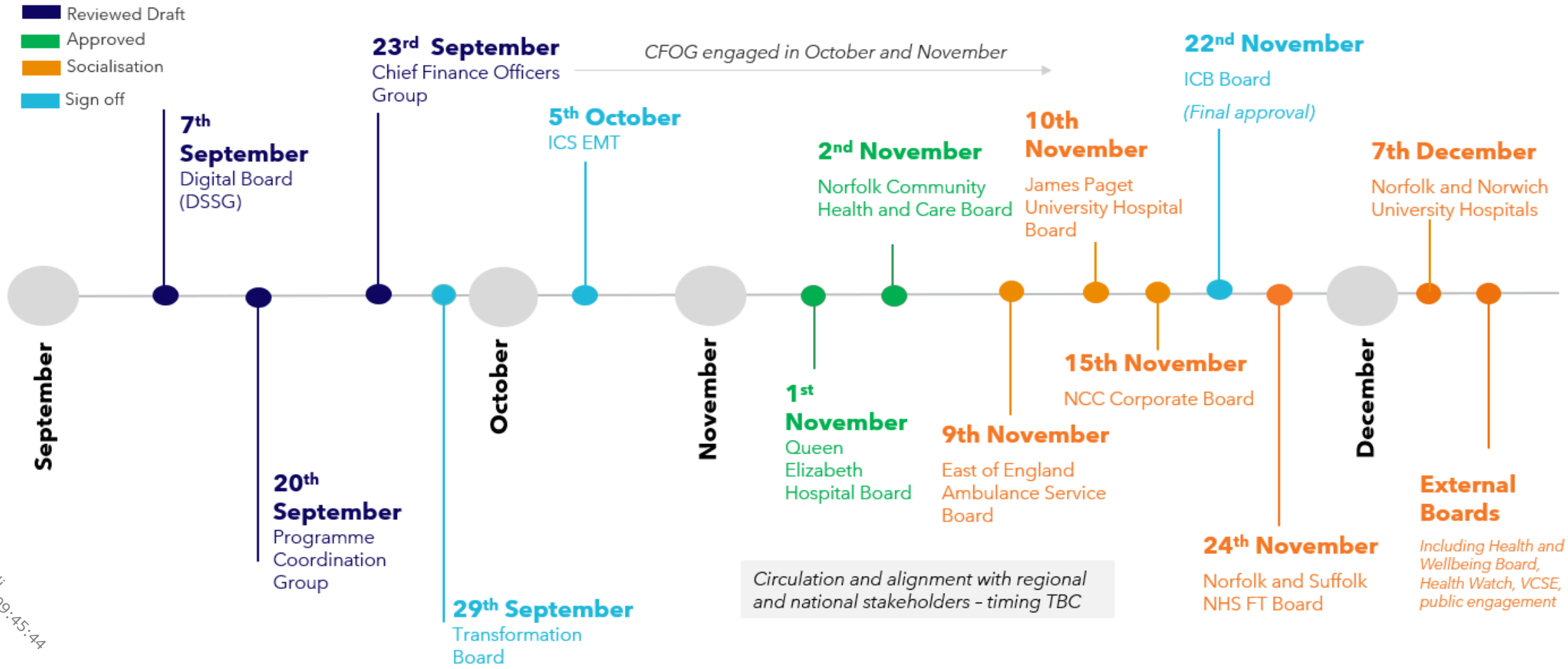
A critical path has been established for review and approval of this strategic plan and roadmap. The path promotes agreement and ownership with all organisations and the ICS.



Next steps

This Digital Strategic Plan and Roadmap provides a direction of travel and a delivery roadmap for digital health and care over the next 3 years. Our priority actions for the ICS Digital Transformation Strategic Roadmap and Investment Plan are to:

Agree and ***continue appointment*** of key digital transformation roles

Further develop strategic implementation plans and investment cases for each digital capability, working closely with the Chief Finance Officers Group

Director of Digital & Data for Norfolk and Waveney ICB to ***lead delivery of the strategy*** via the DSSG leadership; ***Ongoing collaboration*** of the digital teams and existing digital PMO resources to ***progress delivery of the digital transformation strategic plan***

Approval of strategic roadmap and plan via the ICB Board on 22nd Nov, then wider socialisation through external boards (e.g. Health watch, VCSE Assembly)

Review achievements against our goals and objectives at annual intervals, addressing new priorities and adjusting our direction of travel as our clinical strategy evolves.

Thank you

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Thank you to the clinical, operational and digital stakeholders from our ICS and partner organisations who supported the co-development of this Digital Transformation Strategic Plan and Roadmap.

Special thanks to the following for contributing to the development of the Digital Transformation Strategic Plan and Roadmap:

- Our front-line clinicians and staff, leaders in our ICS and partner organisations, and citizens and patients across Norfolk and Waveney for giving of their valuable time to invest in the design of the future digital vision for care.
- Our Digital Transformation Strategic Planning Working Group (DTSPWG), a dedicated group of clinical and digital leads from our ICS and partner organisations.






Key risks and proposed mitigations

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Delivering digital transformation on this scale entails the effective management of risks including the lack of joined-up leadership, transformation siloes, insufficient funding, significant cultural change required, as well as governance challenges.

Area	Risk	Next steps for mitigation
Leadership	• Lack of alignment between system and organisational leaders given competing priorities	• Galvanize leadership on compelling case for change, articulating risks of not digitising and championing this digital roadmap
Funding	• Limited funding to fully deliver strategic ambitions	• Further prioritise digital capabilities, as required • Agree as a system to set a target percentage for digital spend • Engage with regional and national leaders on additional potential funding sources
Culture	• Lack of workforce readiness for transformation • Significant cultural change required, potential for 'change fatigue' • Siloes when it comes to digital and wider transformation efforts across the system	• Join-up efforts around digital and wider transformation including a comprehensive change management programme/workstream that includes digital • Support frontline champions among staff of digital and wider transformation efforts
Governance	• Potential for inertia and delayed decision-making while governance structures are formed and matured	• Rapidly enact the digital governance so that it provides effective and transparent support to the transformation ambitions

Appendix A: Engagement Approach

Our engagement approach

Stakeholders were engaged to co-develop the ICS Digital Transformation Strategic Plan and Roadmap using a variety of channels including interviews, staff survey, workshops and a public patient and citizen forum.

Interviews

Interviews conducted with over **50 key stakeholders** across the ICS to understand the strategic context, **current state, future vision, capabilities** and **challenges**

Survey

Survey distributed and **over 250 responses** gathered to gain perspectives on the **priorities** for digital transformation and **barriers**

Patient journeys

Five patient journey workshops co-facilitated with clinical leads to bring the **digital vision to life** via five exemplar future patient journeys

Working group sessions

Five sessions held to co-develop the strategic plan and roadmap, gaining views on the **digital ambition, key strategic priorities and key capabilities and enablers,** and agreement on the **resource plan and investment priorities**

Patient / citizen forum

Patient and citizen forum held to listen to **patient and citizen voices** on their needs to inform **strategic priorities and the roadmap**

Established governance groups were used for collaboration and decision-making during the development of the roadmap and plan. This ensured ***commitment and ownership of the strategic ambitions***. Governance groups included CCTG, C(x)IO, DSSG and EMT.

Stakeholders interviewed (1/2)

Interviews were held between 6th and 27th of June with key ICS stakeholders to understand the strategic context of the organisations within the system and priorities for digital transformation

Name	Role	Date
Dave Allen	Head of Ops, EEAST	15th June
Pete Best	Head of Insight and Analysis	9th June
Dr Zac Blake	Clinical Lead for ShCR Programme	21st June
Tracey Bleakley	ICB CEO	8th June
Alex Briggs	Associate Director of Information (Primary Care & Commissioning)	9th June
Stephen Bromhall	CIO, EEAST	14th June
Carly West-Burnham	Director of Strategy and Integration, QEH	8th June
Anne Burrows	Associate Director of Special Projects	14th June
Dr Hilary Byrne	GP, Clinical Lead, CCG	16th June
Daryl Chapman	DOF, NSFT	10th June
David Chapman	Technical and Solutions Architect	21st June
Mr Vivek Chitre	Chief Medical Officer, Lead for Digital, JPUHFT	22nd June
Geoff Connell	CIO, NCC	21st June
Dr Dan Dalton	Medical Director, NSFT	10th June
Prof. Erika Denton	Medical Director, NNUHFT	14th June
Martin Evans	EPR Programme	8th June
Ben Everitt	Associate Director of Digital Health, NNUHFT	14th June
James Grainger	Head of Finance – Primary Care & Continuing Health Care	13th June
Shawn Haney	PHM Manager	13th June
Dr Venu Harilal	Medical Director, NCHCT	13th June
Anne Heath	Associate Director of Digital, CCG	16th June
Rt Hon Patricia Hewitt	ICB Chair	16th June
Andrew Hopkins	Director of Finance & Performance at NCHC and Exec Dir for Digital for N&W ICS	13th June
Ian Hutchison	CEO, ECCHC	16th June
Dr Mark Lim	Interim Director of Clinical Services and Clinical Transformation	20th June
Adele Madin	Exec Director of Ops, ECCHC	16th June
Ceinwen Mannall	Assistant Director Clinical Workforce Projects	14th June
Howard Martin	Director for Population Health Management and Health Inequalities	13th June

Stakeholders interviewed (2/2)

Interviews were held between 6th and 27th of June with key ICS stakeholders to understand the strategic context of the organisations within the system and priorities for digital transformation

Name	Role	Date
Amy Metcalf	Communications & Engagement Manager	8th June
Terry Newman	Head of Digital, NCHCT	13th June
Sandy Oosthuysen	Assistant Director of Learning and Organisational Development	14th June
Dr Louise Smith	Director of Public Health (Norfolk)	16th June
Andrew Palmer	Director of Performance, Transformation, Strategy	16th June
Jocelyn Pike	Director of Special Projects	9th June
Jonathon Reddington	Head of Digital Services, JPUHFT	13th June
Mike Shemko	Head of Data Science, NNUH	22nd June
Martin Pettifor	Head of Special Projects	14th June
Dr Ed Prosser-Snelling	Associate MD, NNUHFT	14th June
Stuart Keeble (Suffolk)	Director of Public Health	16th June
Ben Smith	Associate Director System Workforce Efficiency	14th June
Dr Frankie Swords	Medical Director, QEHFT	17th June
Dr Edward Turnham	Clinical Advisor for Digital Strategy	9th June
Emma Wakelin	Associate Director of Workforce Transformation	6th June
Samantha Weston	PHM Programme Manager	13th June
Daniel Williams	VSCE Place Network Lead	17th June
Bill Wilson	ShCR/HCDA Programme	21st June
Dr Clara Yates	Associate Director of Research	13th June

Digital Transformation Strategic Planning Working Group (DTSPWG)

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The DTSPWG was set up to help guide the development of the Digital Transformation Strategic Plan and Roadmap. The purpose and objectives of the DTSPWG are outlined below.

Purpose:

Define and co-develop the ICS Digital Transformation Strategic Plan, including a coherent system vision, 3-year roadmap, and investment priorities.

Objectives:

- Collaborate with a smaller group of core senior stakeholders **to develop and agree a robust and cohesive digital transformation strategic plan** while also reporting progress to the DSSG group;
- Understand the **current state and future vision** for the use of data and digital technology to enable the ICS strategic vision;
- Define the **strategic plan, key capabilities, enablers, resource plan and roadmap;**
- Facilitate **open discussion** to gather and track ideas;
- Share relevant documents and outputs with this group, the wider **DSSG**, and additional key governance groups for comments.

Digital Transformation Strategic Planning Working Group (DTSPWG)

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The DTSPWG was composed of clinical and digital leaders from across each partner organisation. The membership of the DTSPWG is outlined below.

NW CCG

- Edward Turnham, Clinical Digital Lead (Primary Care)
- Alex Briggs, Head of BI
- James Grainger, Financial Lead (Digital)
- Anne Heath, Digital Lead

NCHC

- Terry Newman, Head of Digital
- Emma Jackson, CNIO
- Venu Harilal, MD
- Andrew Hopkins , Dir. of Finance

QEHKL

- Carly West Burnham, Exec Lead for EPR Workstream
- Nigel Hall, CIO

NSFT

- Dave Huggins, CIO
- Toral Thomas, CCIO
- Tracey Holland, CNIO

JPUH

- Vivek Chitre, Assoc MD, Lead for Digital
- Britt van Rooyen, Operations Director
- Rachael Rider, CNIO
- Reet Johal, CCIO for JPUH

NNUH

- Ed Prosser-Snelling, Exec Digital Lead
- Ben Everitt, AD of Digital Health
- Victoria Colman, AD of Quality Improvement
- Emily Wells, CNIO
- Delyse Maidman, Digital Midwife
- Victoria Braide, Matron

ECCHC

- Nick Ansell, Digital Programme Lead

EEAST

- Stephen Bromhall, CIO

NCC & SCC

- Geoff Connell, CIO
- Krishna Yergol, CIO
- Sarah Rank, Head of Business & Tech

ICS

- Andrew Palmer, ICS Director of Planning & Transformation
- Howard Martin, Director for PHM and Health Inequalities
- David Chapman, Technical Solution Architect for the ICS
- Pete Best, BI & Analytics
- Phil Reidlinger, Head of PMO
- Claire Dyke, ICS Social Prescribing Lead
- Claire Euesden, Elective Recovery Lead

Appendix B: Bringing our Digital Transformation Strategy to Life (Patient Journeys)

Overview of patient journeys

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Illustrative future patient journeys were co-developed with clinical and social care leads from across the ICS, highlighting ideal future care models and digital capabilities. The clinical leads for each workshop are noted below, and the full attendance list is at the end of each journey section.

JAKE

BRUNA

MACIEJ

FAIZA

ARTHUR

Workshop Dates	28 July, 12-1pm	29 July, 12-1pm	2 August, 4-5pm	3 August, 12-1pm	4 August, 4-5pm
	Jake is 14 years old. He lives with his mother who has recently split up with an abusive partner. He is prone to anxiety and has been diagnosed with ADHD and also has a learning disability. As a result he doesn't enjoy school and sometimes misses his classes.	**Bruna** is 26 years old and pregnant for the third time. She lives in Great Yarmouth and has recently arrived from Guinea-Bissau. She is overweight and is a heavy smoker. She is suffering from chronic fatigue following long Covid which has left her unable to hold down a full time job. She is entering her third trimester when she is diagnosed with placenta accreta.	**Maciej** is 55 years old and moved to the UK from Poland six years ago and speaks limited English. He has experienced bouts of homelessness and suffers from depression. He has been admitted to A&E in the past for alcohol and drug dependency issues. He presents to A&E after an overdose, receives treatment and is referred to urology.	**Faiza** is 75 years old, retired and lives with her husband. Both her and her husband are physically inactive and have been for many years. Faiza speaks limited English and has poor digital literacy. Faiza suffers from diabetes and is overweight. She has been recently diagnosed with stage 2 breast cancer.	**Arthur** is 86 years old and lives in a care home where he requires around the clock care. He has dementia and is more prone to falls and accidents due to his limited mobility and loss of peripheral sensation. He recently had a fall trying to get out of bed and has been transported to A&E.
	Lead: Sarah Flindall	**Lead:** Delyse Maidman	**Lead:** Mark Shepperd	**Lead:** Maggie Tween	**Leads:** Dave Allen, Sharon Brooks, Jamie Weavers

Patient journey: Jake

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JAKE'S BACKGROUND

Male | 14 years old

King's Lynn

English

Diagnosed learning disability and ADHD, suffers from anxiety

Jake lives in **King's Lynn** with his mother who is in the process of leaving an abusive partner that has lived with them on and off for several years.

Jake has been diagnosed with **ADHD** and suffers from **anxiety**. He doesn't enjoy school and has a diagnosed **learning disability**. His most recent experience with acute anxiety has prompted a referral to **CAMHS** where he is **prescribed medication** for his anxiety and ADHD.

During a particularly difficult month, he **starts missing school** and confides in a schoolteacher about **troubles at home**.

Patient journey: Jake

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Norfolk and Waveney Integrated Care System

- Male | 14 years old
- Learning disability and ADHD
- Anxiety

Reimagining Care and Experiences: 2025 to 2030 Patient Journey

Referred to CAMHS → Prescribed medication → Safeguarding concerns raised → Social services & Police informed → Social Worker / Police visits Jake's home → Ongoing support for Jake and his mother

Jake receives support for his anxiety

Jake is struggling with his anxiety and begins missing school.	Jake's CAMHS referral is analysed and prioritised.	Prior to the appointment, the Psychology team review Jake's SEND plan notes.	During the appointment, Jake's patient record is updated, and he is prescribed medication for his anxiety and ADHD.	Following the appointment, Jake is able to access information about his treatment.
Jake's recent poor school attendance prompts a referral to CAMHS.	Jake's appointment is prioritised as his data is analysed with system insights pulling together all risk factors and calculating that he is high risk.	The CAMHS team also review Jake's health and social care records, ensuring they are already aware of his story before he arrives to the appointment. Jake inputs his current concerns into the notes too.	The Psychology team update Jake's SEND plan, noting his prescription. All relevant professionals have the appropriate access and visibility of Jake's care. Jake and his mum are also informed about self-help apps, support groups, crisis lines and virtual therapy available.	Jake and his mum have access to all appointments, his care plan and medication lists via the patient portal. Jake's medicines reconciliation is accessible to community pharmacies too. The portal allows Jake to input his progress and personalise his care plan. Jake also has visibility of parent/guardian access rights for his account.

Davey, Heidi 22/11/2022 09:45:44

Digital Capabilities

Process automation

Information sharing between all health, care and education partners

PHM Risk Stratification using HCDA (Health & Care Data Architecture)

Patient portal (with accessible content)

Patient journey: Jake

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- Male | 14 years old
- Learning disability and ADHD
- Anxiety

Reimagining Care and Experiences: 2025 to 2030 Patient Journey

Referred to CAMHS → Prescribed medication → Safeguarding concerns raised → Social services & Police informed → Social Worker / Police visits Jake's home → Ongoing support for Jake and his mother

Jake receives safeguarding support

Jake's anxiety worsens and it's not clear if he is taking his medication despite receiving digital reminders.

Jake uses electronic medication management technology which alerts his mother when he takes his medication. Jake also begins missing classes again and the school inform his mother.

Jake confides in a schoolteacher of troubles at home. Safeguarding concerns are raised by the school and social workers and police are informed.

A social worker guides Jake on how to interact with social media to avoid exploitation. The social worker and Jake work together to develop a support plan, which is updated on his record for parent and care professionals' visibility.

Jake is visited at home by the police and social services.

The police visit Jake's home and speak to his mother. Jake is assigned regular visits by social workers (who have access to his record). A way forward is agreed with Jake's mother and both her and Jake are offered online and community resources and support. Resolution documented and multiagency assessments shared with all appropriate care professionals.

Davey, Heidi 22/11/2022 09:45:44

Digital Capabilities

Personalised education and support (e.g., CBT app)

Electronic medication management technology

Electronic Patient Record (EPR)

Digital signposting to community resources

Patient journey: Jake

Improving lives together
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- Male | 14 years old
- Learning disability and ADHD
- Anxiety

Reimagining Care and Experiences: 2025 to 2030 Patient Journey

Referred to CAMHS → Prescribed medication → Safeguarding concerns raised → Social services & Police informed → Social Worker / Police visits Jake's home → Ongoing support for Jake and his mother

Jake and his mother receive ongoing support

Jake receives ongoing support, and his SEND plan is regularly reviewed and updated on the EPR.	Jake is also working with a Child Wellbeing Practitioner (CWP) to support his CBT therapy.	Jake's mother is given ongoing support.	Jake manages his annual learning disability health check appointment on the patient portal.	Jake's data is analysed for future treatment improvement .
Jake's SEND plan is regularly updated by Jake, his mother, his GP, his social care worker(s) and educators via integrated sources that feed into the patient record. Jake records his personal preferences on this portal.	Jake's mother is informed of his progress on a regular basis via the patient portal. Jake's treatment plan is guided by decision support and outcome analytics.	Jake and his mother are signposted to support apps and resources.	His Social Worker reviews his SEND plan on his record and adds progress notes for all appropriate care professionals' visibility.	Aggregated data and advanced analytics are used to analyse Jake's initial presentation, treatment and progress overtime to enable continuous improvement.

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Digital Capabilities


Advanced analytics to evaluate outcomes


Online accessible patient portal


Electronic Patient Record (EPR) (including SEND plan)


Seamless information sharing

Jake's Patient journey: Workshop Attendees

DRAFT for DISCUSSION

Improving lives together
Norfolk and Waveney Integrated Care System

Reimagining Care and Experiences: 2025 to 2030 Patient Journey

Thank you to all of the stakeholders who attended the patient journey workshop and provided their insight and expertise on the future care model and digital capabilities.

Name	Role	Organisation
Caroline Aldridge	Social Worker	Self-employed
Zac Blake	Clinical Lead for ShCR	NHS Norfolk and Waveney ICB
Robert Black	Clinical Team lead	East Coast Community Healthcare CIC
Helen Bradley	Modern Matron of C&YP	Norfolk Community Health and Care NHS Trust
Sharon Brooks	CEO	Carers Voice
Daryl Chapman	Director of Finance	Suffolk NHS Foundation Trust
Claire Euesden	Elective Recovery Programme Lead	Norfolk & Waveney ICB
Abigail Ford	Occupational Lead (Neurodevelopmental service)	UK Health Security Agency
Dr Sarah Flindall	GP and Clinical Advisor	NHS Norfolk and Waveney CCG
Rachel Gates	Senior Programme Manager	NHS Norfolk and Waveney ICB
Shawn Haney	PHM Manager	Norfolk & Waveney ICB
Reet Johal	Chief Clinical Information Officer (CCIO)	James Paget University Hospitals NHS Foundation Trust
Ian Marsland	e-RS Deployment Lead	Norfolk and Suffolk NHS
Thandie Matambanadzo	Chief Operating Officer	Norfolk and Suffolk NHS Foundation trust
Tracy McLean	Head of C&YP & Maternity	NHS Norfolk and Waveney CCG
Terry Newman	Head of Digital Services	Norfolk Community Health and Care NHS Trust
Rachel Gates	Senior Programme Manager	NHS Norfolk and Waveney ICB
Dr Jeanine Smirl	GP and Clinical Advisor	NHS Norfolk and Waveney ICB
Toral Thomas	Chief Clinical Information Officer (CCIO)	Norfolk and Suffolk NHS Foundation trust
Samantha Weston	Programme Manager	NHS Norfolk and Waveney CCG
Sarah Watling	Respite Services Manager	Norfolk Community Health and Care NHS Trust

Patient journey: Bruna

BRUNA'S BACKGROUND

Female | 26 years old

Great Yarmouth

Mixed heritage

Pregnant for the third time. Overweight and heavy smoker.

Bruna is an **expectant mother** who resides in Great Yarmouth and has recently moved to the UK from Guinea-Bissau. She had two previous pregnancies. Bruna is overweight and is a heavy smoker. She is also suffering from **chronic fatigue** following long Covid which has left her unable to hold down a full time job.

After finding out that she is pregnant she makes an appointment with a midwife. She chooses to deliver her baby at **James Paget University Hospital.**

Bruna attends her third trimester prenatal appointment where she is diagnosed with **placenta accreta** and has her care transferred to **Norfolk and Norwich Hospital.** She undergoes a planned **caesarean section** and delivers her baby at 36 weeks.

Patient journey: Bruna

DRAFT for DISCUSSION

Improving lives together
Norfolk and Waveney Integrated Care System

- Female | 26 years old
- Third time pregnant
- Overweight & heavy smoker

Reimagining Care and Experiences: 2025 to 2030 Patient Journey

Self referral to Maternity → Community support → Third trimester ultrasound scan → C-section → Postnatal and Neonatal wards → Discharge and continued care at home

Bruna self-refers to Maternity services (antenatal)

Bruna self-refers to maternity services digitally after discovering she's pregnant (self-referral available in several languages.	**Bruna books her first antenatal appointment with her continuity team midwife.**	**During the appointment, Bruna's midwife updates her patient record and advises Bruna on information sources.**	**The midwife records Bruna's smoking status and weight which automates a referral suggestion.**
Bruna's self referral includes all medical, surgical, obstetric, mental health and social history. Her risk assessment is auto-calculated, based on her responses. She identifies the areas of care for which she would like support and advice. She is then directed to resources and auto-referred to services tailored to her needs (midwife notified). Her pregnancy risk is predicted and flagged to all care team members electronically.	Bruna has a dedicated midwife who proactively works with her and the wider team to coordinate personalised support that is tailored to her needs. She books her appointment electronically in her specified language. This triggers a translator request during the appointment, and notifies primary care and health visitors of expected care. Bruna is able to track her pregnancy and appointments via the patient portal.	Bruna's complete record is accessible to all appropriate care professionals and interoperable across services from any setting. Bruna has access to her record via a portal where she submits an image/video to support symptoms reporting. Tailored antenatal education is available on the portal, which can be translated. An exemption form for prescriptions is automatically generated on the EPR. The midwife can manage her caseload and monitor patients digitally which is efficient and releases sufficient time to care for patients by reducing manual administrative tasks.	Bruna agrees to attend smoking cessation and weight management support services. Her personalised care plan is developed with the midwife. The midwife also records that Bruna suffers from long Covid and episodes of depression, which has impacted her employment. She is automatically connected to employment support and referred for mental health support.

Digital Capabilities

Maternity digital record, including a patient portal

Online booking system with translation support

AI techniques to predict pregnancy risks

Electronic Patient Record (EPR)

Patient journey: Bruna

DRAFT for DISCUSSION

Improving lives together
Norfolk and Waveney Integrated Care System

- Female | 26 years old
- Third time pregnant
- Overweight & heavy smoker

Reimagining Care and Experiences: 2025 to 2030 Patient Journey

Self referral to Maternity → Community support → Third trimester ultrasound scan → C-section → Postnatal and Neonatal wards → Discharge and continued care at home

Bruna is scheduled for a C-section

Bruna attends her third trimester scan and is diagnosed with placenta accreta and Bruna is referred for a c-section.

Bruna's patient record is updated and HCP contacts Bruna to offer support and guidance (as HCP has access to her record). Her care is transferred to Norfolk and Norwich University Hospital for her C-section. Information flows seamlessly to all care settings to support cross boundaries. Translated information is available on her portal and with her Midwife/care team. A health visitor is assigned to Bruna for proactive planning of support. AI supports decision making in her treatment plan by assessing risk factors and generating care recommendations.

She is scheduled for a c-section and remotely monitored.

Scheduling is seamless and integrated with theatres, worklists and e-rostering, enabling effective pre-op and staff planning. Bruna is advised how to manage her care in a virtual ward setting at home and provided the necessary devices to record her levels. She is also signposted to support groups and information which is all available in her first language. Bruna's health visitor communicates with Bruna and her partner to support them with any concerns (e.g. financial).

Bruna attends NNUH for her c-section and delivers her baby at 36 weeks.

Prior to attending the hospital, Bruna completes her pre-op assessment and consents to the c-section digitally. The pre-op assessment automates a notification to issue information leaflets in her first language and to issue pre-op medication and topical preparations with supporting information. When she attends the hospital, care professionals, including the theatres team are updated on her real-time location and status. This allows the Post- and Neo-natal teams to prepare for transfer. The care team signpost Bruna to virtual peer support functions for families with babies in the neonatal unit.

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Digital Capabilities

Seamless information flows between all appropriate care professionals

Advanced data analytics and AI

Intelligent scheduling (AI)

Digital pre-op assessment and e-consent tool

Virtual wards

Patient journey: Bruna

Improving lives together
Norfolk and Waveney Integrated Care System

- **Female | 26 years old**
- **Third time pregnant**
- **Overweight & heavy smoker**

Reimagining Care and Experiences: 2025 to 2030 Patient Journey

Self referral to Maternity → Community support → Third trimester ultrasound scan → C-section → Postnatal and Neonatal wards → Discharge and continued care at home

Bruna and her baby receive neonatal and postnatal care

Post delivery, Bruna is transferred to a post natal ward.

The c-section has no complications and Bruna is transferred to ward care. Bruna's patient record is updated and accessible to all appropriate care professionals and integrated to avoid any unnecessary duplication.

Her baby was born prematurely and is cared for in the neonatal unit.

Central monitoring can track the location of the mother and baby in real time, as baby tags and electronic tracking are generated automatically at birth. Bruna is provided with a tablet to virtually see her baby while apart. Bruna's partner also has access to a video-link as he cannot visit their baby in NICU.

Her baby is registered onto the record.

The maternity digital record automatically pre-populates the baby's records, e.g. NIPE, eRedbook and refers to primary care for ongoing support with development and immunisations. Failsafe is built into the record to automate referrals and follow ups. The baby's screening tests are performed within the neonatal unit and the results are updated on the record.

Data is collected throughout the patient journey.

Maternity data is collected to feed into data and PHM dashboards for healthy population planning. These dashboards are created automatically.

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Digital Capabilities

Electronic Patient Record (EPR) linking mother and baby's records

Video monitoring in NICU

eRedbook with reminders and auto-booking of immunisation and vaccines

Virtual physio tool to support recovery from home

Virtual consultation

Patient journey: Bruna

Improving lives together
Norfolk and Waveney Integrated Care System

- Female | 26 years old
- Third time pregnant
- Overweight & heavy smoker

Reimagining Care and Experiences: 2025 to 2030 Patient Journey

Self referral to Maternity → Community support → Third trimester ultrasound scan → C-section → Postnatal and Neonatal wards → **Discharge and continued care at home**

Bruna and her baby receive neonatal and postnatal care

After 7 days Bruna and her baby are discharged.

Discharge is completed by the care team and a discharge letter is auto-populated on the EPR and accessible to the care team. There is a seamless discharge to community services, including cross border transfers. Electronic discharge notifications are automatically sent to the health visitor and GP involved in Bruna's maternity care. Bruna can schedule appointments in the community digitally which track and monitor her screening pathways. An automatic postnatal follow up is arranged as part of discharge from acute services, and an e-discharge generates electronic prescriptions in primary care.

Upon discharge, Bruna is connected with an HCP and other support services.

She is offered an array of support options and choice of appointment types (face-to-face, phone, video-call), and is provided with information on caring for herself and her baby. She is also signposted to educational videos. She receives digital support for feeding choices, monitoring and support for weight loss and jaundice. She also receives virtual screening and ongoing support for her mental health.

Bruna's continuity team midwife visits her home and advises continuous care measures.

Bruna is diagnosed with post-natal depression and chronic back pain following her delivery. She is verbally and digitally signposted to self-help apps and community support groups, as well as referred to Physiotherapy who offer virtual consultations. Her pregnancy record automatically closes after 6 weeks, accessible to suitable HCPs through the archive.

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Digital Capabilities

Electronic Patient Record (EPR) linking mother and baby's records

Video monitoring in NICU

eRedbook with reminders and auto-booking of immunisation and vaccines

Virtual physio tool to support recovery from home

Virtual consultation

Bruna's Patient journey: Workshop Attendees

DRAFT for DISCUSSION

Improving lives together
Norfolk and Waveney Integrated Care System

Reimagining Care and Experiences: 2025 to 2030 Patient Journey

Thank you to all of the stakeholders who attended the patient journey workshop and provided their insight and expertise on the future care model and digital capabilities.

Name	Role	Organisation
Louise Asprey	Health Records Services Manager	Queen Elizabeth Hospital King's Lynn NHS
Nick Ansell	Digital Programme Lead	East Coast Community Healthcare CIC
Sarah Anguish	Service Engagement Officer • Smoking Cessation Team	East Coast Community Healthcare CIC
Sam Bassett	Head of Midwifery Department	Suffolk County Council
Kristy Ellwood	Postnatal Ward Team Leader	Norfolk and Norwich University Hospitals NHS Foundation Trust
Lorna Edge	Stop Smoking Consultant • Smoking Cessation Team	East Coast Community Healthcare CIC
Rachel Gates	Senior Programme Manager	NHS Norfolk and Waveney ICB
Shawn Haney	PHM Manager	NHS Norfolk and Waveney ICB
Alana Hunt	Midwife	NHS Norfolk and Waveney ICB
Toni Jeary	LMNS Programme Manager	NHS Norfolk and Waveney
Sian Larrington	Community teams	Cambridgeshire Community Services NHS Trust
Delyse Maidman	Digital Midwife	NHS Norfolk and Waveney ICB
Suzanne Meredith	Deputy Director of Public Health	Norfolk County Council
Phillipa Noble	LMNS Practice Development Team	Norfolk and Norwich University Hospitals NHS
Terry Newman	Head of Digital Services	Norfolk Community Health & Care NHS Trust
Jemma Parker	Service Engagement Officer • Smoking Cessation Team	East Coast Community Healthcare CIC
Fay Spencer	Community teams	Cambridgeshire Community Services NHS Trust
Lorna Shailer	Digital Health Clinical Safety Officer	James Paget University Hospitals NHS Foundation Trust
Anne-Louise Schofield	Commissioning Manager	Norfolk County Council

Bruna's Patient journey: Workshop Attendees

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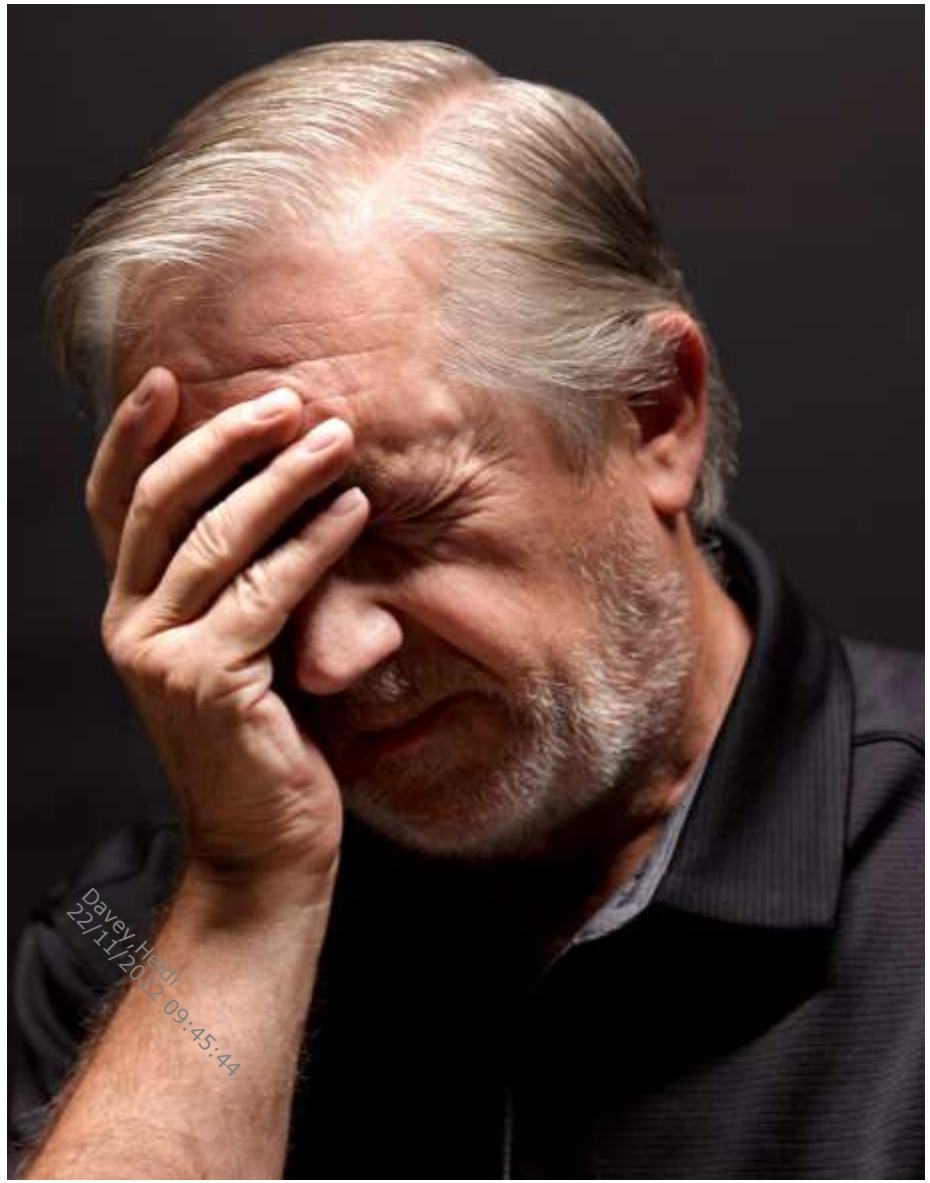
Improving lives together
Norfolk and Waveney Integrated Care System

Reimagining Care and Experiences: 2025 to 2030 Patient Journey

Thank you to all of the stakeholders who attended the patient journey workshop and provided their insight and expertise on the future care model and digital capabilities.

Name	Role	Organisation
Hannant Tracey	Digital Midwife	James Paget University Hospitals NHS Foundation Trust
James Wade	Smokefree Operations Manager	East Coast Community Healthcare CIC
Samantha Weston	PHM Programme Manager	NHS Norfolk and Waveney ICB
Emma Wiskin	Associate Director of Workforce Transformation	NHS Norfolk and Waveney ICB

Patient journey: Maciej



MACIEJ'S BACKGROUND

Male | 55 years old

Norwich

Polish

Drug/alcohol dependency, depression. Has also experienced bouts of homelessness.

Maciej is 55 years old. He moved to **Norwich from Poland** six years ago and speaks **limited English**.

He has experienced **bouts of homelessness** and suffers from **depression**. He has been admitted to A&E in the past for **alcohol and drug dependency issues**.

During a particularly difficult month, Maciej suffers an **overdose** and a member of the public finds Maciej unwell and calls 999. He presents to A&E, is treated for an overdose and is referred to hepatology and urology.

Patient journey: Maciej

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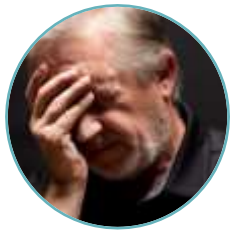
Norfolk and Waveney Integrated Care System



- Male | 55 years old
- Drug/alcohol dependency
- Depression

Reimagining Care and Experiences: 2025 to 2030 Patient Journey

Treatment for overdose → Referral to Hepatology → Urology referral → Surgery → Recovery and discharge → Ongoing support for Maciej

Maciej is admitted to A&E after an overdose

A member of the public finds Maciej unwell and calls 999. Paramedics arrive on scene

The Paramedics acknowledge Maciej's translation support required. They use a mobile translation app to communicate with him. Paramedics access his record and note his unstable living situation. A&E are aware of Maciej's ETA prior to arriving to allow for bed preparation.

Maciej is treated in A&E for the overdose but suffers pyrexia of unknown origin

While in A&E, the CGL (Change, Grow, Live) drug and alcohol team are electronically notified to assess Maciej. All communication is supported by a translation app. Collaboratively all care professionals update Maciej's record and begin proactive discharge planning. Time is saved in efficient documenting, releasing time to care. His natural support network is identified and contacted to update on his condition.

When Maciej's condition stabilises, he is transferred from A&E to a Hepatology Guist Ward to complete detox

Maciej is assessed by mental health services virtually, reducing barriers between services. Further tests are also conducted to determine the cause of his pyrexia. Care teams have digital codes so care professionals are aware of who is caring for Maciej, helping CGL to track him.

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Digital Capabilities

Mobile translation app

Digital codes for team association

Integrated Electronic Patient Record (EPR) sharing information between ambulance and hospital

AI techniques to support diagnostics

Patient journey: Maciej

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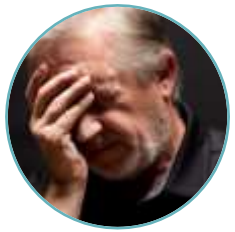
Norfolk and Waveney Integrated Care System



- Male | 55 years old
- Drug/alcohol dependency
- Depression

Reimagining Care and Experiences: 2025 to 2030 Patient Journey

Treatment for overdose → Referral to Hepatology → Urology referral → Surgery → Recovery and discharge → Ongoing support for Maciej

Maciej receives further treatment

Maciej's pyrexia is confirmed as a urinary tract infection secondary to renal stones

He is therefore referred from hepatology to urology for further tests. Maciej's case manager discusses this referral with him and supports appointment booking as Maciej does not have access to a phone. His record is updated with the referral and the care professionals (mental health and CGL) have visibility of this referral. This feeds into his discharge planning which also accounts for Maciej's worries and preferences, in addition to what has / hasn't worked in the past to support discharge.

MDT meet virtually to discuss Maciej's case after being reviewed in urology and decide a fluoroscopy and lithotripsy are required

Maciej is provided a tablet with videos explaining the procedure (in Polish) to enable him to make an informed decision. He consents to the surgery, and the surgical team is automatically electronically notified of his status to prepare. Admin use intelligent scheduling to identify an available surgical team and theatre. He is then transferred to surgery where the procedures are performed.

Following surgery, Maciej recovers in the surgical ward, completes his detox and is transferred back to CGL for community follow up

Collaboratively, Maciej's care team explore support options with him and signposted to a charity that provides him with a mobile phone and limited data for use with health services. Maciej accesses apps which tailor recovery plans and allow him to virtually connect with care professionals. Maciej uses this to video chat with family and friends back in Poland while he recovers. He is then discharged from the hospital with seamless follow-up care into community support teams.

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Digital Capabilities

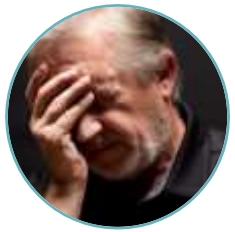
Integrated EPR accessible by all appropriate members of his care team

Procedure surgical videos

Recovery self-help apps

Virtual consultation

Patient journey: Maciej



- Male | 55 years old
- Drug/alcohol dependency
- Depression

Reimagining Care and Experiences: 2025 to 2030 Patient Journey

Treatment for overdose → Referral to Hepatology → Urology referral → Surgery → Recovery and discharge → Ongoing support for Maciej

Maciej is discharged and receives ongoing support

Local Council support Maciej to find temporary accommodation upon discharge

CGL assign Maciej a social worker who supports him in obtaining financial support, exploring opportunities to connect with community support, and digitally upskilling him to virtually communicate with friends / family online. He can also consult with his care professionals when required.

Maciej is supported by the CGL social worker with his mental health

As Maciej was a known opiate user, him and his carers are trained in administering naloxone in case of a relapse. He is also given support in attending his appointments (transport, reminders). His hydration consistency is a concern, so he uses a hydration app.

As Maciej's living situation stabilises, he continues to follow his recovery plan (available on the patient portal from his mobile)

He is signposted to local food banks, a Polish-speaking community centre and a rehabilitation centre by his social care team. Maciej is signposted to networks and charities that can assign him to an available volunteer to connect with in addition to his case manager. Maciej receives medication reminders on his app to manage his condition.

Maciej's experience is analysed as data for PHM analytics

Analysing his data supports care model improvements and enables prevention of similar cases with use of AI. Real time data analysis flags up any similar issues in the local Polish/Eastern European population to enable swift and co-ordinated community action.

Digital Capabilities

Medication reminder app

Patient portal accessible from mobile device

Digital social prescribing

AI and advanced data analytics enabling PHM initiatives

Maciej's Patient journey: Workshop Attendees

DRAFT for DISCUSSION

Improving lives together
Norfolk and Waveney Integrated Care System

Reimagining Care and Experiences: 2025 to 2030 Patient Journey

Thank you to all of the stakeholders who attended the patient journey workshop and provided their insight and expertise on the future care model and digital capabilities.

Name	Role	Organisation
Philip Beck	Head of Committees	Norfolk County Council
Sharon Brooks	CEO	Carer Voice
Beverly Chambers	Team manager	Suffolk County Council
Karen Erskine	Quality and workforce	James Paget University Hospitals NHS Foundation Trust
Dr Sarah Flindall	GP and Clinical Advisor	East Norfolk Medical Practice
Catherine Freeman	Operation lead	East Coast Community Healthcare CIC
Dr Venu Harilal	Medical Director	Norfolk Community Health and Care NHS Trust
Dr Pippa Harrold	GP, clinical and mental health advisor	Norwich Practices Health Centre
Jamshid Melekzad	Health improvement practitioner	East Coast Community Healthcare CIC
Jamie Miller	Health improvement practitioner	East Coast Community Healthcare CIC
Jo Riley	CGL Lead	Change Grow Live
Jonathan Reddington	Head of Digital Services	James Paget University Hospitals NHS Foundation Trust
Mark Tattum-Smith	Digital care advisor	Suffolk County Council
Newman Terry	Head of Digital Services	Norfolk Community Health and Care NHS Trust
Cheal Sarah	Team manager	Norfolk Community Health and Care NHS Trust
Jamie Stewart	Transformation manager	Suffolk County Council
Mark Sheppherd	Director of Integrated Discharge for the System	Norfolk and Norwich University Hospitals NHS
Dr Jeanine Smirl	GP Clinical Advisor	NHS Norfolk and Waveney ICB
Peter Spears	Senior manager	NHS Norfolk and Waveney ICB

Maciej's Patient journey: Workshop Attendees

DRAFT for DISCUSSION

Improving lives together
Norfolk and Waveney Integrated Care System

Reimagining Care and Experiences: 2025 to 2030 Patient Journey

Thank you to all of the stakeholders who attended the patient journey workshop and provided their insight and expertise on the future care model and digital capabilities.

Name	Role	Organisation
Mark Speight	Programme manager	Norfolk and Norwich University Hospitals NHS Foundation Trust
Diane Steiner	Deputy director of public health	Norfolk County Council
Jackie Walls	Physiotherapist and Frailty Specialist	Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
Mandy Webb	Integrated discharge manager	Norfolk Community Health and Care NHS Trust

Patient journey: Faiza

Improving lives together
Norfolk and Waveney Integrated Care System

FAIZA'S BACKGROUND

Female | 75 years old

Breckland

South Asian Heritage

Diabetic and Stage 2 Breast Cancer

Faiza is 75 years old, retired and lives with her husband.

Both her and her husband are physically inactive and have been for many years. Faiza speaks limited English and has low digital literacy.

Faiza **suffers from diabetes and is overweight**. She attends her annual eye screening assessments and manages her condition from home.

She has been recently diagnosed with **stage 2 breast cancer.** Following MDT review, her treatment plan of undergoing a **mastectomy**, together with **chemotherapy and radiotherapy** is agreed.

Patient journey: Faiza

Improving lives together
Norfolk and Waveney Integrated Care System

- Female | 75 years old
- Diabetic
- Stage 2 Breast Cancer

Reimagining Care and Experiences: 2025 to 2030 Patient Journey

GP referral | Diagnostics | MDT | Treatment | Post op and cancer care services | Discharge and continued care at home

Faiza is referred on the urgent suspected cancer pathway

Faiza visits her GP due to a concerning lump.	After reviewing the lump, the GP refers Faiza to NNUH for further tests on an urgent suspected cancer pathway (2WW).	Faiza attends her diagnostics appointment. The hospital provides a translator to support all communication.	Faiza is diagnosed with Stage 2 breast cancer.	Due to her diabetes, her blood glucose levels are monitored remotely to determine her patient care plan.
Her practice is automatically notified that she requires translation support. Translation AR glasses are provided during her consultation.	Her data is seamlessly available for public health and genomics research to improve cancer identification and outcomes. Educational and support material are provided on the patient portal in her first language. She is also directed to in-person support forums and networks.	Faiza informs the care team that she has no access to digital services and therefore the patient portal. She is provided with a free tablet to loan and signposted to Norfolk Libraries for support using the tablet and digital services. She now has access to her record via the patient portal, and can use the device to support with translation via an app.	With support from the digital translation app on her tablet, Faiza is informed of her diagnosis and next steps are discussed. She is signposted to the Cancer Connect scheme and research opportunities that may be of benefit to her. She is also signposted to local networks with women who are from her cultural background with breast cancer.	She does this using a remote implanted monitoring device. Her blood glucose levels automatically feed into the cloud and are analysed with other daily stats. Her levels and tailored advice for management are accessible from the patient portal. A notification is sent to a community diabetes nurse if the levels exceed a threshold.

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Digital Capabilities


AR translation glasses


Patient portal


Remote glucose monitoring device


Cloud storage for data

Patient journey: Faiza

DRAFT for DISCUSSION

Improving lives together
Norfolk and Waveney Integrated Care System

- Female | 75 years old
- Diabetic
- Stage 2 Breast Cancer

Reimagining Care and Experiences: 2025 to 2030 Patient Journey

GP referral | Diagnostics | **MDT** | **Treatment** | Post op and cancer care services | Discharge and continued care at home

Faiza is referred on the urgent suspected cancer pathway

MDT review occurs virtually and Faiza's treatment plan is agreed *(mastectomy, supported with chemotherapy and radiotherapy).*

The MDT have quick access to all required information to discuss patients efficiently. The outcome is communicated straight away. A translator helps Faiza to understand her treatment and the care team use VR to provide visual overview of the surgery and what to expect to ensure she understands.

Faiza prepares for her surgery with digital prehabilitation.

Faiza's patient portal provides links and images/videos guiding her on how to physically and mentally prepare for surgery to ensure the best outcome.

Faiza's mastectomy is scheduled and easily amendable by Faiza through the patient portal.

Her translation support requirements are already noted on her record for the surgical team to prepare for. Her records are consistently updated and integrated with health and care services which allows routine data to be collected for trials directly.

Faiza attends the hospital for her mastectomy. She is then referred for chemotherapy and radiotherapy.

Prior to attending the hospital, Faiza completes her pre-op assessment using remote monitoring tools and consents to surgery digitally from home. When she attends, she is prepared in pre-op and transported to Theatres. Her location is updated by recording onto the EPR and tracked in real-time to update Theatres on her arrival, optimising theatre and staffing planning.

Digital Capabilities


Virtual Reality (VR)


Patient portal


Advanced data analytics


Digital pre-op and e-consent tool


Electronic Patient Record (EPR)

Patient journey: Faiza

- Female | 75 years old
- Diabetic
- Stage 2 Breast Cancer

Reimagining Care and Experiences: 2025 to 2030 Patient Journey

GP referral → Diagnostics → MDT → Treatment → Post op and cancer care services → Discharge and continued care at home

Faiza is referred on the urgent suspected cancer pathway

Faiza is cared for and monitored in post-op.

Based on Faiza's holistic needs assessment, individual care plan and end of treatment summary, resources relevant to her are flagged on the system. The nurse discusses this tailored list of community resources with her, with translation support. Her discharge letter is prepared efficiently as information auto-populates from her record.

Faiza is discharged and returns home. She is provided a care package, and her family are provided a family support plan.

She receives ongoing support for her weight management, diabetes and long-term surveillance. She is also signposted to several recovery support networks and has access to a cancer care review in primary care. She is provided with a telehealth wearable to continue monitoring her stats which also triggers notifications to her family / support network.

Faiza continues to manage her diabetes and attends an annual eye screening.

Her grandchildren are briefed by care professionals on how to support upskilling Faiza to access digital services. With these skills, she records her blood pressure and completes sensory testing of her feet for her diabetic foot check. This information automatically uploads to her EPR record. Her family receive diabetes education via links to useful information including low sugar recipes. She attends virtual routine check- ups to ensure full recovery.

Davey Heidi 22/11/2022 09:45:44

Digital Capabilities

Telehealth wearable for remote monitoring

Electronic Patient Record (EPR)

Information website links available via patient portal

Virtual consultation

Faiza's Patient journey: Workshop Attendees

DRAFT for DISCUSSION

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Norfolk and Waveney Integrated Care System

Reimagining Care and Experiences: 2025 to 2030 Patient Journey

Thank you to all of the stakeholders who attended the patient journey workshop and provided their insight and expertise on the future care model and digital capabilities.

Name	Role	Organisation
Tracy Amies	Diabetes specialist	Norfolk Community Health and Care NHS Trust
Philip Beck	Social work advocate	Norfolk County Council
Sharon Brooks	CEO	Carer Voice
Yvonne Christley	Deputy Chief Nurse	Norfolk and Norwich University Hospitals NHS Foundation Trust
Georgina Chapple	Breast cancer support group	NHS Norfolk and Waveney ICB
Katy Dogbey	Consultant Midwife	James Paget University Hospitals NHS Foundation Trust
Rachel Donovan	Planned Care & Cancer Services Administrator	NHS Norfolk and Waveney ICB
Dr Sarah Flindall	GP and Clinical Advisor	East Norfolk Medical Practice
Shawn Haney	PHM Manager	NHS Norfolk and Waveney ICB
Lauren Isaacs	Pathway Administrator	Norfolk Community Health and Care NHS Trust
Georgina Jones	Outpatients Transformation Delivery Partner	NHS England
Kerry Jones	Compliance Manager	Norfolk Community Health and Care NHS Trust
Dr Vera Litza	Acute medical consultant	James Paget University Hospitals NHS Foundation Trust
Julie Marks	Office Manager	Together for Mental Wellbeing
Luis Marques	Critical Care Nurse	East Coast Community Healthcare CIC
Wendy Marchant	Information Service Manager	Norfolk and Norwich University Hospitals NHS Foundation Trust
Howard Martin	Director of Population Health Management and Health Inequalities	NHS Norfolk and Waveney ICB
Terry Newman	Head of Digital Services	Norfolk Community Health and Care NHS Trust
Lee Pike	Community Matrons	East Coast Community Healthcare CIC
Rachael Rider	Chief Nursing Informatics Officer (CNIO)	James Paget University Hospitals NHS Foundation Trust
Jonathan Reddington	Head of Digital Service	James Paget University Hospitals NHS Foundation Trust

Faiza's Patient journey: Workshop Attendees

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Reimagining Care and Experiences: 2025 to 2030 Patient Journey

Thank you to all of the stakeholders who attended the patient journey workshop and provided their insight and expertise on the future care model and digital capabilities.

Name	Role	Organisation
Mike Shemko	Head of Data Science	Norfolk and Norwich University Hospitals NHS Foundation Trust
Sandra Sharman		Norfolk Community Health and Care NHS Trust
Patrick Spragg	Business Intelligence and Performance Manager	NHS Norfolk and Waveney ICB
Clare Symms	Senior Manager	NHS Norfolk and Waveney ICB
Mark Tattum-Smith	Social Worker	Suffolk County Council
Sue Trohear	Cancer Transformation Project Officer	NHS Norfolk and Waveney ICB
Maggie Tween	CCG Cancer Lead	NHS Norfolk and Waveney ICB
Michael Twigg	Surgery Consultant	NHS Norfolk and Waveney ICB
Sally Watson	Project Manager	East Coast Community Healthcare CIC
Marie Willgress	Community Matrons	East Coast Community Healthcare CIC
Helena Wilson	Operational Business Manager	Norfolk Community Health and Care NHS Trust

Patient journey: Arthur

ARTHUR'S BACKGROUND

Male | 86 years old

Norwich

English

Dementia and prone to falls

Arthur lives in a care home where he requires around the clock care.

He has **dementia** and is more prone to falls and accidents due to his **limited mobility and loss of peripheral sensation.**

Arthur has a fall, trying to get out of bed, and is transported to A&E. He is assessed and has sustained no serious injuries but is **extremely frail**.

Arthur continues to deteriorate and is discharged back to the care home for **end of life care.**

Patient journey: Arthur

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- Male | 86 years old
- Dementia
- Prone to falls

Reimagining Care and Experiences: 2025 to 2030 Patient Journey

Fall at care home → Ambulance → A&E assessment → Discharge → End of life at care home → Arthur dies

Arthur has a fall and is taken to A&E

Arthur is in a care home for support with his frailty and dementia.

He is receiving end-of-life care in the care home. Arthur has previously avoided hospitalisation due to the number of technology interventions that support falls prevention such as remote monitoring and movement sensors.

Arthur has a fall one day and the nurses call 999 to get Arthur an ambulance.

Despite Arthur having sensors to alert carers if Arthur is getting out of bed, he falls before they could attend to him. The nurses access Arthur's record and update the record with the incident which automatically notifies his family.

Paramedics arrive at the scene and assess Arthur.

The paramedics complete a quick assessment on a tablet which updates his patient record. They conduct a scan with a hand held ultrasound device and confirm there is no skeletal injury. They are concerned about his frail state, so have a video call triage with an ED consultant to assess Arthur. The consultant advises Arthur should attend the hospital for further tests. This is updated on his record which automatically updates his family.

Arthur is taken to A&E.

Arthur's care plan is accessible from his record for all care professionals. En-route, the paramedics support Arthur in calling his family to keep him calm and ensure they're present when he arrives in A&E.

Davey, Heidi 22/11/2022 09:45:44

Digital Capabilities


Electronic Patient Record (EPR)


Motion Sensors

Digital assessment


Portable ultrasound

Video call triage

Patient journey: Arthur

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- Male | 86 years old
- Dementia
- Prone to falls

Reimagining Care and Experiences: 2025 to 2030 Patient Journey

Fall at care home → Ambulance → A&E assessment → Discharge → End of life at care home → Arthur dies

Arthur is assessed in A&E

Arthur is assessed in A&E.

Arthur's son attends A&E to support him. The clinician acknowledges Arthur's care plan and ReSPECT form on his record and can see his current medications, allergies and extent of dementia from one screen view (EPR). Arthur's record on the EPR flags he is on an anticoagulant which prompts the clinician to order a head CT. AI technology supports rapid reading of the CT to support clinical / radiology time. Blood tests are also conducted.

The care team inform Arthur and his son that he has not sustained any serious injuries after reviewing his results.

The results are automatically updated on his record which the care home have access to and are notified of his expected return. While there is no need for Arthur to remain in hospital, he remains frail and confused upon discharge. The team prepare effective discharge planning, including requesting transport support for Arthur via digital comms.

Arthur is discharged for end-of-life care in the care home and his physical condition continues to deteriorate.

Before he is discharged, Arthur and his carers are provided with remote monitoring technology to enable the clinicians to assess his condition without Arthur having to be in the hospital. This will help prevent a failed discharge where he returns to the hospital. The care home are prepared before he arrives and have access to his notes and updated care plan. Arthur's family are engaged in all stages of discharge planning to ensure they can feed into decisions.

Digital Capabilities


Artificial Intelligence (AI)


Clinical decision support (CDS) via the Electronic Patient Record (EPR)


Collaborative digital care plan


Remote monitoring

Patient journey: Arthur

Improving lives together
Norfolk and Waveney Integrated Care System

- Male | 86 years old
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Reimagining Care and Experiences: 2025 to 2030 Patient Journey

Fall at care home → Ambulance → A&E assessment → Discharge → End of life at care home → Arthur dies

Arthur receives end-of-life care in the care home

Arthur receives end-of-life care at the care home.

Arthur's carers are aware of Arthur and his families' wishes as it is noted on his patient record. They also have visibility of his electronically prescribed medications, and a clinician can administer or amend his medication doses. They amend the infusion rate remotely using intelligent syringe drivers with some of his medications (not controlled drugs).

He is remotely monitored for the first 3 days after returning to the care home.

The hospital clinician can assess Arthur while he's at the care home as his vital signs automatically feed into the EPR. On the third day, Arthur and a carer have a remote consultation with the Frailty specialist. They advise that he is stable and no longer requires assessment and prescribe him medication to support with his palliative care. The carers are confident with using such digital tools as they receive virtual digital training regularly.

Arthur continues to deteriorate over the following weeks.

In addition to visiting in the care home, Arthur's family regularly video call Arthur as he has access to a tablet in the care home. Unfortunately after a few weeks, Arthur deteriorates. His family are notified, so they are with him as he dies. His family is digitally signposted to available community bereavement resources, as they have requested support.

Davey Heidi 22/11/2022 09:45:44

Digital Capabilities

Electronic Prescribing and Medicines Administration (EPMA)

Intelligent remote syringe drivers

Remote consultation

Remote monitoring

Video calling

Arthur's Patient journey: Workshop Attendees

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Reimagining Care and Experiences: 2025 to 2030 Patient Journey

Thank you to all of the stakeholders who attended the patient journey workshop and provided their insight and expertise on the future care model and digital capabilities.

Name	Role	Organisation
Dave Allen	Head of Operations	East of England Ambulance Service NHS Trust
Dr Abhijit Bagade	Public Health Medicine Consultant	Norfolk County Council
Dr Zac Blake	Clinical Lead for ShCR	NHS Norfolk and Waveney ICB
Sharon Brooks	CEO	Carer Voice
Vivienne Donaldson	Co-ordinator of Children's Centre	Norfolk Community Health and Care NHS Trust
Dr Sarah Flindall	GP and Clinical Advisor	East Norfolk Medical Practice
Tanya Garnham	Community Nurse	East Coast Community Healthcare CIC
Dr Venu Harilal	Medical Director	Norfolk Community Health and Care NHS Trust
Maria Karretti	Adult safeguarding and SEND	NHS Norfolk and Waveney ICB
Deborah Lanagan	Programme Manager	Suffolk County Council
Andy McGowan	Head of Engagement	Caring Together
Silvia Nunes	Care Provider Quality Improvement Nurse	NHS Norfolk and Waveney ICB
Jennifer Parsons	Programme Director	James Paget University Hospitals NHS Foundation Trust
Jennie Starling	Head of communication	NHS Norfolk and Waveney ICB
Jamie Stewart	Transformation Manager for Practice & Culture	Suffolk County Council
Cheryl Topper	Associate Director Specialist Services	East Coast Community Healthcare CIC
Dr Edward Turnham	Clinical Advisor for Digital Strategy	NHS Norfolk and Waveney ICB
Maggie Tween	CCG Cancer Lead	NHS Norfolk and Waveney ICB
Liz Waddy	GP Advisor	NHS Norfolk and Waveney ICB
Jamie Weavers	Clinical Programmes Manager	NHS Norfolk and Waveney ICB

Appendix C: Our Digital Transformation Implementation Plan

High-level Implementation Plan – Digitised Patient Records

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Digitising records across all health and care settings will provide streamlined access to a single source of truth through the roll out of the acute Electronic Patient Record in the acute trusts, as well as the Digital Social Care Record, and the digitised Mental Health Record.

	Year 0 – FY 22/23	Year 1 – 23/24	Year 2 – 24/25	Year 3 – 25/26
Acute EPR	• Approve Outline Business Case. • Commence procurement of the EPR solution.	• Develop Full Business Case for preferred EPR supplier. • EPR readiness works (e.g. current state process mapping).	• Commence implementation.	• **Implement a single EPR across all three acute Trusts:** • Trust A– April '25 • Trusts B and C– June'25
Mental Health EPR	• Provide access to our Primary Care EPR (SystmOne) to support Mental Health nurses working in GP practices.	• Develop FBC for preferred EPR supplier.	• Commence implementation.	• **Implement new EPR** with enhanced capabilities and usability achieving a fully digitised Mental Health record.
Adult Digital Social Care Record	• Digitise adult social care records, achieving 60% adoption of the DSCR by March 2023 by all CQC registered providers.	• **Continue digitising adult social care records, achieving 80% of registered care home providers by March 2024** (and all CQC registered providers).	• Optimise digital social care records.	• Continue to enhance digital social care records.
Primary Care EPR	• Continue to optimise current EPR systems (e.g., enhancing reporting capability).			

High-level Implementation Plan – Shared Information

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Shared Information across health and care settings will optimise the way professionals interact and work together through the deployment of the Shared Care Record, digitised histopathology solution, a single acute waiting list, infection control system, vendor neutral archive, and the interoperable Radiology Information System.

	Year 0 – FY 22/23	Year 1 – 23/24	Year 2 – 24/25	Year 3 – 25/26
Shared Care Record (ShCR)	• **Deploy core Shared Care Record (MVS)**, with read-only view of GP, community, social care, mental health and acute patient records.	• **Expand the Shared Care Record,** with write/read functionality, including access by Community Pharmacies, Care Homes, carers/third party providers, district councils to enable the use of shared care plans and advance treatment decisions.	• Further enhancements to the Shared Care Record.	
Interoperable Radiology Information System (RIS)	• Prepare for the interoperable RIS solution deployment.	• **Seamless image transfer and viewing among the 3 acute Trusts via the interoperable RIS Solution**, enabling the Diagnostic Assessment Centre.	• Optimise use of the RIS solution.	• Integrate with the acute EPR and other core systems.
Digital Histopathology	• **Digitise histopathology** to streamline diagnostics and support remote working.	• Implement PACS Reporting System. • Implement digital outsourced reporting.	• Optimise digital histopathology, considering opportunities for automation.	• LIMS (Laboratory Information Management System) replacement. • Explore AI and ML.
Infection Prevention Control Single System	• Procure IPC system to replace current outdated and siloed systems in the acute Trusts. • **Implement IPC system** - March '23, with all three acute Trusts on a single system enabling ease of information sharing.		• Enhance the IPC system, exploring analytic capabilities to further reduce infections.	• Integrate (or replace, subject to Trust decision-making) the IPC with the acute EPR.
Single waiting list	• **Implement a single waiting list** across the 3 acute Trusts.	• Optimise the management of the single waiting list, aligned to PHM and analytic capabilities, to reduce inequalities and improve outcomes.		• *Single waiting list via the acute EPR.*
Vendor Neutral Archive (VNA)	• Prepare for the VNA deployment (including data-sharing agreements, infrastructure requirements, process standardisation, etc.).	• **Implement VNA** as a safer way to store clinical images that are easily accessible across organisations.	• Optimise the VNA.	• Integrate VNA with the Acute EPR and other core systems.

High-level Implementation Plan – Data and Analytics

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Data and Analytics solutions and advancements will improve accessibility and quality of patient data through scaling of the Health and Care Data Architecture (HCDA), as well as BI and analytics capabilities.

	Year 0 – FY 22/23	Year 1 – 23/24	Year 2 – 24/25	Year 3 – 25/26
Health and Care Data Architecture (HCDA)	• **Complete and sign off business case with key stakeholders.** • Agree key data sources and priority use cases (i.e., system wide PTL solution). • Agree and sign of the data pipeline. process from provider organisations into the HCDA environment (for example the migration of Data Management Engine (DME) into HCDA). • Standardise data models and define common data model. • Agree governance structures, stand up programme and delivery team. • Begin to create the Master Patient Index (MPI). • **Stand up HCDA (summary version for single page view).** • Integrate discharge datasets for improved dataflows across the ICS.	• **Continuously develop datasets**, including the cleansing, transforming, and modelling of data. • Import and/or create hierarchy tables to match data to descriptors. • NHS data dictionary download. • Begin work to develop the Trusted Research Environment (TRE) & Clinical data environment.	• **Agree specification and deliver the Patient Longitudinal Record.**	• Continue to iterate and enhance HCDA with relevant and complimentary datasets. • **Develop the HCDA into the data layer for the Shared Care Record.**

High-level Implementation Plan – Data and Analytics

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Improving lives together
Norfolk and Waveney Integrated Care System

Data and Analytics solutions and advancements will improve accessibility and quality of patient data through scaling of the Health and Care Data Architecture (HCDA), as well as BI and analytics capabilities.

	Year 0 – FY 22/23	Year 1 – 23/24	Year 2 – 24/25	Year 3 – 25/26
Business Intelligence	• **Agree the system model for roll out and use of PowerBI as the visualisation tool of choice across N&W organisations.** • **Agree standardised reporting** definitions and logic across N&W organisations. (I.e. for performance metrics). • **Agree standardised reporting suites** and priority analytics use case for system insight and develop. • Undertake a skills appraisal for individuals working in this space; agree role definitions and develop plan to upskill staff • Determine the specialist training required to upskill staff as required • **Deploy BI capabilities to benchmark performance and outcomes, reduce inequalities, and address unwarranted variation in care, including improved demand and capacity management across the system.**	• **Create Self-serve reporting tooling.** • **Define and deliver Predictive and Prescriptive Analytics** use cases • Shift towards a more proactive culture of analytical insight • Begin to shape a system wide 'Analytics Academy'.	• **Continue to advance and expand system-wide analytical capabilities, working in collaboration with the Advanced Insight (AI, ML) and PHM workstreams to provide joined-up insight.** • Build a 'one team' culture across organisations to encourage system wide collaboration and reduce analytical duplication and inefficiency in the system.	• Enhance BI, taking advantage of technology advancements.
Advanced Insight (Machine Learning and AI)	• **Identify prioritised use cases and develop business case for ML and AI.**	• **Deploy ML and AI** use cases, dependant on what is agreed in the year 1 business case.	• **Enhance ML and AI**, building on lessons learnt from initial use cases.	• Scale ML and AI, aligned to system needs and priorities.
RPA (Robotic Process Automation)	• **Deploy ongoing process automation** (e.g., automating information transfer between **ambulance service and adult social care system)** • **Agree system-wide RPA approach.**	• **Deploy additional RPA use cases** to improve system efficiencies (e.g., referral management, IT helpdesk responsiveness).	• Scale RPA across an increasing number of use cases to automate further clinical, administrative and back-office processes.	• Enhance RPA, applying AI and ML techniques for increasingly intelligent automation.

High-level Implementation Plan – Population Health

DISCUSSION

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Population Health Management applies a holistic view to a defined population and enables personalised and proactive care though enhancing population health management, population insights, risk stratification and personalised care.

	Year 0 – FY 22/23	Year 1 – 23/24	Year 2 – 24/25	Year 3 – 25/26
PHM Programme	• **Continue establishment of PHM Programme** building team capacity, standardising methodology and tools, developing and designing HCDA enablers/requirements including PHM platform, and BI/reporting to scale PHM).	• **Continue development, enhancement and scaling of PHM programme** (e.g. building robust insights, monitoring and evaluation of existing pilots and initiatives including closer working with the Evidence and Evaluation Hub).	• **PHM capabilities scaled to system partners** (e.g. system partners are using PHM tools and analysis to inform clinical and operational decision making).	• **Continue evolution and development of PHM Programme and capability** (e.g. PHM platform/population insights, risk stratification tools with expanded data sets and personalisation approaches using CRM across the system).
PHM Insights	• **Continue expansion of PHM capability using existing tools and risk stratification capability** (e.g. integration of existing data sets into Eclipse and integration into shared care record).	• **Build PHM platform/data layer in HCDA.** • **Build PHM BI/reporting dashboards.** • Continued expansion of capability to undertake whole population analysis (e.g. joining PHM and public health data in HCDA/integrated data flows). • Data sharing agreements in place with system partners.	• **PHM platform is live and being used by PHM Programme Team and system partners.** • **Real-time pull of health and care data from HCDA.** • Link the Evidence and Evaluation Hub into HCDA and PHM platform (timing dependent on HCDA development).	
Risk Stratification	• **Initiate 18 month procurement for risk stratification tool** • Agree priority use cases using existing risk stratification capabilities.	• **Agree consistent risk stratification tool and approach across ICS** (end of 18 month procurement). • Integrated risk stratification tool into HCDA and PHM platform/data layer. • Scale risk stratification tool across ICS.	• **Continued expansion of risk stratification tool capability drawing on HCDA** expanded dataset.	
Personalisation	• **Continue expansion of CRM capability to enable personalisation agenda** (e.g. consider patient portal functionality linked to NHS App).	• **Continue support to scale adoption of CRM tool**, linking into PHM programme pilots and initiatives.		

High-level Implementation Plan – Citizen and Patient Tools

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Norfolk and Waveney Integrated Care System

Citizen and patient tools will provide a joined-up, personalised care experience through deployment of a single digital front door for the public, eRedbook, integrated patient portal and AI-enabled patient triage.

	Year 0 – FY 22/23	Year 1 – 23/24	Year 2 – 24/25	Year 3 – 25/26
Patient portal and apps	• Deploy Norfolk and Waveney All-Age Single Digital Portal for mental health support with AI embedded, Mental Health Integrated Front Door (CYP Website & Adult Phase Website) and directory of services. • NHS App Development and PCN Hubs for direct bookable appointments with Mental Health Practitioners. • Deploy specialist apps, such as the colorectal cancer prehab app.	• **Integrate existing portals with NHS app, enabling a single digital front door across all health care settings** • **Digitally signpost citizens / patients to available resources** using voice recognition technology. • Streamline access to self-management apps via the single digital front door.	• **Enhance the single digital front door by integrating social care information** • Integrate social media and wellness apps with the single digital front door.	• Continue to explore and deploy AI and ML use cases.
eRedbook	• Project launch and initiation (planning, high level design, development)	• **Implement eRedbook** (national milestone)	• Optimise use of eRedbook	
Patient triage	• **Deploy a Directory of Services (DoS)** with extensive VCSE resource listings for 111 Option 2. • **Establish a Proof of Concept digital triage hub** (UEC, 111 and 999 services), including link from Mental Health Services to UEC DoS	• Roll out the digital triage hub for system efficiencies and improved patient experiences	• Implement AI-enabled triage to enhance the digital triage hub	• Optimise digital triage, enabled by HCDA data flows and advanced analytics
Digital Social Prescribing	• Map community asset resources • Creation of a shared directory for digital social prescribing available and accessible across primary, secondary, voluntary, community, social care and also to schools, police and emergency services	• **Expand capabilities to digitally refer citizens / patients to community resources** • ICS submission of numbers of personal health budgets to be in place by end 2023/24 (National Milestone)	• Enhance digital social prescribing, exploring opportunities for predictive and prescribe analytics	• Optimise digital social prescribing, informed by wider public sector data (e.g., housing, police, education) from HCDA
Emerging tools (e.g. IoT, Virtual Reality)	• **Deploy home sensors** to support independent living and advanced monitoring	• **Agree system-wide approach for emerging tools and innovation** • Continue pilots of emerging tools, sharing insights across the ICS	• Expand use of emerging technology, e.g. Internet of Things (IoT) use cases and Virtual Reality	

High-level Implementation Plan – Virtual Health and Care

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Virtual health and care will streamline referrals ensuring faster access to treatment, offer personalised care from home through scaling of remote monitoring and virtual wards, enhanced e-referrals, and digital pre-operative assessments.

	Year 0 - FY 22/23	Year 1 - 23/24	Year 2 - 24/25	Year 3 - 25/26
Remote monitoring and Virtual wards	• **Pilot remote monitoring pilot in care homes** • Offer falls prevention assistive tech to care home residents, using (Internet of Things) IoT network capabilities • Pursue additional remote monitoring pilots using home digital analysis (e.g., urine analysis) • Roll out weekend virtual ward rounds to care home residents • **Offer virtual ward support** (533 beds) to frailty and respiratory patients, expanding to an additional 173 virtual ward beds by April 2023 • **Agree cohesive system approach to scaling virtual wards and remote monitoring**, including the design of a central hub and prioritisation of clinical pathways	• Mobilise central hub • Scale remote monitoring in care homes • **Offer remote monitoring to patients with long-term conditions,** maximising opportunities from innovative tech (e.g., wearables) • **Expand virtual wards to priority pathways** (e.g., heart failure), achieving 368 beds by Jan 2024	• **Enable 440-550 virtual ward beds** by April 2024 (National Target) • Support increasing numbers of patients in virtual ward beds) and via remote monitoring, co-ordinated via the central hub	• **Continue to enhance, scale, and innovate** models (1000+ virtual ward beds)
Improved e-referrals	• **Improve referral functionality** (between primary and secondary care), including integration with image sharing and capability to better triage referrals • Deploy a referral management portal (central hub) • **Go-live of Portal:** UEC referral management through integration of portal and IC-24 system (including community providers) by Nov. '22 • **Explore and agree approach for the use of advanced analytics and automation** to improve referral management	• **Deploy advanced analytics (e. AI) and RPA capabilities** for improved efficiencies and patient outcomes	• **Continue to enhance** e-referrals across all care settings	• Further improve and streamline e-referrals via the acute EPR and advancements in analytics
Digital pre-operative assessments	• Deploy digital pre-op assessment across all 3 acute Trusts	• Enhance digital pre-op assessments through further integration with pathology systems	• Further optimise, considering opportunities for advanced analytics and risk stratification	• Integration with Acute EPR and other core systems

High-level Implementation Plan – Digital Workforce Tools

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Digital workforce tools will enhance care delivery though advanced digital solutions across standardised systems including user devices refresh, the standardisation of the Electronic Staff Record (ESR) systems including the e-roster, creation of the virtual careers office and an integrated Learning Management System (LMS).

	Year 0 – FY 22/23	Year 1 – 23/24	Year 2 – 24/25	Year 3 – 25/26
End User Devices	• **IT device refresh** – replace and upgrade 1000's of out of warranty devices, providing high quality, new equipment (rolling refresh)			
Integrated ESR (Electronic Staff Record) and Digital Staffing Bank	• **Standardise use of Electronic Staff Record systems** for accessible and accurate workforce data • Move all nursing and AHP staff to the e-roster • Review and assess e-rostering provider contract e	• Move all medical staff to the e-roster • **Enhance and integrate ESRs (full integration)** • Improve efficient workforce analytics, minimising manual interventions	• **E-roster continuous support and development** (centralised database for all provider organisations) • **Deploy a staff digital central bank** – an integrated database of clinical, administrative and HCA staff to aid recruitment into posts across the system (including an integrated database of locums)	• **Further enhance system-wide rostering and workforce planning,** enabled by advanced analytics and integrated rostering systems
Virtual Careers Office	• **Develop a virtual careers office website** for staff to broaden career development, using chatbots for quick access to resources, and automated access to career champions and career advisors.	• **Enhance leadership & management development digital offering**	• Continuously improve digital support across career pathways, in line with system and user needs	
Integrated system-wide Learning Management System (LMS)	• Support staff to optimise use of current LMSs	• Define requirements; develop investment case for an integrated LMS	• Prepare for implementation of an integrated LMS, including standardisation of key processes and training curriculum across the system	• **Deploy an integrated LMS**, enhancing consistency and improving e-learning across the ICS
Digital solution to streamline the learning placement process	• Define requirements, design digital solution, and standardise processes for learning placement management	• **Streamline the learning placement process and support self-management** with a single database/repository, incl. HEI placements, portfolio working and secondments	• Continuously improve, expanding scope	• Utilise advanced analytics (e.g. prescriptive and predictive analytics) to further support learning placements

High-level Implementation Plan – Infrastructure and Connectivity

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Norfolk and Waveney Integrated Care System

Fully integrated infrastructure and connectivity will improve ways of working and collaboration among staff and ensure robust data protection standards and cyber security through deployment of a new cloud solution, cyber security solutions and enhanced Wi-Fi network and connectivity.

	Year 0 – FY 22/23	Year 1 – 23/24	Year 2 – 24/25	Year 3 – 25/26
Infrastructure, Network and Connectivity upgrades	• **Install WAN**: wide area network capable of delivering connectivity for all, single log on • **Update network – Project Gigabit (ultra-fast Wi-Fi)** for improved Wi-Fi connectivity across all sites • Commence working group around IT centralisation (common ICT functions) • Identify contracts for renewal/replacement of IT infrastructure across partners	• Implement shared domain • Install infrastructure to improve access to high speed connectivity and devices for care providers • **Deploy Community Diagnostic Hubs infrastructure and connectivity requirements** • Agree shared ICT function, incl. common standards • Network standardisation to ensure device connectivity regardless of site	• Complete infrastructure, network and connectivity improvements in advance of acute EPR deployment	• Continuous improvement of infrastructure, network and connectivity to evolve with market technology trends and business needs
Enhanced collaboration (AD/N365)	• Optimise use of N365	• **Enhance collaborative working** via N365 and information sharing agreements	• Agree and deploy solutions for further enhancements in collaborative working across the system	
Cyber Security	• Deploy new Firewall (cloud solution) and cyber security solution	• Mobilise system-wide cyber security approach and team	• Implement information security management system	
Cloud First Infrastructure (Azure, Shared Cloud, One Drive)	• Continue migration to cloud technology (including cloud telephony in 60% of GP practices)	• **Achieve cloud telephony** in 100% of GP practices	• Further advance transition to cloud infrastructure	• Fully on cloud infrastructure

High Level Milestone Summary

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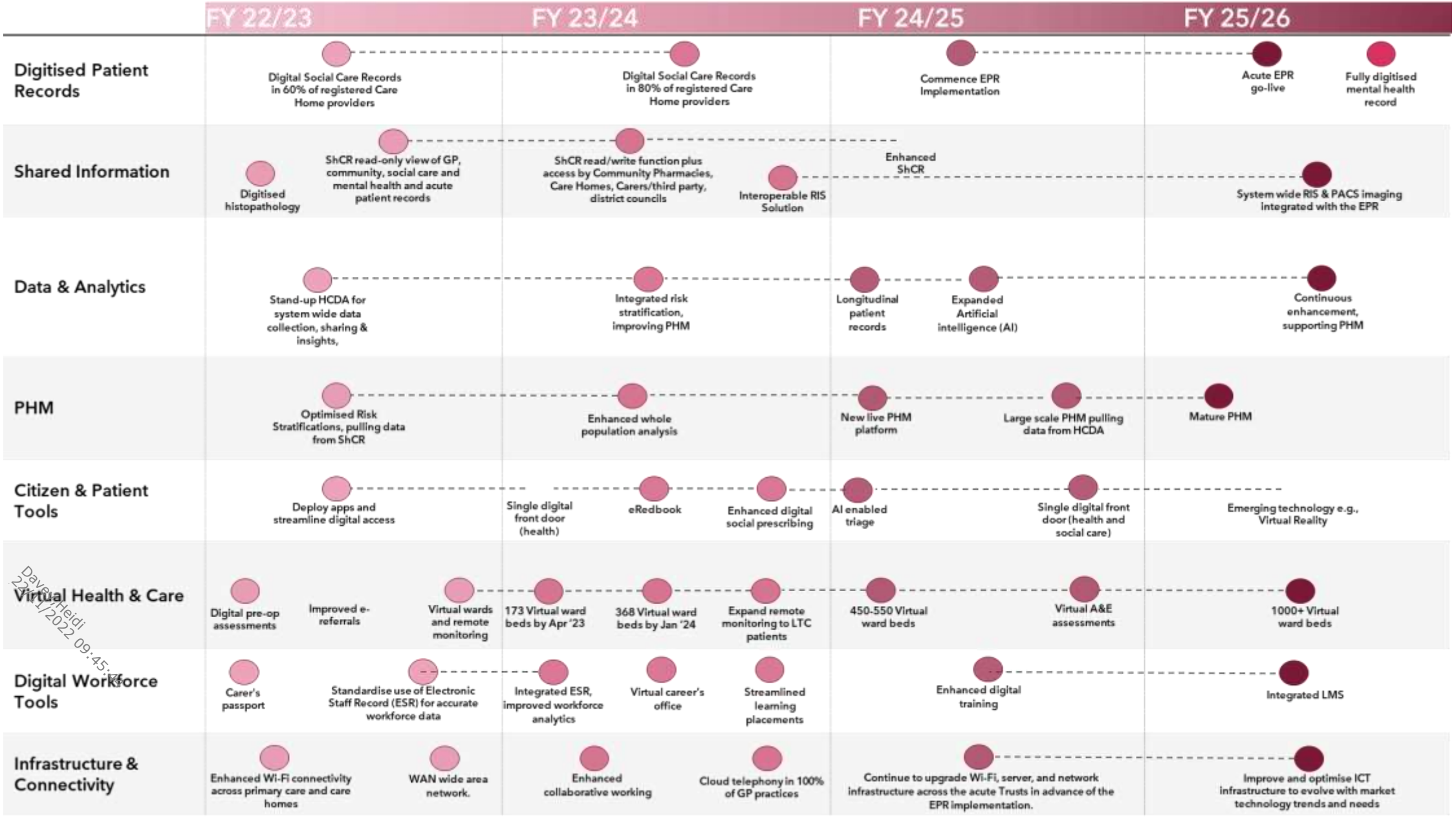
We will build our capabilities by delivering key milestones by FY25/26.



Appendix D: Digital Transformation Investment Plan

Costed plan

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Norfolk and Waveney Integrated Care System

To deliver our digital transformation strategic roadmap, ~£236m of total investment is required, of which ~£105m requires additional funding*.

Digital Capabilities	FY22/23 – 25/26 (Years 0-3)					
	Estimated Investment Required		Funding Identified or Secured		Estimated Funding Gap	
	Capital ('£000)	Revenue ('£000)	Capital ('£000)	Revenue ('£000)	Capital ('£000)	Revenue ('£000)
Digitised Patient Records, incl. Acute EPR	91,689	38,845	72,272	21,171	19,417	17,674
Shared Information, incl. ShCR	4,946	21,429	2,673	12,435	2,273	8,994
Data, Analytics, incl. HCDA	2	18,962	-	7,974	2	10,988
Population Health Management	-	9,606	-	1,631	-	7,975
Citizen & Patient Tools	1,582	1,371	-	-	1,582	1,371
Virtual Health & Care, incl. remote monitoring and virtual wards	3,703	14,015	2,115	7,085	1,588	6,930
Infrastructure & Connectivity, incl. cyber, cloud	1,362	11,769	863	2,043	499	9,726
Digital Workforce Tools, incl. End User Devices, improved workforce data	2,938	5,618	1,250	2	1,688	5,616
Enablers: Digital Inclusion and Unified Digital Team	413	8,104	-	-	413	8,104
Total ('£000)	**106,635**	**129,718**	**79,173**	**52,341**	**27,462**	**77,377**

- *Cost estimates have been established based on Business Cases, if available, high-level estimates from project teams, or using Rough Order of Magnitude (ROM) estimates from use cases adjusted to reflect context and size of Norfolk and Waverley.
- Due to the early stage at which some of the cost estimates and scope have been captured, a 10% contingency has been applied to all costs at programme level from FY22/23 to FY25/26. As scope for each programme is further defined, it is expected that specific levels of contingency and optimism bias will be applied. This will remove the need to apply a standard 10% contingency to all costs. A 5% contingency has been applied to EPR programme costings provided.
- An annual 8% inflation rate has been applied (from FY23/24). Though the published national tariff inflation rate is 5.2%, given the high proportion of non- pay costs, it was deemed appropriate to use a higher rate that was closer to 10% to reflect real costs/ current inflation rate.
- 'Funding identified' means that funding has been earmarked/ requested, but not necessarily confirmed/allocated. 'Funding secured' means that funding has been confirmed.

Estimated Investment Required – Digitised Patient Records

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Norfolk and Waveney Integrated Care System

Investment is required to fund the implementation of the Acute EPR, Mental Health EPR, and the Adult Digital Social Care Record, as well as further optimisation of our Primary Care EPR*.

Digitised Patient Records	Source of Cost Estimates	FY22/23 – 25/26 (Years 0-3) Estimated Investment Required		Funding Identified or Secured		Estimated Funding Gap	
		Capital ('£000)	Revenue ('£000)	Capital ('£000)	Revenue ('£000)	Capital ('£000)	Revenue ('£000)
Acute EPR	Project Team Confirmed costs	87,044	32,475	68,772	16,468	18,273	16,007
Mental Health EPR	Project Team Estimates	4,645	2,027	3,500	1,500	1,145	527
Digital Social Care Record	Project Team Estimates – Norfolk only	-	4,342	-	3,203	-	1,139
Total ('£000)		**91,689**	**38,845**	**72,272**	**21,171**	**19,417**	**17,674**

Note: 'Project Team Confirmed costs'- Costs which are based on a detailed Business Case, 'Project Team Estimates'- High level estimates based on high level assumptions, 'Rough Order of Magnitude (ROM) Estimate' - where no cost information has been available, use cases have been applied and adjusted to reflect context and size of Norfolk and Waverley.

**Additional resource has been added to the Unified Digital Team to support further optimisation of SystmOne (Primary Care EPR)*

Estimated Investment Required – Shared Information

Investment is required to fund the enhancement and continuation of the Shared Care Record, Imaging (RIS) Interoperability and Digital Histopathology programmes.

Shared Information	Source of Cost Estimates	FY22/23 – 25/26 (Years 0-3)					
		Estimated Investment Required		Funding Identified or Secured		Estimated Funding Gap	
		Capital ('£000)	Revenue ('£000)	Capital ('£000)	Revenue ('£000)	Capital ('£000)	Revenue ('£000)
Shared Care Record	Project Team Confirmed Costs	2,554	12,040	2,273	7,513	282	4,527
Imaging (RIS) interoperability	Project Team Confirmed Costs	1,673	1,376	-	-	1,673	1,376
Digital Histopathology	Project Team Estimates	458	7,714	400	4,922	58	2,792
Single Infection Prevention Control System	Project Team Confirmed Costs	261	300	-	-	261	300
Total ('£000)		**4,946**	**21,429**	**2,673**	**12,435**	**2,273**	**8,994**

Pending validation of assumptions with key stakeholders

Estimated Investment Required – Data and Analytics

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Investment is required to fund the implementation of the Health and Care Data Architecture (HCDA) and Analytics, Machine Learning, Artificial Intelligence, and Robotic Process Automation programmes.

		FY22/23 – 25/26 (Years 0-3)					
		Estimated Investment Required		Funding Identified or Secured		Estimated Funding Gap	
Data, Analytics	**Source of Cost Estimates**	Capital ('£000)	Revenue ('£000)	Capital ('£000)	Revenue ('£000)	Capital ('£000)	Revenue ('£000)
Health and Care Data Architecture (HCDA), incl. integrated data sets	Project Team Estimates	-	6,982	-	474	-	6,508
Artificial Intelligence, Machine Learning, Robotic Process Automation	Project Team Estimates + ROM costs*	2	1,948	-	1,160	2	787
Analytics	Project Team Estimates	-	10,032	-	6,340	-	3,692
Total ('£000)		**2**	**18,962**	**-**	**7,974**	**2**	**10,988**

**Rough Order of Magnitude (ROM) costs used from external examples, with pro rating to Norfolk and Waveney for licenses/usage.*

Estimated Investment Required – PHM

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Investment is required to fund the continued development of the Population Health Management (PHM) programme, including procurement of the risk stratification tool.

PHM	Source of Cost Estimates	FY22/23 – 25/26 (Years 0-3)					
		Estimated Investment Required		Funding Identified or Secured		Estimated Funding Gap	
		Capital ('£000)	Revenue ('£000)	Capital ('£000)	Revenue ('£000)	Capital ('£000)	Revenue ('£000)
Population Health Management	Project Team Estimates	-	9,606	-	1,631	-	7,975
Total ('£000)		**-**	**9,606**	**-**	**1,631**	**-**	**7,975**

Estimated Investment Required – Citizen and Patient Tools

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Investment is required to fund the implementation of the Single Digital Front Door app, Patient Triage, Digital Social Prescribing, eRedbook, and other emerging tools.

		FY22/23 – 25/26 (Years 0-3)					
		Estimated Investment Required		Funding Identified or Secured		Estimated Funding Gap	
Citizen & Patient Tools	**Source of Cost Estimates**	Capital ('£000)	Revenue ('£000)	Capital ('£000)	Revenue ('£000)	Capital ('£000)	Revenue ('£000)
Single Digital Front Door (Portal, apps, Digital Triage, and Directory of Services)	Project Team + ROM Estimates	1,568	729	-	-	1,568	729
Digital Social Prescribing	Project Team Estimates	13	433	-	-	13	433
eRedbook	ROM Estimate*	-	209	-	-	-	209
Total ('£000)		**1,582**	**1,371**	**-**	**-**	**1,582**	**1,371**

**Rough Order of Magnitude (ROM) costs used from external examples, with pro rating to Norfolk and Waveney for licenses/usage.*

Estimated Investment Required – Virtual Health and Care

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Norfolk and Waveney Integrated Care System

Investment is required to fund the implementation and advancements of Remote Monitoring and Virtual Wards, E-referrals, and Digital Pre-op Assessments solution.

		FY22/23 – 25/26 (Years 0-3)					
		Estimated Investment Required		Funding Identified or Secured		Estimated Funding Gap	
Virtual Health & Care	**Source of Cost Estimates**	Capital ('£000)	Revenue ('£000)	Capital ('£000)	Revenue ('£000)	Capital ('£000)	Revenue ('£000)
Remote monitoring & virtual wards	Project Team Estimates	3,703	11,463	2,115	6,737	1,588	4,726
Improved e-referrals	Project Team Estimates	-	823	-	-	-	823
Digital pre-op assessments	Project Team Confirmed Costs + ROM Estimate	-	1,729	-	348	-	1,381
Total ('£000)		**3,703**	**14,015**	**2,115**	**7,085**	**1,588**	**6,930**

Estimated Investment Required – Infrastructure and Connectivity

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Norfolk and Waveney Integrated Care System

Investment is required to fund continued enhancements and upgrades in Infrastructure, Network and Connectivity, Cyber Security, and Cloud First Infrastructure.

		FY22/23 – 25/26 (Years 0-3)					
		Estimated Investment Required		Funding Identified or Secured		Estimated Funding Gap	
Infrastructure & Connectivity	**Source of Cost Estimates**	Capital ('£000)	Revenue ('£000)	Capital ('£000)	Revenue ('£000)	Capital ('£000)	Revenue ('£000)
Infrastructure, Network, and Connectivity upgrades	Project Team Estimates	1,026	802	863	643	162	160
Enhanced Collaboration: AD / M365	Project Team Estimates	-	475	-	400	-	75
Cyber Security	Project Team Estimates	-	6,272	-	-	-	6,272
Compliant standards, e.g. ISO27001	Project Team Estimates	-	374	-	-	-	374
Cloud First Infrastructure (Azure, Shared Cloud, One Drive)	Project Team Estimates	337	3,846	-	1,000	337	2,846
Total ('£000)		**1,362**	**11,769**	**863**	**2,043**	**499**	**9,726**

- Note: Infrastructure and connectivity costs for Community Diagnostic Hub is fully funded, but not included within these numbers.

Estimated Investment Required – Digital Workforce Tools

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Norfolk and Waveney Integrated Care System

Investment is required to fund implementation and procurement of End User Devices, improved workforce data, a Virtual Careers Office, an integrated LMS and to streamline the learning placement process.

Digital Workforce Tools	Source of Cost Estimates	FY22/23 – 25/26 (Years 0-3) Estimated Investment Required Capital ('£000)	Estimated Investment Required Revenue ('£000)	Funding Identified or Secured Capital ('£000)	Funding Identified or Secured Revenue ('£000)	Estimated Funding Gap Capital ('£000)	Estimated Funding Gap Revenue ('£000)
End User Devices	Project Team Estimates	2,498	-	1,250	-	1,248	-
Integrated ESR (Electronic Staff Record)	Project Team Estimates	-	3,757	-	-	-	3,757
Virtual Careers Office	ROM Estimate*	143	85	-	-	143	85
Integrated system-wide Learning Management System (LMS)	ROM Estimate*	-	1,039	-	-	-	1,039
Digital solution to streamline the learning placement process	ROM Estimate*	297	-	-	-	297	-
Improved Remote support/Hybrid IT support	Project Team Estimates	-	44	-	2	-	42
Digital Staffing Bank	Project Team Estimates	-	693	-	-	-	693
Total ('£000)		**2,938**	**5,618**	**1,250**	**2**	**1,688**	**5,616**

Note: Project Team Estimate – High level cost estimates developed by project team, based on assumptions, Project Team Confirmed Costs- Developed cost estimates through business case process, ROM Estimates- Where no cost information was available

*Rough Order of Magnitude (ROM) costs used from external examples, with pro rating to Norfolk and Waveney for licenses/usage.

Estimated Investment Required – Enablers

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Investment is required into Digital Inclusion and the Unified Digital Team to enable the capabilities previously listed.

		FY22/23 – 25/26 (Years 0-3)					
		Estimated Investment Required		Funding Identified or Secured		Estimated Funding Gap	
Infrastructure & Connectivity	**Source of Cost Estimates**	Capital ('£000)	Revenue ('£000)	Capital ('£000)	Revenue ('£000)	Capital ('£000)	Revenue ('£000)
Digital Inclusion	Project Team Estimates	413	1,494	-	-	413	1,494
Unified Digital team	Project Team Estimates	-	6,610	-	-	-	6,610
Total ('£000)		**413**	**8,104**	**-**	**-**	**413**	**8,104**

Appendix E: Strategic Alignment

Strategic documents reviewed

The digital strategic roadmap is aligned to organisational digital strategies, system strategic thinking, and existing business cases.

Document
Norfolk and Waveney ICS Clinical strategy
Norfolk and Waveney ICS Education Plan
Norfolk and Waveney STP Digital Strategy
Norfolk and Waveney Population Health Management Roadmap
Norfolk County Council Digital Strategy and Roadmap
Norfolk and Waveney ICS People Plan
James Paget University Hospitals FT Clinical Strategy
Queen Elizabeth Hospital Digital Data Strategy
East Suffolk Digital Strategy
Norfolk and Suffolk Trust Strategy
East of England Ambulance Service Strategy
Norfolk and Waveney ICS System Development Plan
HCDA Business Case
Shared Care Record Business Case
Electronic Patient Record Business Case
Digital Histopathology Business Case
Norfolk and Waveney Outpatient Programme
Norfolk and Norwich University Hospital Digital Roadmap

ICS Digital Transformation Guidance

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Norfolk and Waveney Integrated Care System

Our Digital Transformation capabilities and enablers align with the 7 success measures of the NHSX 'What Good Looks Like' framework, as mapped below.

NHSX 'What Good Looks Like' Framework

Well led	Ensure smart foundations	Safe practice	Support people	Empower citizens	Improve care	Healthy populations
Leadership and Decision Making	Data and Analytics	Shared Information	Data and Analytics	Citizen and Patient Tools	Data and Analytics	Population Health Management
Unified Digital Team	Digitised Patient Record	Digitised Patient Record	Digitised Patient Record	Shared Information	Shared Information	Data and Analytics
Governance	Digital Workforce Tools	Governance	Virtual Health and Care	Virtual Health and Care	Virtual Health and Care	Shared Information
	Shared Information		Digital Workforce Tools	Data and Analytics	Population Health Management	Digital Workforce Tools
	Infrastructure and Connectivity		Shared Information	Digital and Data Skills and Inclusion	Citizen and Patient Tools	Digitised Patient Record
	Unified Digital Team		Infrastructure and Connectivity		Digital Workforce Tools	Innovation and Partnerships
	Digital & Data Skills and Inclusion		Transformation and Culture Change		Digitised Patient Record	Transformation and Culture Change
	Governance		Digital and Data Skills and Inclusion		Transformation and Culture Change	

Key: Capabilities Enablers

Norfolk and Waveney
Integrated Care Board

Agenda item: 11.i

Subject:	**Maternity Digital Strategies**
Presented by:	**Tricia D'Orsi ICB Director of Nursing** (Senior Responsible Officer for Local Maternity and Neonatal) **Toni Jeary** LMNS Programme Manager
Prepared by:	**Toni Jeary** LMNS Programme Manager **Delyse Maidman** LMNS Digital Midwife
Submitted to:	**ICB Board**
Date:	**22 November 2022**

Purpose of paper:

Norfolk and Waveney Integrated Care Board (ICB) are asked to approve the Local Maternity and Neonatal System (LMNS) digital strategies as part of the ICB digital transformation programme.

Executive Summary:

The ICB has responsibility for the Local maternity and Neonatal System (LMNS). The LMNS is a system partnership responsible for supporting the implementation of the Maternity Transformation Programme, formed to co-ordinate and undertake the recommendations from the Better Births (2016) report and National Maternity review.

A key Maternity Transformation deliverable for 22/23 is:
Local maternity systems to support the expectation of Trusts that, by October 2022, they have an up-to-date digital strategy for its maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy must be signed off by the Integrated Care Board.

On 28 September 2022 the LMNS approved digital maternity strategies submitted by:

- James Paget Hospital
- Norfolk & Norwich University Hospital
- Norfolk & Waveney LMNS
- Queen Elizabeth Hospital King Lynn

These strategies had been approved by the LMNS Digital workstream and the responsible Trusts and are presented to ICB Board for final approval.

Report

Digital technology and advancements are changing how maternity care is delivered. This is further driven by consumer expectations to have greater visibility of their clinical maternity record, care plans, results and 'pregnancy and birth' information to enable them to make informed choices about the care they wish to receive. The evolution of technology in

healthcare requires a specialised workforce where midwives and maternity multi-professional teams have the skills to use data, information, digital knowledge and technology to deliver person-centered quality care. Ultimately driving safety, providing a better maternity experience for women and their families and improving outcomes.

A key Maternity Transformation Deliverable for 22/23 is:
Local maternity systems to support the expectation of Trusts that, by October 2022, they have an up-to-date digital strategy for its maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy must be signed off by the Integrated Care Board.

On 28 September 2022 the LMNS approved digital maternity strategies submitted by:

- James Paget Hospital
- Norfolk & Norwich University Hospital
- Norfolk & Waveney LMNS
- Queen Elizabeth Hospital King Lynn

These strategies had been approved by the LMNS Digital workstream and the responsible Trusts

All strategies have used the "What Good Looks Like (WGLL)" framework. This provides a vision which outlines the 7 success measures that establish best practice for the LMNS and Trusts to accelerate digital transformation. The framework identifies how this applies specifically to nursing and has been adapted for use by midwives and midwifery leaders. It provides objectives and a blueprint of how leaders can facilitate digital transformation locally and for the profession.

The strategies have a focused 1-year action plan. Progress will be monitored by the LMNS Digital and Data Workstream and reported to LMNS Board. During this period the selection of a Trust / ICB Electronic Patient Record (EPR) will be closely monitored as this will impact on the future direction / actions of maternity digital strategies. Work will continue to align digital strategies within Trusts and across the ICB.

Recommendation to the Board:

Review and approve the Digital Maternity Strategies for:

- James Paget Hospital
- Norfolk & Norwich University Hospital
- Norfolk & Waveney LMNS
- Queen Elizabeth Hospital King Lynn

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	
Legal:	

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

Governance

Process/Committee approval with date(s) (as appropriate)	Audit Committee for information.

NHS
James Paget University Hospitals
NHS Foundation Trust

Maternity Digital Strategy 2022-2024

DIGITAL MIDWIVES
Women centred, clinically led, digitally driven

Norfolk and Waveney Local Maternity & Neonatal System

Introduction

The James Paget is a vibrant university hospital providing the best possible care to a population of 250,000 residents across Great Yarmouth, Lowestoft, and Waveney, as well as many visitors who come to this part of East Anglia.

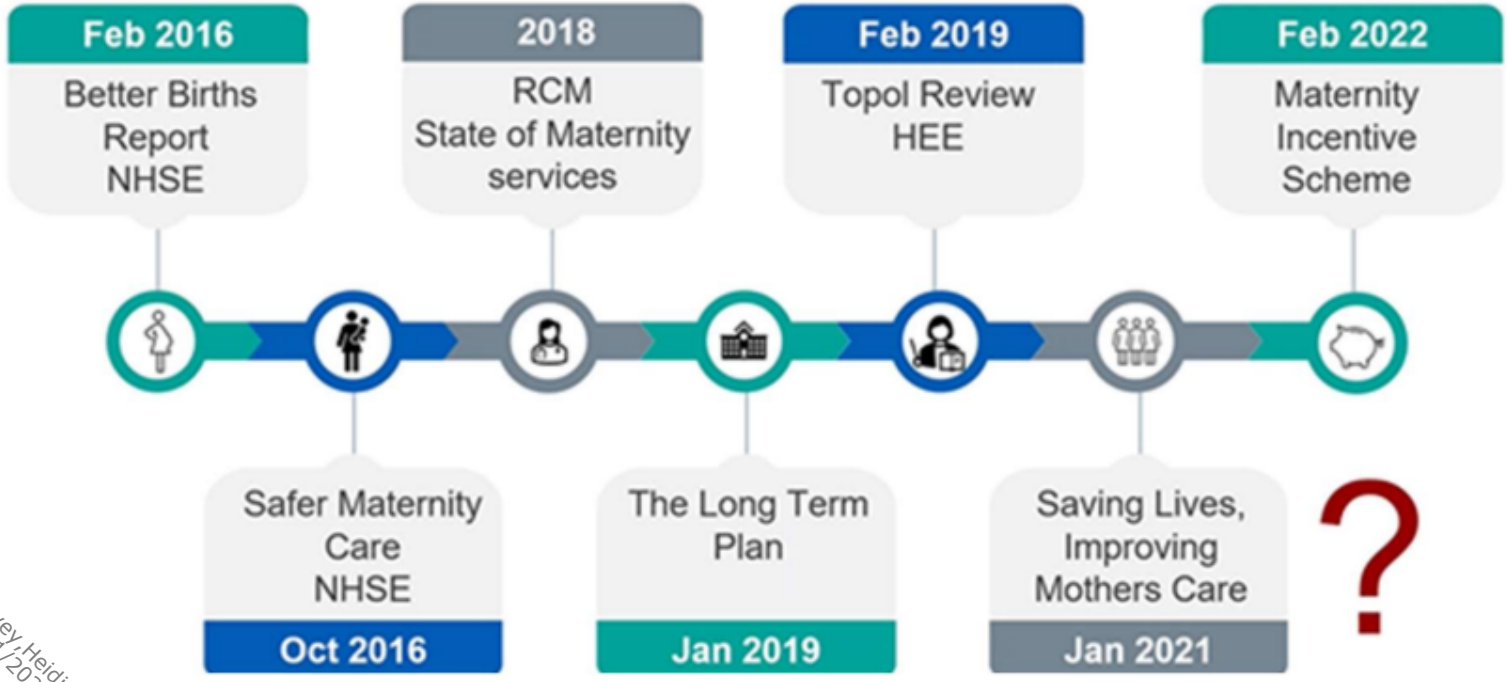
Our maternity department provides care to women and birthing people, throughout their pregnancy journey. We have a central delivery suite, with an alongside midwife-led birthing unit – known as the Dolphin Suite, as well as an antenatal and postnatal in-patient ward and maternity assessment unit. Maternity continuity of carer is our model of midwifery care, and we are proud of our achievements in promoting safety and choice for women and birthing people.

The latest Care Quality Commission report, published in 2018, rated our maternity services as good.

The maternity digital strategy compliments the Trust Digital Strategy.

#Proud of the Paget

National Digital Maternity Drivers



Local Context

Geographical & clinical landscape:

James Paget University Hospitals Trust (JPUH) provide care for 250,000 residents of the Great Yarmouth, Lowestoft, and Waveney area, including areas of rural countryside as well as areas of significantly low deprivation. By 2030 it is predicted our population will rise by 9%, with 3.3% of our population belonging to non-white ethnic groups. JPUH facilitate approximately 2000 births per annum supported on site by a level 1 Neonatal service. We have close links with our Regional Maternal Medicine unit, based at the Norfolk and Norwich University Hospital (NNUH) and are part of the wider Norfolk and Waveney Local Maternity and Neonatal System (LMNS).

Maternity digital landscape:

Our Euroking maternity information system (MIS) is supplied by Wellbeing Software. The Norfolk and Waveney Digital Maternity Discovery Report (May 22) highlighted a burden of paperwork and duplication of data recording; no end-to-end digital maternity record; lack of connectivity within Trust, across maternity units or into primary care; poor community access to digital records. These factors all reduce time to care for women and birthing people and raise the risk for errors.

ICB digital landscape:

The three acute Trusts across Norfolk and Waveney are working towards implementation of an electronic patient record (EPR), with maternity services currently in scope. The selected EPR will need to be assessed against NHSE MIS requisites catalogue to determine suitability. If the selected EPR does not meet the MIS specification, procurement for a single MIS across the three acute Trusts, that is connected to the EPR, will need to be factored in.

Problem Statement

"The current Maternity systems do not cover the entirety of the maternity episode: the record has gaps and there is a consequent reliance on paper/auxiliary/secondary systems. A reliance on paper to fill the gaps, compromises patient safety as the record is incomplete, not timely and may have transcription errors, all of which could lead to errors in decision-making.

Information for key parts of the record has to be sourced and sometimes re-transcribed from other systems with staff having to log-in to numerous different systems to obtain these. The time taken to do this reduces the availability of time to care for women and birthing people. The systems lack intuition and have lengthy workflows.

Use fo the systems is further hampered by lack of access to devices or devices that have insufficient build quality for the systems being used.

Connectivity is an issue for those working in the community, where system freezing and dropouts are being reported. All of these things again reduce the time available to care for women and birthing people.

Staff consider interoperability/interfacing of the systems they regularly use to complete the detail of the maternity record to be the highest priority for transformation and this would begin to save time spent tracking down information"

Norfolk and Waveney Digital Maternity Discovery Report – 09 May 2022 – Ethical Healthcare Consulting

Vision and themes

Strategic Vision:

A digitally enabled maternity service, that is connected, inclusive and supports 'smart working'. Where our users are empowered to manage their personalised maternity journey and clinicians are digitally supported to provide safe, timely care, regardless of setting.

Strategic themes:

In order to make this vision a reality, we have developed an action plan, grouped into seven themes based on the 'Digitalise, Connect and Transform' success factors included in 'What Good Looks Like' digital framework.

Digitalise

Well Led: Our leadership is confident and inspires a culture of digital transformation, data literacy, inclusion and collaboration.

Ensure Smart Foundations: We have reliable, modern, safe, and resilient infrastructure and data capabilities. We review and continuously improve our core IT and digital services.

Safe Practice: We ensure that our systems, and our use of technology meets and maintains high quality safety and service standards.

Connect

Support People: Our workforce are digitally literate and empowered to work within data and technology systems – and we can work seamlessly across our LMNS.

Empower Citizens: Citizens are at the center of our service design. We ensure that our digital services suit all health literacy, inclusion and demographic needs.

Transform

Improve Care: We make the best use of technology and data to improve care pathways in our Trust and across our LMNS.

Healthy Populations: We have an effective strategy to encourage innovative thinking, developing new models of care informed by data insights and digital capabilities.

Gap analysis against WGLL

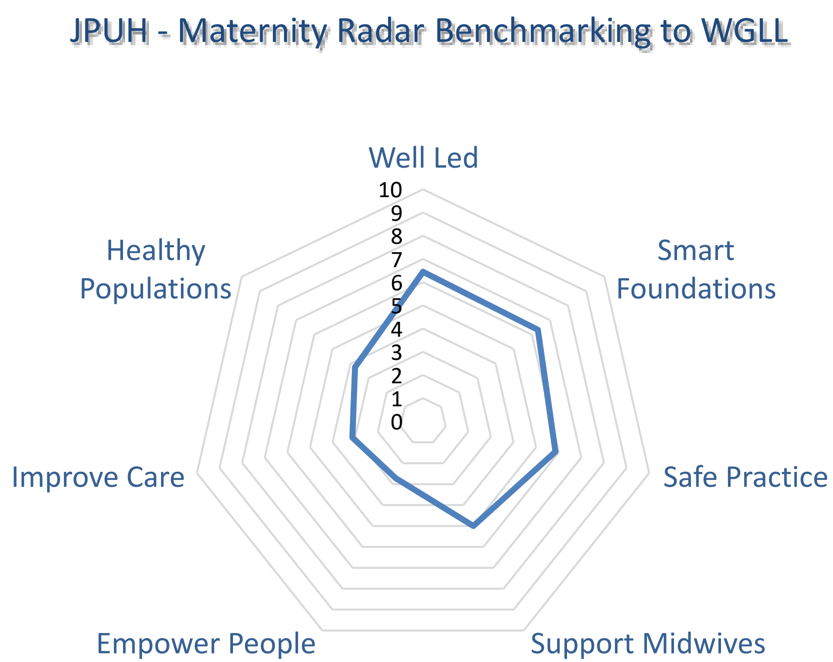
Strategic Vision:

A digitally enabled maternity service, that is connected, inclusive and supports 'smart working'. Where our users are empowered to manage their personalized maternity journey and clinicians are digitally supported to provide safe, timely care, regardless of setting.

WGLL for JPUH

A gap analysis was undertaken using the amended WGLL framework tool for Nursing to include Midwifery.

- The gap analysis has helped to inform focus areas within the maternity digital strategy action plans.
- The radar chart provides a visual benchmark of progress across the WGLL framework



What Good Looks Like (WGLL) for JPUH.
Theme 1: Well Led

Success Factor 1: Well Led states:

The Trust has a clear strategy for digital transformation and collaboration. Leaders across the Trust collectively own and drive the digital transformation journey, placing citizens and frontline perspectives at the centre. All leaders promote digitally enabled transformation to efficiently deliver safe, high quality care.

Current State:

- Trust board recognises the importance of digital and collaboration within its transformational roadmap and are investing to establish a strong digital leadership team with clinical experience.
- Digital Midwife (DM), with administration support, and IT Project Lead for maternity in post. Working closely with LMNS colleagues to share learning and improve digital maturity across the region.
- DM has secured a place on Foundations of Digital Health course, provided by Imperial College London.
- Digital Maturity at JPUH is below national average and this has impacted our ability to progress transformations and embrace new technologies or opportunities.
- Digital Midwife forging close collaborative relationship with the CXIO team at the Trust, has a voice at Digital Forums and is included in Trust wide digital initiatives.

JPUH Action Plan:

- DM role to be embedded, with substantive post.
- DM will lead an appropriately resourced multidisciplinary team, all sharing a clear focus to deliver digital health transformations.
- They will promote digital maternity resources and training within the Trust, as part of the wider LMNS digital team.
- They will undertake digital health learning programmes, sharing learning and building a quality team to lead digital maternity transformations.
- DM to continue to work with CXIO network, ensuring maternity needs are showcased and prioritised in relation to EPR/Maternity Digital Record.
- DM will continue to build strong relationships with key stakeholders, with a focus on collaborative working.

What Good Looks Like (WGLL) for JPUH.
Theme 2: Smart Foundations

Success Factor 2: Smart Foundations states:

Digital, data, and infrastructure operating environments are reliable, modern, secure, sustainable, and resilient. Across the Trust there are well-resourced teams who are competent to deliver modern digital and data services.

Current State:

- DM working with other LMNS DM's to build well resources & supported team of digital midwifery leaders, working together to align strategic visions.
- The Trust Digital Maternity team are newly established, learning the role and building multi-disciplinary networks across the LMNS and within regional DMERG, to share good practice and establish collaborative working groups.
- The Trust is working within the lowest digital maturity within the country. Our MIS does not have end-to-end maternity digital record and there is currently no patient portal.
- The DM and team have contributed to the MIS specification and will use this to benchmark against an EPR/MIS.

Dave Hagan 22/11/2022 09:45:44

JPUH Action Plan:

- The Trust are committed to levelling up and improving digital maturity, whereby the digital record is accessible in a timely manner, regardless of care setting.
- The Trust will actively promote a quality, sustainable MIS, that safely supports birthing people and clinicians moving between places of care.
- The Trust will encourage the development of digital teams to work collaboratively, sharing good practice and aligning digital pathways.
- The Trust will promote aligned data collections and deliver a quality dashboard, that is relevant to stakeholder groups.

What Good Looks Like (WGLL) for JPUH.
Theme 3: Safe Practice

Success Factor 3: Safe Practice states:

The Trust maintains standards for safe care, as set out by the Digital Technology Assessment Criteria for health and social care (DTAC). The Trust routinely reviews system-wide security, sustainability, and resilience.

Current State:

- Data and digital pathways are inconsistent, partly due to variation in maternity digital solutions.
- The MIS provides very limited informed decision making at point of care.
- There is limited interoperability between MIS and key clinical systems.
- The maternity digital record is not shared between the three LMNS acute Trusts.
- Data quality is poor and often duplicated, requiring significant resource to improve accuracy of the patient record and quality of data submissions.
- The Trust submits data to MSDS and are currently CNST compliant, however, data quality issues continue and require significant resource to monitor and improve.
- Data quality is included within mandatory midwifery training at the Trust.
- DM is building relationships with the CSO and has completed e-learning on digital clinical safety.

JPUH Action Plan:

- The Trust will promote clinical quality & safety through information sharing, with clear visibility across the LMNS.
- The Trust will actively support implementation of a quality MIS that has digital tools embedded to support safe care.
- The Trust will promote alignment of data and digital pathways.
- The Trust will promote collaboration between the CSO, CXIO's, DM and team to ensure safe practice.
- DM and team will establish oversight of SI's where digital is a significant factor.
- DM and team will provide education, training and support to ensure digital transformation projects are delivered in a transparent and efficient manner, linking in with PDM's.
- DM and team will participate in audits to ensure data quality is improved, supporting staff with learning and development opportunities.

What Good Looks Like (WGLL) for JPUH.
Theme 4: Support People

Success Factor 4: Support People states:

The workforce at the Trust is digitally literate and able to work optimally with data and technology. Digital and data tools and systems are fit for purpose and support staff to do their jobs well.

Current State:

- DM and team are supported by an experienced lead DM at LMNS level, who is compliant with up-to-date relevant digital leadership training.
- Trust DM and team are new in post. DM has secured a place on relevant digital leadership training.
- Stakeholder networks are being established to develop multi-disciplinary shared learning.
- There is low digital maturity across the region and digital literacy is subsequently low.
- DM is part of regional DMERG network to share learning and provide support.
- Digital literacy self assessment is not currently in place and there is no robust tool to support reflective practice.

JPUH Action Plan:

- Trust to support digital leadership training for its digital team.
- The Trust will promote digital literacy and personal accountability within digital record keeping, supporting maternity staff to have an awareness& understanding of why data is collected & how it is used.
- The Trust will promote digital user experience for both staff and birthing people using maternity services.
- DM and team will introduce self reflection tool, pending robust tool being available, to improve data quality and embed this into safe practice.

What Good Looks Like (WGLL) for JPUH.
Theme 5: Empower People

Success Factor 5: Empower People states:

Citizens are at the centre of service design and have access to a standard set of digital services that suit all literacy and digital inclusion needs. Citizens can access and contribute to their healthcare information, taking an active role in their health and wellbeing.

Current State:

- No app available for birthing people to access and contribute to their maternity record, meaning digital PCSP's are not available locally.
- Low digital maturity does not facilitate use of many national digital tools.
- Whilst we have, and engage with, an MVP aligned with the Trust there are limited resources, which hampers involvement in digital transformation initiatives.
- LMNS are offering local birthing people use of iPads to improve access to digital services.

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JPUH Action Plan:

- The Trust will actively support and promote birthing people accessing their personalised maternity digital record via maternity portal and NHS app, encouraging active collaboration with their care planning.
- The Trust will support the digital roadmap to move to a modern digital platform that enables access to digital tools.
- The Trust will prioritise digital inclusion to ensure equity for all.
- The Trust will help develop and promote digital PCSP.
- The Trust will seek opportunities to work collaboratively with local user participation groups e.g. MVP's

What Good Looks Like (WGLL) for JPUH.
Theme 6: Improve Care

Success Factor 6: Improve Care states:

The Trust embeds digital and data within their improvement capability to transform care pathways, reduce unwarranted variation and improve health and wellbeing. Digital solutions enhance services for patients and ensure that they get the right care when they need it and in the right place across the Trust.

Current State:

- The low digital maturity across the region prevents access to many new technologies and limits digitally supported pathways.
- DM and team strive to promote digital and data within clinical pathways and conduct regular audits to identify and act on systemic issues contributing to poor digital quality.
- Duplication of data entry, and paperwork is required to capture data requisites and ensure complete clinical record.
- Data items are inconsistent across the MIS.
- DM and team work with the LMNS digital team to work collaboratively with regional and national teams to drive quality data

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JPUH Action Plan:

- The Trust's digital team will actively support and promote a digital roadmap that steers towards a quality MIS, acting as the maternity voice within the CXIO network.
- The Trust will promote opportunities that result in an end-to-end digital record and removal of paper records.
- The Trust will seek opportunities that are digitally driven to support quality, timely data capture at point of care, and support smart working.
- The Trust will support and drive alignment of data and production of quality dashboards that are accessible to the different stakeholder groups.
- The Trust will adopt a shared approach to creating a data driven culture that supports midwifery practice.

What Good Looks Like (WGLL) for JPUH.
Theme 7: Healthy Populations

Success Factor 7: Healthy Populations states:

The Trust uses data to design and deliver improvements to population health and wellbeing, making best use of collective resources. Insights from data are used to improve outcomes and address health inequalities.

Current State:

- The LMNS funds a Public Health Midwife to lead the midwifery voice in population health management.
- Data items and sources are inconsistent in the Trust.
- Support and collaboration with information team at the Trust is limited.
- DM team at the Trust has access to MSDS, but are inexperienced in submission and monitoring of data.
- Data feeding into the LMNS is not aligned, resulting in difficulties gaining quality population health data in a timely manner.

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JPUH Action Plan:

- The digital team will conduct regular reviews and audits of maternity digital data to identify areas where changes are required.
- The Trust will participate in the equity and equality strategy to encourage the use of data to design and deliver improvements to population health and wellbeing.
- The maternity team will liaise with LMNS population health midwife to ensure focus is given to areas of most need.
- The maternity team will make best use of collective resources, applying insights from data to improve outcomes & address health inequalities in line with national public health initiatives.
- The Trust will encourage and support maternity services team to identify and register population health data gaps in their maternity digital records, engaging with suppliers and national digital leaders.

Priority Actions

Priority Actions	Measure of success	WGLL success measure	By When?
Secure substantive funding for permanent Digital Midwife (DM) role and continue to build a digital team within maternity that are skilled in supporting and delivering digital transformation for the Trust.	DM role will be substantive Digital team in support of DM will be in place	1. Well Led 2. Smart Foundations	30/06/2023
Conduct data quality audits to address shortfalls in knowledge and understanding in a timely manner.	Digital team will be conducting regular audits in support of data quality improvements, consequently data quality will be improved.	2 - Smart Foundations 3 - Safe Practice	31/12/2023
Improve data quality through education and support activity.	DM will attend mandatory training for midwives to provide oversight of current projects, highlight consistent areas of challenge and encourage midwives to consider impact on women, birthing people and babies of incorrect data.	2 - Smart Foundations 3 - Safe Practice	31/12/2022
Introduce self-reflection tool to encourage improved awareness of consequences of data quality errors in a supportive environment for staff, omissions/errors to be identified from audits, incidents, performance discussions and through professional midwifery advocates (PMA)	Self-reflection tool will be available and embedded into practice discussions with maternity team members, driving improvements in data quality through increased awareness of consequences of omissions/errors.	2 - Smart Foundations 3 - Safe Practice	31/12/2023

Priority Actions, continued

Priority Actions	Measure of success	WGLL success measure	By When?
Improve awareness and understanding of digital transformation plans through engagement with all levels of maternity staff.	In addition to DM attending mandatory midwifery training, DM will issue bulletins/attend unit meetings to share information and encourage participation in digital transformation	4 - Support Midwives and Nurses	31/12/2023
Encourage maternity staff to participate in digital transformation projects.	DM to invite maternity staff to share ideas, promoting opportunities to be involved in upcoming projects/deliverables, growing pool of subject matter experts within maternity services.	4 - Support Midwives and Nurses	31/12/2023
Build relationships with local maternity voices partnership (MVP) to ensure voice citizens is sought, listened to and included in digital transformation projects.	Digital team to be in regular contact with MVP and citizens are involved in digital transformation projects at the Trust.	5 - Empower Citizens	31/12/2023
Work with maternity information system (MIS) provider to deliver software updates, enabling patient portal to be launched.	Citizens will be able to access their maternity information via a patient portal.	5 - Empower Citizens	31/12/2022
Develop assessments to understand digital literacy, to enable early identification of extra support required for citizens.	Assessment tool will be available and being used to identify additional support needs	5 - Empower Citizens	31/12/2023

Making it Happen – Next Steps

Our Strategic Vision is:

A digitally enabled maternity service, that is connected, inclusive and supports 'smart working'. Where our users are empowered to manage their personalized maternity journey and clinicians are digitally supported to provide safe, timely care, regardless of setting.

Next Steps:

This draft strategy will be presented for discussion and agreement in the following groups:

- Trust board
- LMNS board

The final version is anticipated in October 2022

Refresh:

- This strategy document will be reviewed annually to ensure it is well aligned with the developing EPR/MIS and other key Trust/LMNS and ICS programmes.
- Trust and LMNS strategies will be refreshed every 3 years, with reports on progress.

Glossary

- CNST – Clinical Negligence Scheme for Trusts
- CSO – Clinical Safety Officer
- CXIO – Clinical ‘Digital’ Information Officer
- DM – Digital Midwife
- DMERG – Digital Midwives Expert Reference Group
- DTAC – Digital Technology Assessment Criteria
- EPR – Electronic Patient Record
- HEE – Health Education England
- ICB – Integrated Care Board
- ICS – Integrated Care System
- LMNS – Local Maternity and Neonatal Services
- MIS – Maternity Information System
- MSDS – Maternity Services Data Set
- MVP – Maternity Voices Partnership

Glossary, continued

- NHSE – NHS England
- PCSP – Personalised Care & Support Plan
- PDM – Practise Development Midwives
- RCM – Royal College of Midwives
- WGLL – What Good Looks Like

Supporting Information

Supporting Information:

- What Good Looks Like – NHS Transformation Directorate (England.nhs.uk)
- What Good Looks Like Gap Analysis
- Norfolk & Waveney Digital Maternity Discovery Report – 9 May 2022 – Ethical Healthcare Consulting
- ICB Strategy
- Norfolk and Waveney LMNS Strategy

Maternity Drivers:

- Better Births Report: NHSE Feb 2016
- Safer Maternity Care – Oct 2016
- State of Maternity Services: RCM – 2018
- NHS Long Term Plan: NHSE – Jan 2019
- Topol Review: HEE – Feb 2019
- Saving Lives, Improving Mothers Care: MBRRACE – Jan 2021
- Best Start for Life Report: DHSC – March 2021
- Maternity Incentive Scheme: NHSR – Feb 2021
- Final Report of the Ockenden Review: DHSC – March 2022

Our Vision
The best care for every patient

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

A Strategy for Digital & Data Transformation in Maternity (DRAFT)

DIGITAL MIDWIVES

Women centred, clinically led, digitally driven.

A one-year plan for digital transformation in maternity

October 2022 to October 2023

Executive Summary

This Digital Maternity Roadmap 'A Strategy for Digital Transformation in Maternity' sets out the vision for the next 12 months.

The strategy is developed against the What Good Looks Like Framework (August 2021) 7 success measures.

It has been developed in line with the system-wide Norfolk & Waveney ICB digital strategy and supports the Norfolk and Norwich Trust organisational digital strategy.

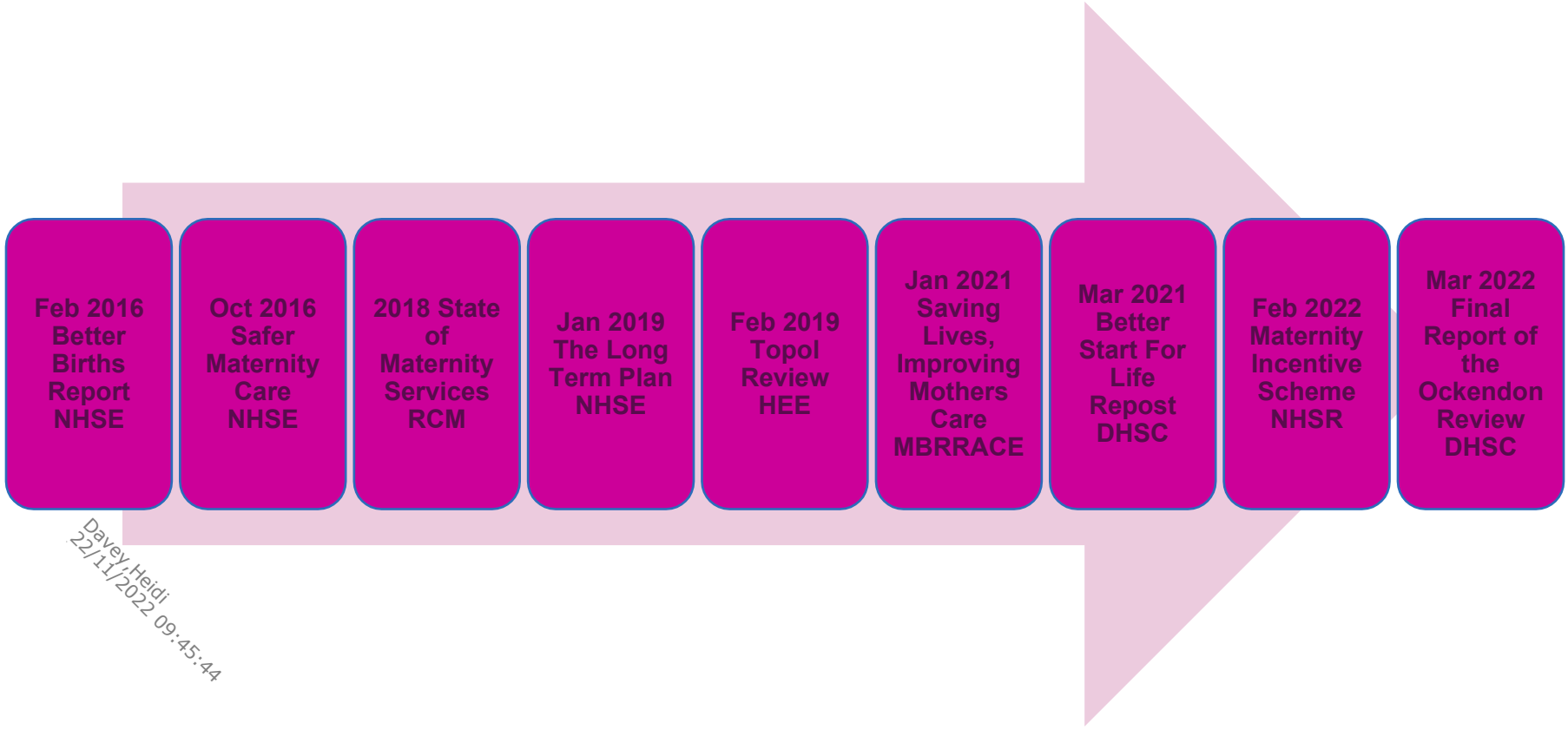
National Context

Digital technology and advancements are changing how maternity care is delivered and this is further driven by consumer expectations to have greater visibility of their clinical maternity record and care plans, results and pregnancy and birth information to enable them to make informed choices about the care they wish to receive. The **evolution of technology** in healthcare requires a **specialised workforce** where midwives and maternity multi-professional teams have the skills to use data, information, digital knowledge and technology to **deliver person-centred quality care**. Ultimately **driving safety**, providing a better maternity experience for women and their families and improving outcomes.

The previous **Health Secretary**, Sajid Javid, furthermore identified the power of digital to drive a **new era of recovery and reform** following the **Covid-19 pandemic** and focusses on **4 priorities**. These are: firstly, making sure the NHS is set up properly for success; secondly, levelling up across the NHS and social care; thirdly, pursuing personalisation; and fourthly, making big breakthroughs on emerging technologies and data.

The **"What Good Looks Like (WGLL)" framework** provides a vision which outlines the **7 success measures** that establish best practice for ICBs and organisation to accelerate digital transformation. The framework identifies how this applies specifically to nursing and has been adapted for use by midwives and midwifery leaders. It provides objectives and a **blueprint of how leaders can facilitate digital transformation** locally and for the profession. This provides impetus for the professionalism of digital maternity leader and midwife roles within organisations.

Digital Maternity Drivers



Our Vision
The best care
for every patient

Norfolk and Norwich
University Hospitals
NHS Foundation Trust

Local Context

Norfolk and Norwich Trust

We are a busy unit caring for approximately 5100 women and their babies per year. We are dedicated to providing outstanding maternity care and are continually looking to improve our services to meet the needs of women, birthing people and their families.

Geographically we cover from coast to country and the City in-between, bringing with it a unique set of challenges for those working in the community setting.

We work alongside a level 3 neonatal unit and provide Fetal and Maternal Medicine services to the region as well was many specialist services, including our home birth team, Bereavement Team and Skylark Complex Social Factors Team, all of whom ensure the wellbeing of the families in the Norfolk and Waveney region.

Maternity Digital Landscape

Norfolk and Norwich Maternity Department are currently using Euroking as its maternity information system (MIS) which is supplied by Wellbeing. Our Neonatal Unit use Badger Neonatal.

Euroking in its current form is not an end to end system and we know it is now a legacy product for Wellbeing, who are working to produce their next generation system.

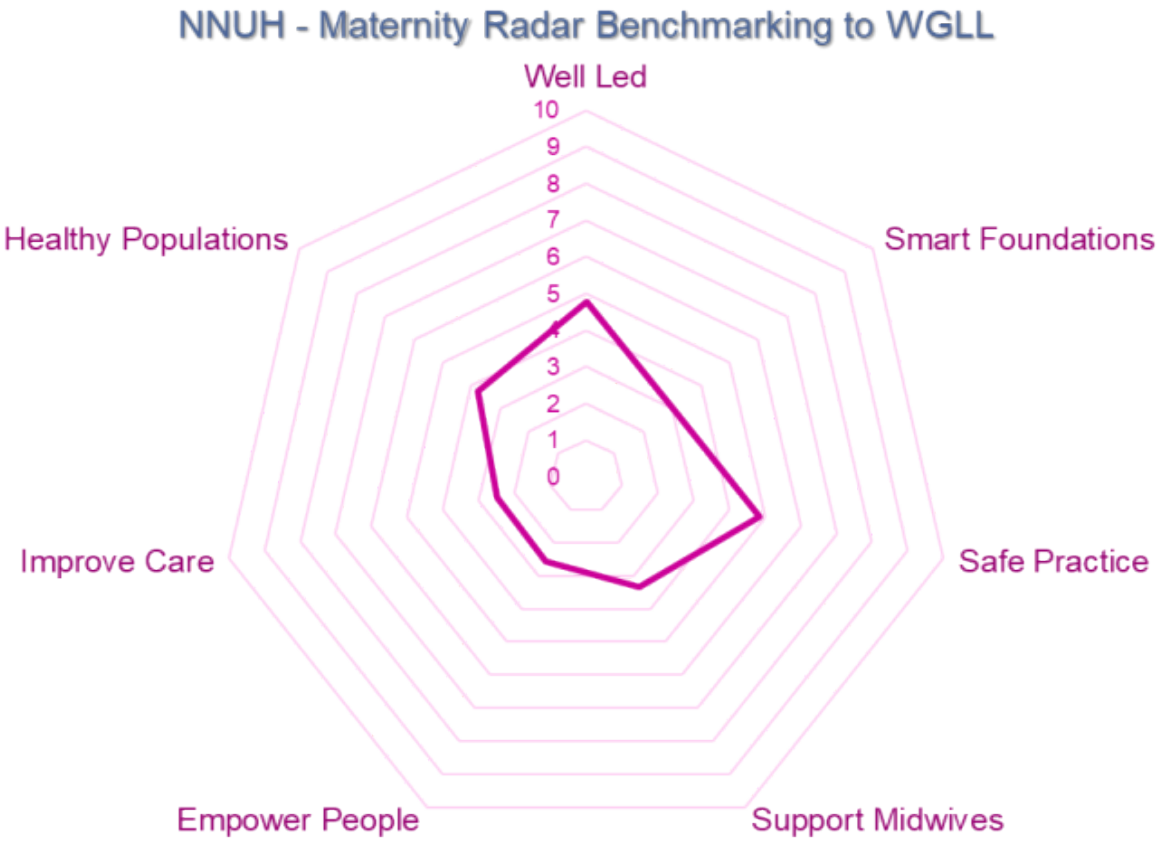
Following a region wide consultation of staff about their experiences of using the MIS, we know that they find the systems cumbersome and often hamper the care they are trying to provide. The lack of interoperability, connectivity issues, problems with devices, lack of intuition and heavy reliance on paper rather than the digital record, all impact on their ability to do their jobs well. (*Norfolk & Waveney Digital Maternity Discovery Report - 9th May 2022. Ethical Healthcare Consulting)*

All three acute Trusts across Norfolk and Waveney are looking to implement a region wide Electronic Patient Record (EPR) and maternity services are currently part of this process. There is a recognition that the system chosen my not be able to meet the NHSE&I standards for a MIS and that as such there may need to be scope to purchase a region wide MIS to meet the demands of the three maternity units.

Our Vision
The best care for every patient

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Maternity Mapping to the What Good Looks Like



RAG rating : 10 to 0

- Where 10 indicates fully meets success measure
- 0 indicates does not meet success measure at all

Vision, Mission and Themes

The Trust Strategic Vision is:

A digitally-enabled hospital where access to information, services and support make it easy to provide high quality care for our patients.

To work along side this, our mission in Maternity is:

To ensure we have a digitally enabled maternity service, that is connected, inclusive and supports 'smart working'. Where our users are empowered to manage their personalised maternity journey and clinicians are digitally supported to provide safe, timely care, regardless of setting.

Vision, Mission and Themes cont.

Strategic themes

In order to make this vision a reality, we have developed an action plan, grouped into seven themes based on the 'Digitise, Connect, Transform' success factors included in the 'What Good Looks Like' (WGLL) digital framework.

We have structured this Strategy using these 7 success factors to achieve alignment with national strategy, ICB and across the three Acute Trusts in Norfolk & Waveney.

Digitise	**Well Led:** Our leadership is confident and inspires a culture of digital transformation, data literacy, inclusion, and collaboration
	Ensure Smart Foundations: We have reliable, modern, safe, and resilient infrastructure and data capabilities. We review and continuously improve our core IT and digital services
	Safe Practice: We ensure that our systems, and our use of technology meets and maintains high-quality safety and service standards
Connect	**Support People:** Our workforce are digitally literate and empowered to work with data and technology systems - and we can work frictionlessly across our ICS
	Empower Citizens: Citizens are at the centre of our service design. We ensure that our digital services suit all health literacy, inclusion and demographic needs
Transform	**Improve Care:** We make the best use of technology and data to improve care pathways across our ICS
	Healthy Populations: We have an effective strategy to encourage innovative thinking, developing new models of care informed by data insights and digital capabilities

Theme 1: Well Led

Current Status:

- Lead Digital Midwife and administration support already in place.
- Director of Midwifery is Chair of Data and Digital LMNS Board.
- Strong Trust digital leadership with CNIO, CCIO and Digital Health Clinical Operations Lead in post.
- Lead Digital Midwife has a secured place on the Foundation Digital Leadership course, provided by Imperial College, to commence Spring 2023.
- Lead Midwife working with other Digital Leads from JPH and QEH and supported by Lead Digital Midwife for the LMNS. All are part of the wider national Digital Midwives Expert Reference Group (DMERG)

Action Plan:

- Recruit and replace Band 6 Digital Midwife to support Lead Midwife to deliver digital strategy to the multidisciplinary team.
- Continue to work with CNIO and CCIO and the wider CXIO network to ensure maternity voice is heard in Trust wide digital transformation.
- To build a strong departmental digital user group to ensure key relationships with stakeholders are prioritised, learning is shared and a quality patient recorded is maintained.

Theme 2: Ensure Smart Foundations

Current Status:

- Poor digital maturity and Euroking is not currently an end to end maternity record.
- Working together with the Trust to secure a suitable EPR system.
- Server migration in process to move Euroking from 2008 server to 2019 server.
- Due system upgrade to Euroking version 1.8 – to commence once server migration complete.
- With 1.8 we will also have the ability to launch the Maternity Personal Health Record (mPHR) via Euroking
- Working with Trust to launch E-Obs within maternity

Action Plan:

- Ensure Maternity voice is heard in all EPR discussions and if the chosen system is unable to meet standards required of a maternity information system, ensure opportunity to consider a stand alone system
- An end to end system is required across the LMNS with connectivity and inclusivity being a priority
- Complete all system upgrades in a timely manner
- Newly formed User Group to ensure current system is fit for purpose and streamline all existing workflows.

Theme 3: Safe Practice

Current Status:

- Low digital maturity across region.
- Poor connectivity in many areas.
- Limited interoperability with many systems.
- None of the local systems communicate with each other.
- Heavy reliance on paper documentation due to limitations of MIS resulting in triplication.
- Requests for changes to the system are slow to implement.
- Lots of duplication leading to data quality errors.
- Data quality takes a lot of policing to ensure compliance with MSDS etc.
- Staff try their best with an imperfect system.

Action Plan:

- To make the most of the system we have until an alternative is sourced with Trust wide EPR or stand alone MIS across the LMNS.
- Better engagement with stakeholders via a user group to ensure feedback heard and system improvements made by those using the system.
- Ensure staff have a better understanding of data and data quality via shared learning.
- Ensure Trust in compliant with data and digital measures.

Theme 4: Support People

Current Status:

- Inconsistent digital literacy across the workforce with no current self assessment in place.
- No stakeholder group to help drive future practices.
- No Band 6 support, means less opportunity to release time for additional training or 121 support for staff.
- Strong CNIO leadership offering monthly 121 to Digital Midwife
- Linking with other Digital Midwives across the region with strong representation and leadership in regional DMERG and LMNS groups

Action Plan:

- Leadership training secured for Digital Midwife commencing Spring 2023.
- Plans to recruit Band 6 support.
- To introduce a new Digital Maternity User Group with representation from all key stakeholders to be held monthly.
- Introduce digital self assessment and ascertain training needs of staff to ensure digital literacy is accessed across the workforce.

Theme 5: Empower Citizens

Current Status:

- Low digital maturity across the region means limited availability of nationally recognised tools for women and their families.
- Trust does not yet have the 'Patient Portal' provided by Euroking.
- To date there has been very limited engagement with the MVP with regards to the MIS as none of it is currently patient facing.
- No current programmes in place to support families wit limited digital engagement opportunities.

Action Plan:

- Plans to start works on the 'Patient Portal' once system upgrade to version 1.8 is complete – we need the upgrade to facilitate the portal.
- Once in a position to start to populate the content of the portal we will need MVP and service user engagement.
- Portal will allow all women to have an electronic copy of their pregnancy notes available throughout their journey.
- By Nov 22 we should also have vision of the shared care record in the community which women will also be able to access.
- Work with the LMNS to improve digital access for those who need it.

Theme 6: Improve Care

Current Status:

- Trust has multiple digital solutions being implemented to help improve care, for example E-Obs, which is currently building a maternity module to allow electronic documentation of MEOWs scores.
- Staff have a lack of understanding of the importance of data and how it influences care pathways.
- Poor connectivity, lack of interoperability, duplication and replication on paper, unwieldly MIS all contribute to challenges when providing care to women.
- Digital Maternity Team working to improve data and information sharing to demonstrate improvements in care.

Action Plan:

- To support Trust in creating an EPR that enables and end to end digital patient record that removes paper and duplication from the service and ensures a woman and those caring for her can see her complete record where ever she may be receiving care. Either included with the Trust EPR or if necessary, a dedicated stand alone MIS that is fit for purpose.
- Digital Maternity Team to ensure all data and dashboards are inline with national recommendations and standards.
- Ensure that Maternity are included in all suitable digital transformation provided by the Trust.

Theme 7: Healthy Populations

Current Status:

- Currently working with the LMNS to support programmes to improve health and wellbeing of families in our care. However, data feeding into the necessary workflow is misaligned across the region.
- At a local level the MIS data items are inconsistent and need review and improvement. This will then improve data provided at a local and national level.
- Not using our colleagues in information services enough to help produce data to be presented to a wider audience.

Action Plan:

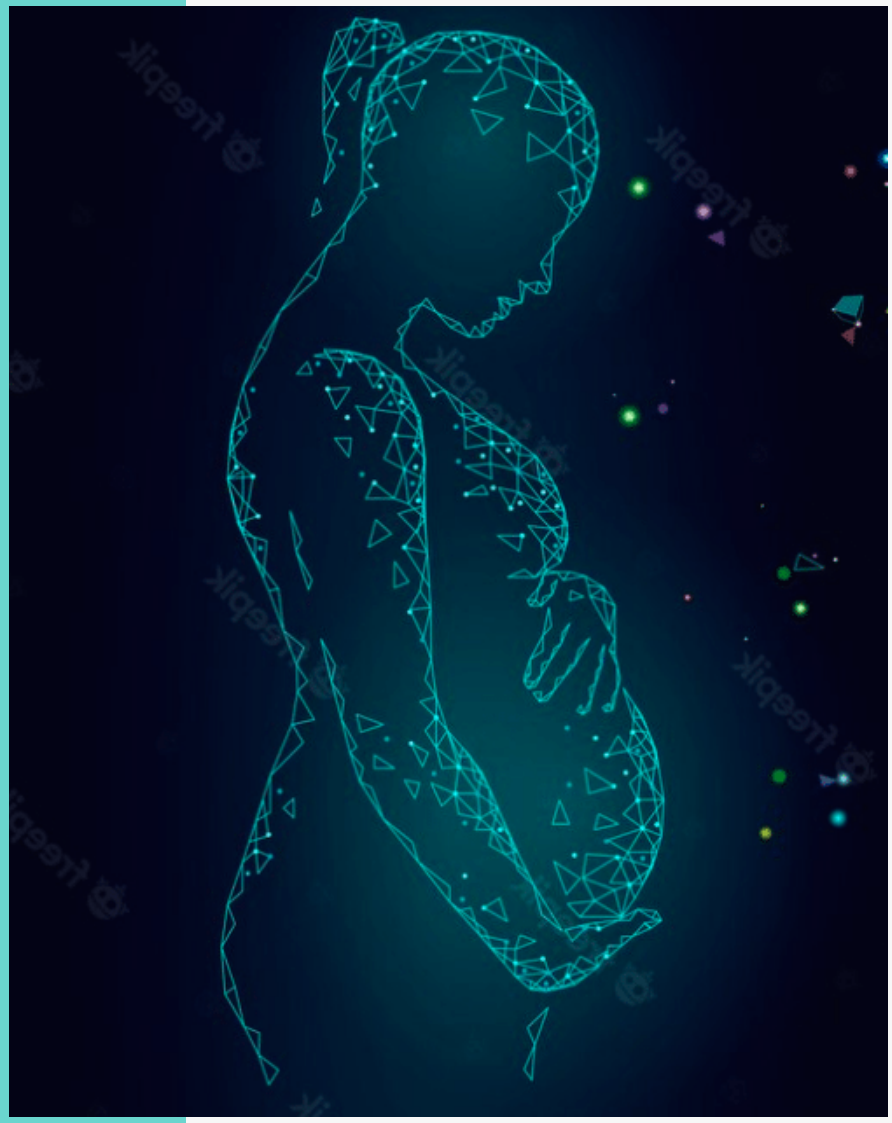
- Stream line and improve current MIS workflows to ensure data recorded is relevant, current and supports the care we wish to provide to women. Newly formed user group to support in this and invite key stakeholders for feedback and understanding of workflows.
- Use of MSDS and evidence based, nationally recognised KPIs to benchmark the Trust and recognise themes for improvement or recognition.
- Continue to work with LMNS and IS team to improve data collected to help address health inequalities for women in our care.

Next Steps

Making it Happen:

- Create Digital Maternity User Group and invite key stakeholders to join and support the development of the digital pathway in Maternity.
- Ensure all necessary infrastructure work for current MIS is completed by the end of 2022 to allow for improvements to system and launch of 'Patient Portal'.
- Until a decision is made about the future of EPR/MIS systems, work to improve and align the current MIS system to needs of the service and data requirements.
- This strategy should be reviewed again in 12 months time and a new assessment completed to determine the success of the intended measures to be taken and review any changes that need to be made.

Strategy for Digital & Data Transformation in Maternity



Norfolk and Waveney Local Maternity System

Version :1.0
Date Published : 02/08/22
Author : Delyse Maidman

LMNS Board : Norfolk & Waveney ICB
ICB Sponsor: Tricia D'Orsi
Date of Approval [.. Sept 22]

Contents

Norfolk & Waveney LMNS

A Strategy for Digital & Data Transformation in Maternity

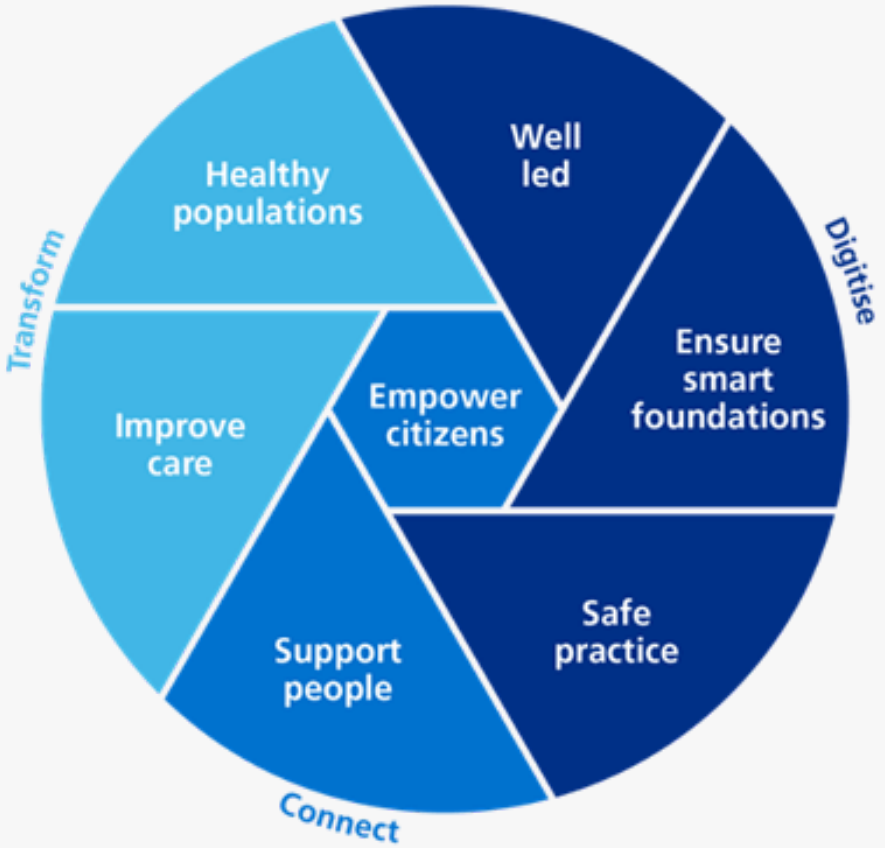
1. The Executive Summary

This Digital Maternity Roadmap **'A strategy for Digital & Data Transformation in Maternity'** sets out the vision for the next year, with an action plan to achieve that vision.

The strategy is developed against the 7 success measures within the What Good Looks Like Framework (August 2021)

It has been developed in line with the system-wide **Norfolk & Waveney ICB** digital strategy and supports the organisational strategies at ;

- **James Paget Hospital,** Great Yarmouth
- **Norfolk & Norwich Hospital**, Norwich
- **Queen Elizabeth Hospital**, Kings Lynn



2. National Context

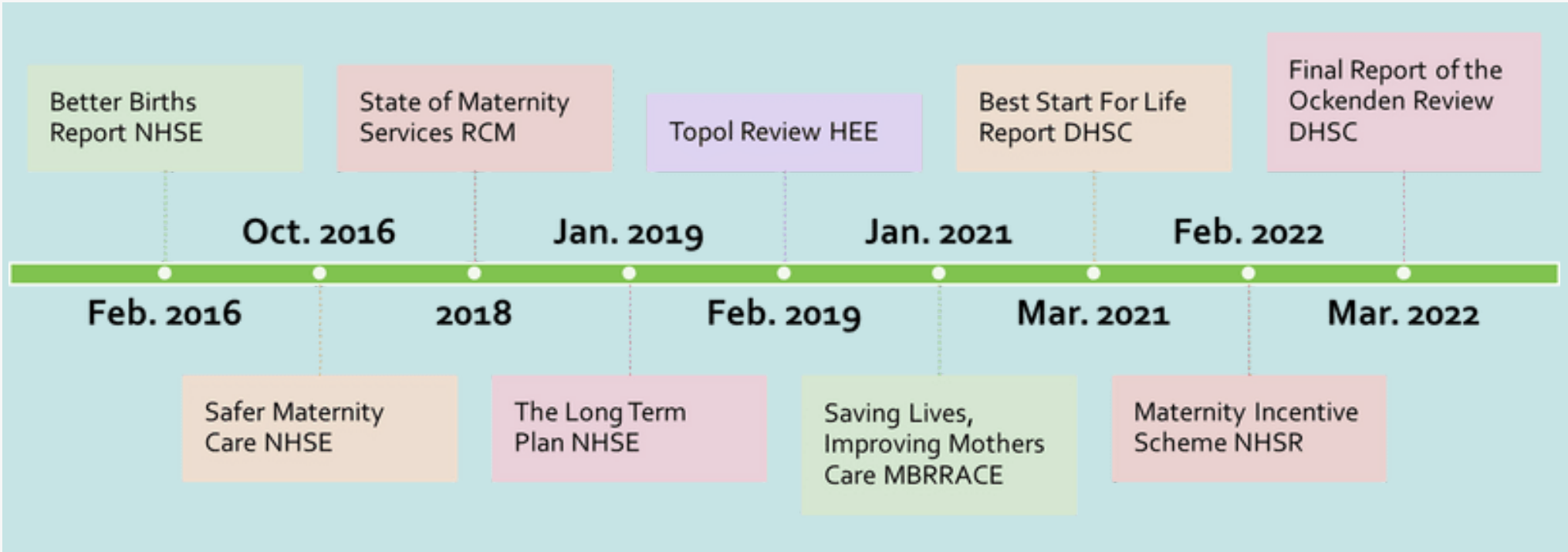
Digital technology and advancements are changing how maternity care is delivered. This is further driven by consumer expectations to have greater visibility of their clinical maternity record, care plans, results and 'pregnancy and birth' information to enable them to make informed choices about the care they wish to receive. The evolution of technology in healthcare requires a specialised workforce where midwives and maternity multi-professional teams have the skills to use data, information, digital knowledge and technology to deliver person-centred quality care. Ultimately driving safety, providing a better maternity experience for women and their families and improving outcomes.

The previous Health Secretary, Sajid Javid, identified the power of digital to drive a new era of recovery and reform following the Covid-19 pandemic, focussing on 4 priorities.

1. **Making sure the NHS is set up properly for success;**
2. **Levelling up across the NHS and social care;**
3. **Pursuing personalisation;**
4. **Making big breakthroughs on emerging technologies and data.**

The "What Good Looks Like (WGLL)" framework provides a vision which outlines the 7 success measures that establish best practice for ICBs and organisation to accelerate digital transformation. The framework identifies how this applies specifically to nursing and has been adapted for use by midwives and midwifery leaders. It provides objectives and a blueprint of how leaders can facilitate digital transformation locally and for the profession. This provides impetus for the professionalism of digital maternity leader and midwifery roles within organisations.

3. Digital Maternity Drivers



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- Feb 2019: **Topol Review** - Health Education England
- Jan 2021: **Saving Lives, Improving Mothers Care** - Mothers & Babies: Reducing Risk through Audits & Confidential Enquiries
- Mar 2021: **Best Start for Life Report** - Department for Health & Social Care
- Feb 2022: **Maternity Incentive Scheme** - NHS Resolution CNST
- Mar 2022: **Final Report Of The Ockenden Review** - Department for Health & Social Care

4. Local Context

Geographical & clinical Landscape:

Norfolk & Waveney LMNS provide care over c2,900 square miles, including rural countryside and areas of significantly low deprivation. By 2030 it is predicted our population will rise to 1.1 million people, with 3.5% of our population from non-white ethnic groups.
3 acute trusts deliver approximately 10,00 births per annum supported by a regional Maternal Medicine unit and level 3 Neonatal services.

Maternity Digital Landscape:

2 maternity suppliers provide 3 Maternity Information Systems (MIS). The Norfolk & Waveney Digital Maternity Discovery Report (May 22) highlighted; a burden of paperwork and duplication of data recording; no end-to-end digital maternity record; lack of connectivity within Trust, across maternity units or into primary care; poor Community access to digital records. These factors all reduce time to care and raise the risk for errors.

ICB Digital Landscape:

The 3 acute Trusts across Norfolk and Waveney are working towards implementation of an Electronic Patient Record (EPR), with Maternity services currently in scope.
The selected EPR will need to be assessed against the NHSE&I MIS requisites catalogue to determine suitability. If the selected EPR does not meet the MIS specification, procurement for a single MIS across the 3 acute trusts, that is connected to the EPR will need to be factored in.

5. Problem Statement

'The current Maternity systems do not cover the entirety of the maternity episode; the record has gaps & there is a consequent reliance on paper / auxiliary/secondary systems
A reliance on paper to fill the gaps, compromises patient safety as the record is incomplete, not timely & may have transcription errors all of which could lead to errors in decision-making.
Information for key parts of the record has to be sourced & sometimes re-transcribed from other systems with staff having to log-in to numerous different systems to obtain these. The time taken to do this, reduces the availability of time to care for women.
The systems lack intuition and have lengthy workflows.
Use of the systems is further hampered by lack of access to devices or devices that have insufficient build quality for the systems being used.
Connectivity is an issue for those working in the Community where system freezing & dropouts are being reported. All of these things again reduce the time available to care for women.
Staff consider interoperability/interfacing of the systems they regularly use to complete the detail of the maternity record to be the highest priority for transformation & this would begin to save on time spent tracking down information.'

Norfolk & Waveney Digital Maternity Discovery Report - 9th May 2022
Ethical Healthcare Consulting

6. Vision and Themes

Strategic Vision:

A digitally enabled maternity service, that is connected , inclusive and supports 'Smart' working' . Where our users are empowered to manage their personalised maternity journey and clinicians are digitally supported to provide safe, timely care, regardless of setting.

Strategic themes

In order to make this vision a reality, we have developed an action plan, grouped into seven themes based on the 'Digitise, Connect, Transform' success factors included in the 'What Good Looks Like' (WGLL) digital framework.

We have structured this Strategy using these 7 success factors to achieve alignment with national strategy, ICB and across the three Acute Trusts in Norfolk & Waveney.

Digitalise

Well Led: Our leadership is confident and inspires a culture of digital transformation, data literacy, inclusion and collaboration.

Ensure Smart Foundations: We have reliable, modern, safe, and resilient infrastructure and data capabilities. We review and continuously improve our core IT and digital services

Safe Practice: We ensure that our systems, and our use of technology meets and maintains high quality safety and service standards

Connect

Support People: Our workforce are digitally literate and empowered to work with data and technology systems - and we can work frictionlessly across our LMNS

Empower Citizens: Citizens are at the centre of our service design. We ensure that our digital services suit all health literacy, inclusion and demographic needs

Transform

Improve Care: We make the best use of technology and data to improve care pathways across our LMNS

Health Populations: We have an effective strategy to encourage inovative thinking, developing new model of care informed by data insights and digital capabilities

6. Gap analysis against WGLL

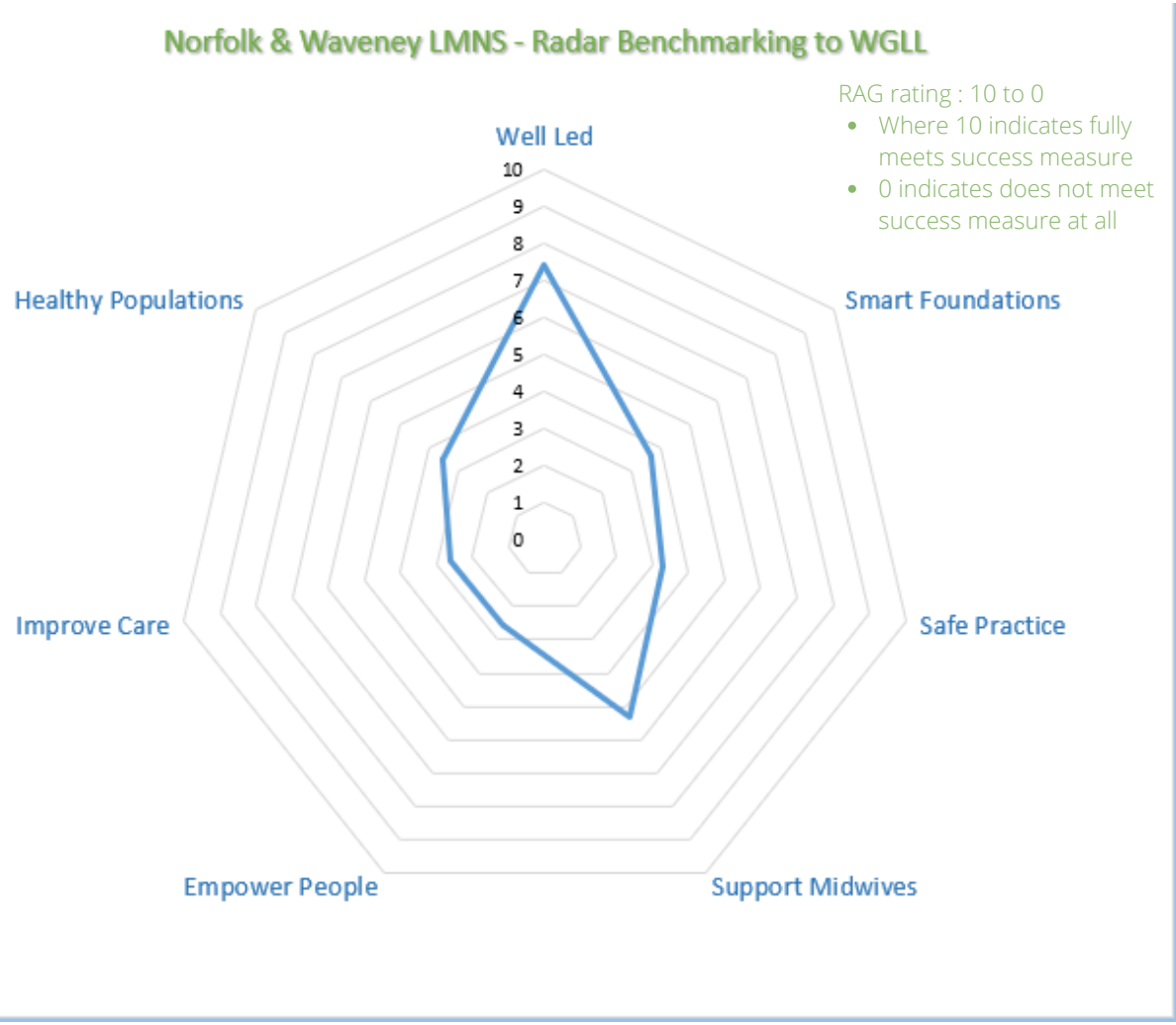
Strategic Vision:

A digitally enabled maternity service, that is connected , inclusive and supports 'Smart' working' . Where our users are empowered to manage their personalised maternity journey and clinicians are digitally supported to provide safe, timely care regardless of setting.

WGLL for Norfolk & Waveney LMNS

A gap analysis was undertaken using the amended WGLL framework tool for Nursing to include Midwifery.

- The Gap analysis has helped to steer the focus areas within the maternity digital strategy action plans.
- The Radar chart provides a visual benchmark against the WGLL Framework



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7. What Good Looks Like. Theme 1 Well Led

What Good Looks Like (WGLL) for the LMNS Success Factor 1: **Well-Led states**

Your ICS has a clear strategy for digital transformation and collaboration. Leaders across the ICS collectively own and drive the digital transformation journey, placing citizens and frontline perspectives at the centre. All leaders promote digitally enabled transformation to efficiently deliver safe, high quality care.

Integrated Care Boards (ICBs) build digital and data expertise and accountability into their leadership and governance arrangements, and ensure delivery of the system-wide digital and data strategy.

Current state:

- The LMNS board recognises the importance of 'digital' and 'collaboration' within its transformation roadmap and are investing to establish a strong digital leadership team with clinical expertise.
- A Lead digital Midwife is in post who works closely with the LMNS lead and Project manager, building vital networks with key stakeholders; regionally, nationally and within the 3 acute trusts and ICB and primary care.
- The low Digital maturity across the ICB has significantly impacted the LMNS to progress transformations, embrace new technologies or opportunities.
- The Lead Digital Midwife works closely with the CXIO network, representing the maternity voice within the digital strategy, EPR planning and future roadmap.

LMNS Action Plan:

- The digital team will be establish substantive CMIO - or equivalent-posts in place supported by a LMNS DM on each Trust site
- The DM will lead an appropriately resourced multidisciplinary team; all sharing a clear focus to deliver digital health transformations.
- They will promote digital maternity resources and training across the LMNS.
- The LMNS System Digital team will undertake Digital health learning programmes, sharing learning and building a quality team to lead digital maternity transformations
- The LMNS DM will continue to work closely with the CXIO network, ensuring the maternity needs are showcased and prioritised in relation to the EPR / maternity digital record.
- The LMNS DM will continue to build strong relationships with key stakeholders with a focus on collaborative working.

7. What Good Looks Like. Theme 2: Smart Foundations

What Good Looks Like (WGLL) for the LMNS Success Factor 2: **Ensure smart Foundations**

Digital, data and infrastructure operating environments are reliable, modern, secure, sustainable and resilient. Across your ICS, all organisations have well-resourced teams who are competent to deliver modern digital and data services.

Current state:

- The LMNS is working with the Digital Midwives across the 3 trust to build a well resourced & supported team of digital midwifery leaders, working together to align strategic visions.
- The team are newly established, learning the role and building multi-disciplinary networks across the LMNS and within regional DMERG, to share good practice and establish collaborative working groups.
- However the team are working within the lowest Digital maturity within the country, with 3 maternity solutions and without an end-to-end Maternity digital record.
- Data & dashboards are recognised to be inconsistent across the LMNS
- The DM team are contributing to the MIS specification and will use this to benchmark against an EPR / MIS

LMNS action plan:

- The LMNS is committed to levelling up and improving digital maturity across the LMNS, whereby the digital record is accessible in a timely manner regardless of care setting.
- The LMNS will actively promote a quality, sustainable single MIS across the 3 acute hospitals, that safely supports mothers and clinicians moving between places of care.
- The LMNS will encourage the developing digital teams to work collaboratively, sharing good practice and aligning digital pathways.
- The LMNS will promote aligned data collections and deliver a quality dashboard that is relevant to stakeholder groups

7. What Good Looks Like. Theme 3: Safe Practice

What Good Looks Like (WGLL) for the LMNS Success Factor 3: **Safe Practice**

Organisations across the ICS maintain standards for safe care, as set out by the Digital Technology Assessment Criteria for health and social care (DTAC). They routinely review system-wide security, sustainability and resilience.

Current state:

- Data and digital pathways are inconsistent across the LMNS, partly due to variation in maternity digital solutions.
- The MIS provides very limited informed decision making at point of care.
- The maternity digital record is not shared between the 3 trusts
- Data capture is often duplicated and quality poor, requiring significant resources at all 3 trusts to improve accuracy of the patient record and quality of data submissions.
- All 3 Trusts submit to MSDS and are currently CNST compliant, but data quality issues continue.
- Data quality is included within mandatory training at each trust.
- The DMs are building relationships with the CSO, and require training in digital clinical safety.

LMNS action plan:

- The LMNS will promote clinical quality & safety through information sharing, with clear visibility across the LMNS, working towards a single MIS.
- The LMNS will actively support the implementation of a quality MIS that has digital tools embedded to support safe care.
- The LMNS will promote alignment of data and digital pathways.
- The LMNS will promote collaboration between the CSO and DMs to ensure safe practice.
- The LMNS will include a digital lens when reviewing SI's & look to establish oversight where digital is a significant factor.
- Training data to be included in LMNS quarterly training report
- Trust Audits to be agreed at digital workstream, reviewed & signed off at Q & S oversight group

7. What Good Looks Like. Theme 4: Support People

What Good Looks Like (WGLL) for the LMNS Success Factor 4: **Support People**

Your workforce is digitally literate and are able to work optimally with data and technology. Digital and data tools and systems are fit for purpose and support staff to do their jobs well.

Current state:

- The LMNS has an experienced digital midwife with up-to-date relevant digital leadership training.
- The Trust digital midwives are new to post and have secured relevant digital leadership training.
- Stakeholder networks are being established to develop multi-disciplinary shared learning.
- There is low digital maturity across the LMNS and digital literacy is subsequently low.
- Shared learning across the LMNS and regionally via the DMERG network is being established.
- Digital literacy self assessment are not in place and there are no robust tools in place to support reflective practice.

LMNS action plan:

- The LMNS will continue to support and promote digital leadership training for its DM team.
- The LMNS will promote digital literacy and personal accountability within digital record keeping, supporting maternity staff to have an awareness & understanding of why data is collected & how it is used.
- The LMNS will promote digital user experience for both staff & women using maternity services.
- The LMNS will support Trust PDM teams to promote digital literacy within all training environments

7. What Good Looks Like. Theme 5: Empower People

What Good Looks Like (WGLL) for the LMNS Success Factor 5: **Empower People**

Citizens are at the centre of service design and have access to a standard set of digital services that suit all literacy and digital inclusion needs. Citizens can access and contribute to their healthcare information, taking an active role in their health and well-being.

- **Current state:**
- Only 1 of the 3 maternity units has an app that enables mothers to access and contribute to their Maternity digital record.
- The low digital maturity does not facilitate use of many national digital tools
- The LMNS has limited access to MVPs within the region due to limited MVP resources.
- Digital exclusion project is supported at 1 trust whereby digitally excluded mothers are gifted a tablet device via libraries to support digital inclusion.
- Digital Personalised care plans are not available

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LMNS action plan:

- The LMNS will actively support and promote mothers accessing their personalised maternity digital record via maternity portal and NHS app, encouraging active collaboration with their care planning.
- The LMNS will support the digital roadmap to move to a modern digital platform that enables access to digital tools.
- The LMNS will prioritise digital inclusion to ensure equity for all.
- The LMNS will help develop and promote digital PCSP across all 3 acute trusts.
- The LMNS will seek to work collaboratively with user participation groups i.e MVPs

7. What Good Looks Like. Theme 6: Improve Care

What Good Looks Like (WGLL) for the LMNS Success Factor 6: **Improve Care**

Your ICS embeds digital and data within their improvement capability to transform care pathways, reduce unwarranted variation and improve health and wellbeing. Digital solutions enhance services for patients and ensure that they get the right care when they need it and in the right place across the whole ICS.

Current state:

- The low digital maturity across the LMNS prevents access to many new technologies and limits digitally supported pathways
- The LMNS and Trust DMs strive to promote digital and data within clinical pathways , however digital opportunities are often not accessible or supported due to the low digital maturity.
- Duplication of data entry and paperwork, is required to capture data requisites and ensure a complete clinical record.
- Data items are inconsistent across the MIS
- LMNS and DMs work collaboratively with regional and national teams to drive quality data

LMNS action plan:

- The LMNS will actively support and promote a digital roadmap that steers towards a quality MIS, acting as the maternity voice within the CXIO network
- The LMNS will promote opportunities that result in an end-to-end digital record and removal of paper records.
- The LMNS will seek opportunities that are digitally driven to support quality, timely data capture at point of care, and support smart working.
- The LMNS will support and drive alignment of data and production of quality dashboards that are accessible to the different stakeholder groups.
- Shared approach to creating a data driven culture that supports midwifery practice

7. What Good Looks Like. Theme 7: Healthy Populations

What Good Looks Like (WGLL) for the LMNS Success Factor 7: **Healthy Populations**

Your ICS uses data to design and deliver improvements to population health and wellbeing, making best use of collective resources. Insights from data are used to improve outcomes and address health inequalities.

Current state:

- The LMNS funds a Public Health Midwife to lead the midwifery voice in population health management.
- Data items and sources are inconsistent across the 3 acute trusts
- Support and collaboration with the information service teams varies across the 3 acute trusts
- DMs have varied level of access to the MSDS, with some have little or no access.
- Data feeding into the LMNS is not aligned, resulting in difficulties gaining quality population health data in a timely manner.

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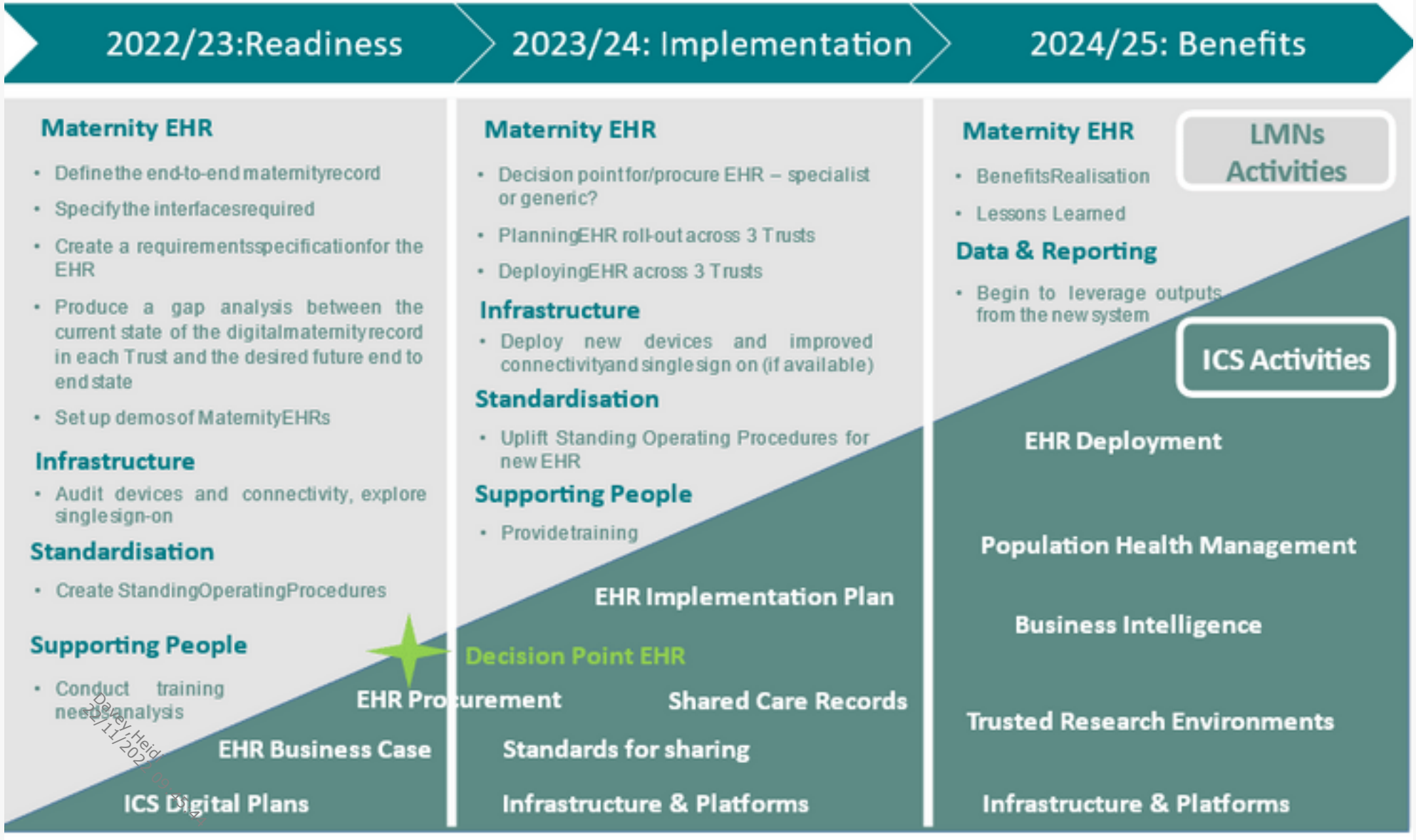
LMNS action plan:

- The LMNs will encourage regular reviews & audit of the maternity digital data to identify areas for change in care provision that promote health & wellbeing
- The LMNS will complete the Equity and Equality strategy to encourage the use of data, to design & deliver improvements to population health & wellbeing.
- The LMNS will make best use of collective resources, applying insights from data to improve outcomes & address health inequalities in line with the national public health initiatives.
- The LMNS will encourage the maternity services to identify and register population health data gaps with their maternity digital record suppliers and national digital leaders.

9a. The Roadmap



10. Making it Happen - Next steps

Our Strategic Vision is:
A digitally enabled maternity service, that is connected, inclusive and supports 'Smart' working' . Where our users are empowered to manage their personalised maternity journey and clinicians are digitally supported to provide safe, timely care regardless of setting.

Next steps:
This draft strategy will be presented for discussion and agreement at the following groups:

- LMNS digital and data workstream
- LMNS board
- CXIO network
- ICS board

The final version will be available from Oct 2022

Refresh:

- This strategy document will be reviewed every 3 years to ensure we aligned with the developing EPR / MIS and other key LMNS/ICS programmes.
- The 3 year plan will be refreshed annually with a report on progress to date

11. Glossary

Glossary:

- **CSNT**: Clinical Negligence Scheme for Trusts
- **CSO**: Clinical Safety Officer
- **CxIO**: Clinical 'Digital' Information Officer
- **DM**: Digital Midwife
- **DMERG**: Digital Midwives Expert reference Group
- **EPR**: Electronic Patient record
- **ICB**: Integrated Care Board
- **ICS**: Integrated Care System
- **LMNS**: Local Maternity & Neonatal System
- **MIS**: Maternity Information Systems
- **MSDS**: Maternity Services Data Set
- **MVP**: Maternity Voices Partnership
- **PCSP**: Personalised Care & Support Plan
- **PDM**: Practice Development Midwife
- **Q & S** : Quality & Safety
- **WGLL**: What Good Looks Like

11. Supporting Information

Supporting Information:

- What Good Looks Like - NHS Transformation Directorate (england.nhs.uk)
- Norfolk & Waveney Digital Maternity Discovery Report - 9th May 2022 - Ethical Healthcare Consulting
- WGLL gap analysis
- Trust strategies
- ICB strategy

Maternity Drivers:

- Better Births Report NHSE - Feb 16
- Safer Maternity Care - Oct 16
- State of Maternity Services RCM - 2018
- The Long Term Plan NHSE - Jan 2019
- Topol Review HEE - Feb 2019
- Saving Lives, Improving Mothers Care MBRRACE - Jan 2021
- Best Start for Life Report DHSC - March 2021
- Maternity Incentive Scheme NHSR - F2b 2022
- Final Report Of The Ockenden Review DHSC - March 2022

NHS
The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Midwifery Digital Strategy

Our one year roadmap

August 2022 - 2023

Approved 22nd September 2022

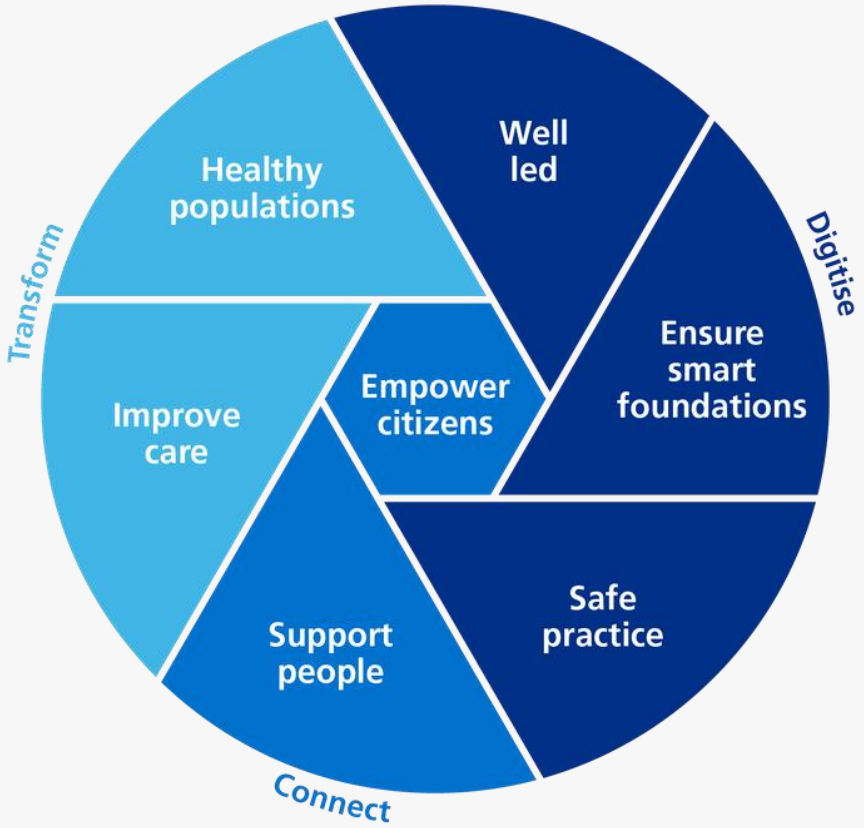
EXCELLENCE STARTS HERE

The Executive Summary

This Digital Maternity Roadmap 'A Strategy for Digital Transformation in Maternity' sets out the vision for the next year.

The strategy is developed against the What Good Looks Like Framework (August 2021) 7 success measures.

It has been developed in line with the system-wide Norfolk and Waveney ICB digital strategy and also supports The Queen Elizabeth Hospital organisational digital strategy.

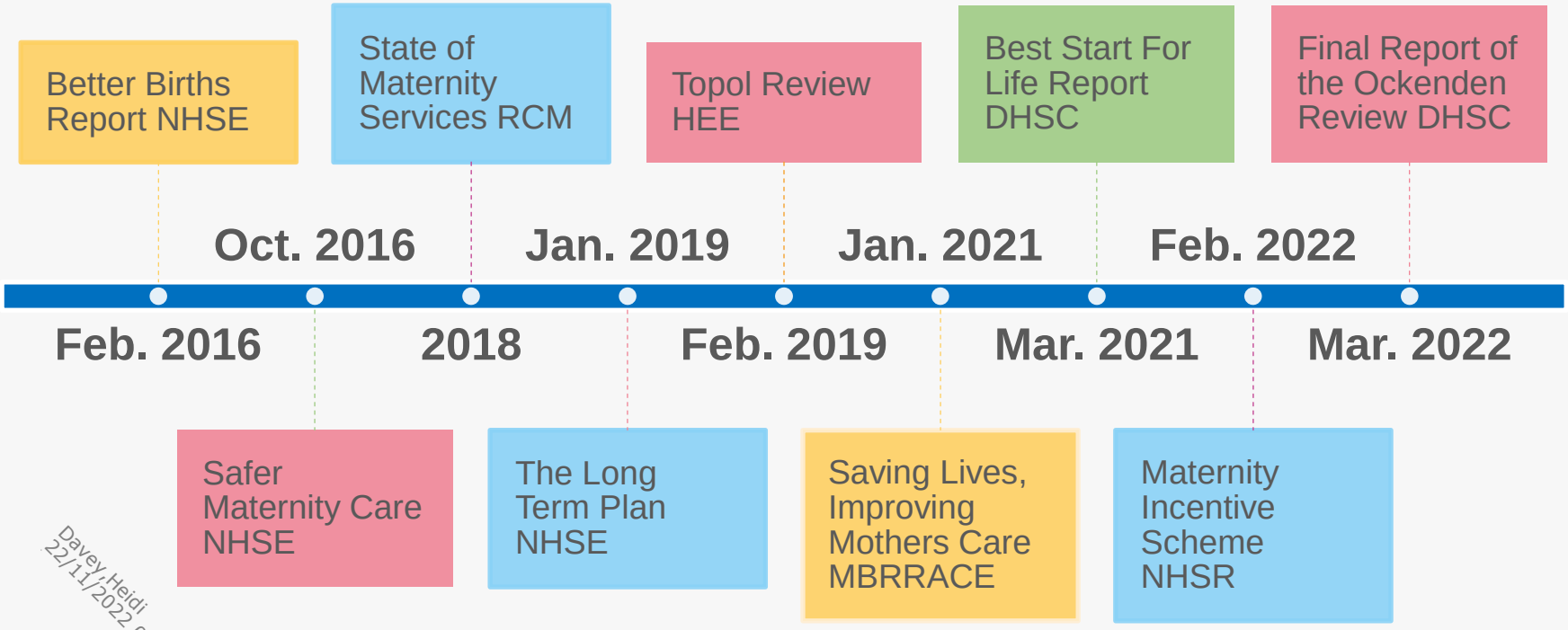


National Context

Digital technology and advancements are changing how maternity care is delivered and this is further driven by consumer expectations to have greater visibility of their clinical maternity record and care plans, results and pregnancy and birth information to enable them to make informed choices about the care they wish to receive. The evolution of technology in healthcare requires a specialised workforce where midwives and maternity multi-professional teams have the skills to use data, information, digital knowledge and technology to deliver person-centred quality care. Ultimately driving safety, providing a better maternity experience for women and their families and improving outcomes.

The previous Health Secretary, Sajid Javid, furthermore identified the power of digital to drive a new era of recovery and reform following the Covid-19 pandemic and focusses on 4 priorities. These are: firstly, making sure the NHS is set up properly for success; secondly, levelling up across the NHS and social care; thirdly, pursuing personalisation; and fourthly, making big breakthroughs on emerging technologies and data.

The "What Good Looks Like (WGLL)" framework provides a vision which outlines the 7 success measures that establish best practice for ICBs and organisation to accelerate digital transformation. The framework identifies how this applies specifically to nursing and has been adapted for use by midwives and midwifery leaders. It provides objectives and a blueprint of how leaders can facilitate digital transformation locally and for the profession. This provides impetus for the professionalism of digital maternity leader and midwife roles within organisations.



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Digital Maternity Drivers

Background and Local Context

Our Vision is to be the best rural District General Hospital for patient and staff experience. Our mission is working with patients, staff and partners to improve the health and clinical outcomes of our local communities.

Our Maternity Service is a shared Midwife and Consultant service covering King's Lynn and the surrounding area. We provide antenatal care at The Queen Elizabeth Hospital King's Lynn; at Rowan Lodge, which is based within North Cambridgeshire Hospital; Maple Hub in King's Lynn and Juniper Hub situated in Downham. We offer choice to women around labour and birth with settings in the Central Delivery Suite, Waterlily our midwifery-led birthing unit and a homebirth service.

Our vision is to deliver compassionate and safe care for our women, children and families. We will do this by listening and working together to ensure the best outcomes are achieved.

In July 2022 , we saw our newly revamped Brancaster Unit open. During the initial plans for development, it was important we thought about future digital development. To continue modernising our estate we have installed ethernet ports to enable E-CTG and with the personal use of USB ports available for our women to utilise.

The use of Badgernet has enabled us to support our MSDS data and streamline approach

From August 2021 to August 2022 our annual birth rate was 2031 babies born.

Maternity Digital Landscape

We currently have a ‘paper light Maternity Information System’ in place called BadgerNet provided by CleverMed. Our Maternity Services are not currently utilising the system to its full capacity but are working towards this at pace.

BadgerNet allows real-time recording of all pregnancy events where ever they occur; in the community, hospital or home. This includes high risk and low risk pregnancy pathways. Based on women-centred care models, the BadgerNet Maternity system comes with a portal for women to access their own maternity records via a web browser or smart device. Enabling women to document journeys through their pregnancy diary, upload images while creating their pregnancy memories.

To access BadgerNet, we have iPads enabled with the BadgerNet App with online and offline capabilities, a desktop application that can go entirely offline, and access to national servers

anywhere there is a secure connection. We have made great progress with the supply of new iPads to our community and core midwives, with another batch arriving soon. This will enable all midwives to access and utilise their own individual iPads to support accessibility across the workforce.

Further scope for development would be to enable future accessibility and connectivity within our local community.

We are aware of some challenges we are currently facing within our infrastructure within Norfolk. The community teams are Aware of the common geographical areas with connectivity concerns.

BadgerNet allows women to access their summary maternity data online. As a fully opt-in

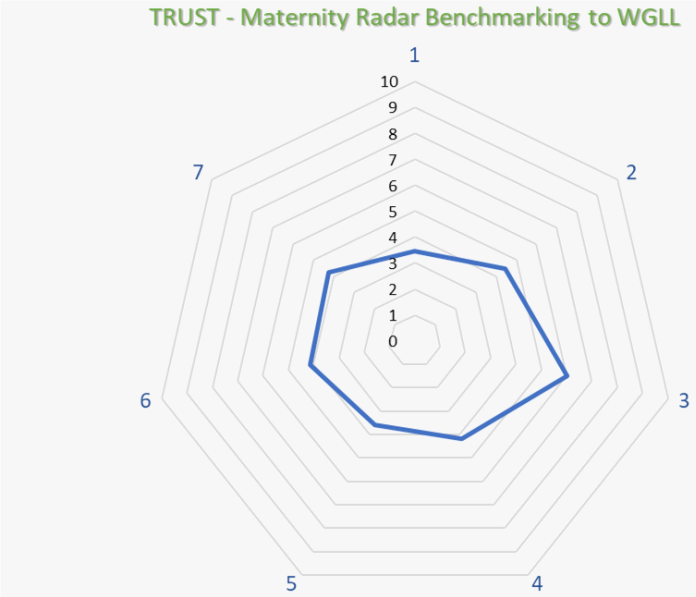
process, women can choose to see their pregnancy details on a dedicated iphone app or over a web browser.

In addition women can contribute to their record, allowing for feedback and birth plans to directly fed back into the clinical record.

Maternity Mapping to the What Good Looks Like

We have developed our Digital Roadmap for Midwifery aligned to the seven What Good Looks Like success measures and the wider strategic goals of The Queen Elizabeth Hospital and/or Norfolk and Waveney ICB Strategic Plan.

1. Well led
2. Ensure smart foundations
3. Safe practice
4. Support people
5. Empower citizens
6. Improve care
7. Healthy populations



Well Led

What we will do:

- Recruit to a substantive Digital Midwife in 2022
- Digital Leadership Academy
- Ensure Digital Midwife/ Digital Team are well connected with the wider Trust and represented at all Trust and system wide meetings
- Support the involvement of all of our teams within W&C to support and identify future data and digital opportunities to join up care.

What does good look like for your ICS:

Has a clear strategy for digital transformation and collaboration. Leaders across the ICS collectively own and drive the digital transformation journey, placing citizens and frontline perspectives at the centre. All leaders promote digitally enabled transformation to efficiently deliver safe, high-quality care.

Integrated Care Boards (ICBs) build digital and data expertise and accountability into their leadership and governance arrangements and ensure delivery of the system-wide digital and data strategy.

What does good look like for your organisation:

Boards are equipped to lead digital transformation and collaboration. They own and drive the digitally enabled transformation journey, placing citizens and frontline perspectives at the centre

Ensure Smart Foundations

What we will do:

- To ensure midwifes are provided with protected time to help design, implement, test and evaluate our Maternity Information system and any technology used within the service.
- Ensure we are sharing best practice across the region
- Implement ‘why data matters’ workshops for colleagues
- Continue to maintain stakeholder relationships with the MVP.

What does good look like for your ICS:

Digital, data and infrastructure operating environments are reliable, modern, secure, sustainable and resilient. Across your ICS, all organisations have well-resourced teams who are competent to deliver modern digital and data services.

What does good look like for your organisation:

Digital, data and infrastructure operating environments are reliable, modern, secure, sustainable and resilient. Organisations have well-resourced teams who are competent to deliver modern digital and data services.

Safe Practice

What we will do:

- Connect maternity staff with the trusts Clinical safety officer (CSO) through engagement and clinical forums to ensure safe midwifery practice and digital clinical safety.
- Collaborative working across the LMNS to identify risks associate with digital maturity and reviewing sustainability and resilience of our current EPR.
- Appoint Badgernet Champions in clinical areas to support training and development of all staff members.
- Educate managers and digital leaders on the structured approach to promote and ensure safe effective applications of clinical risk management by organisations responsible for the development and maintenance of health IT systems and its use within the health care system and environment, - This standard gives staff and patients confidence that digital health technology meets NHS standards.

What does good look like for your ICS:

Organisations across the ICS maintain standards for safe care, as set out by the Digital Technology Assessment Criteria for health and social care (DTAC). They routinely review system-wide security, sustainability and resilience.

What does good look like for your organisation:

Organisations maintain standards for safe care. They routinely review digital and data systems to ensure they are safe, robust, secure, sustainable and resilient. Digitally-enabled outcome-driven transformation is at the heart of safe care.

Support People

What we will do:

- Ensure all staff have access to the technology and up to date services that best support their roles
- To collaborate a training system with the PDM and digital team to support further training for all members of staff
- Roll out of clinical forums to increase engagement through learning and development opportunities.
- Update maternity teams on the Digital Literacy Self Assessment Diagnostic tool and the importance of engagement to support self assessment digital literacy skills. Develop a learning needs analysis to support digital maturity and increase awareness through anonymous data to increase training needs.
- Support the roll out of the Badger Link.

What does good look like for your ICS/organisation:

Your workforce is digitally literate and able to work optimally with data and technology. Digital and data tools and systems are fit for purpose and support staff to do their jobs well.

Empower Citizens

What we will do:

- Support the incorporation and work with the MVP to enable their voices to be heard through listening events to gauge findings, share experiences and to design digitally enabled care, with the incorporation of our Badgernet Portal
- Empower colleagues to provide feedback, thoughts and ideas within our service design. What would our staff like to see.
- "Meet the teams" – to enable a visual design for our women and their families.
- To support digital exclusion, to not leave anyone behind. To support staff, increase their awareness and support their usage on digital elements.

What does good look like for your ICS/organisation:

Citizens are at the centre of service design and have access to a standard set of digital services that suit all literacy and digital inclusion needs. Citizens can access and contribute to their healthcare information, taking an active role in their health and well-being.

Improve Care

What we will do:

- Shared approach with our local universities and PDMs to enable a shared vision on digital safety and creating a digital culture to support midwifery practice.
- Incorporate additional training within the preceptorship period, incorporate within the induction period and engage through feedback sessions.
- Work in partnership with the CNO to obtain leadership programmes which can support the development and improve quality outcome through data improvement and digital priorities.

What does good look like for your ICS:

Your ICS embeds digital and data within their improvement capability to transform care pathways, reduce unwarranted variation and improve health and wellbeing. Digital solutions enhance services for patients and ensure that they get the right care when they need it and in the right place across the whole ICS.

What does good look like for your organisation:

Health and care practitioners embed digital and data within their improvement capability to transform care pathways, reduce unwarranted variation and improve health and wellbeing. Digital solutions enhance services for patients and ensure that they get the right care when they need it and in the right place

Healthy Populations

What we will do:

- Collaborate with midwives and managers to identify through data analysis population health gaps to enable us to ascertain and to advocate for their inclusion.
- Draw up plans to improve inclusion and embark on a project to enable data to close the gap . Informatics support will enable consistent collection of data, allow us to understand the data and act on the data provided to increase patient outcomes and digital maturity.
- Development strategies are in the process with Clevermed to enable non –English speaking women to access their portal within their own language.

What does good look like for your ICS:

Your ICS uses data to design and deliver improvements to population health and wellbeing, making best use of collective resources. Insights from data are used to improve outcomes and address health inequalities.

What does good look like for your organisation:

Organisations use data to inform their own care planning and support the development and adoption of innovative ICS-led, population-based, digitally-driven models of care.

Digital Maternity Road Map

Ensure we are sharing best practice across the region

Connect maternity staff with the trusts Clinical safety officer (CSO) through engagement and clinical forums to ensure safe midwifery practice and digital clinical safety.

Recruitment substantive Digital Midwife

The roll out of Badger link

Empower colleagues to provide feedback, thoughts and ideas within our service design. What would our staff like to see.

Improving lives **together**

Norfolk and Waveney Integrated Care System

Integrated Care Board Finance Report

October (month 07)

Board: 22nd November 2022

Contents

1. Executive Highlights

Integrated Care Board (ICB) statutory organisation

- This report represents the year-to-date August position of the organisation – this comprises the April to June CCG position (pre-audit), plus the July to October ICB position.
- The consolidated CCG and ICB has reported a **year-to-date break-even position**, which is in line with the plan submission, this is a result of some offsetting variances, the major items being:
  - £(2.4)m increase in acute independent sector activity;
  - £(1.6)m Elective Recovery Fund underachievement;
  - £(0.6)m increases in Community Equipment supporting acute provider discharges;
  - £(2.9)m non-achievement of system back office efficiency target;
  - £(1.8)m Continuing Health Care (CHC) expensive high acuity cases and excess inflation above funded levels; offset by
  - £2.6m benefit relating to the movements against year-end accruals in CHC, Primary Care and Prescribing;
  - £4.7m benefit relating to the availability of non-recurrent mitigations;
  - £1.5m of combined smaller favourable benefits;
  - £0.5m pay vacancies throughout the organisation.
- The **ICB forecast out-turn (FOT)** position is also a **break-even position**, in line with the plan submission.
- The plan included £5.4m of unmitigated risks in line with NHSEI guidance – relating to excess CHC inflation and Elective Recovery Fund (ERF) income – £3.1m has crystalised in the year-to-date position and £5.2m is forecast for the full year.
- The full value of potential risks to the forecast out-turn position amount to £13.4m (M06 £17.7m) – these are items which have not yet crystalised but have been identified as having the possibility of producing a financial issue.

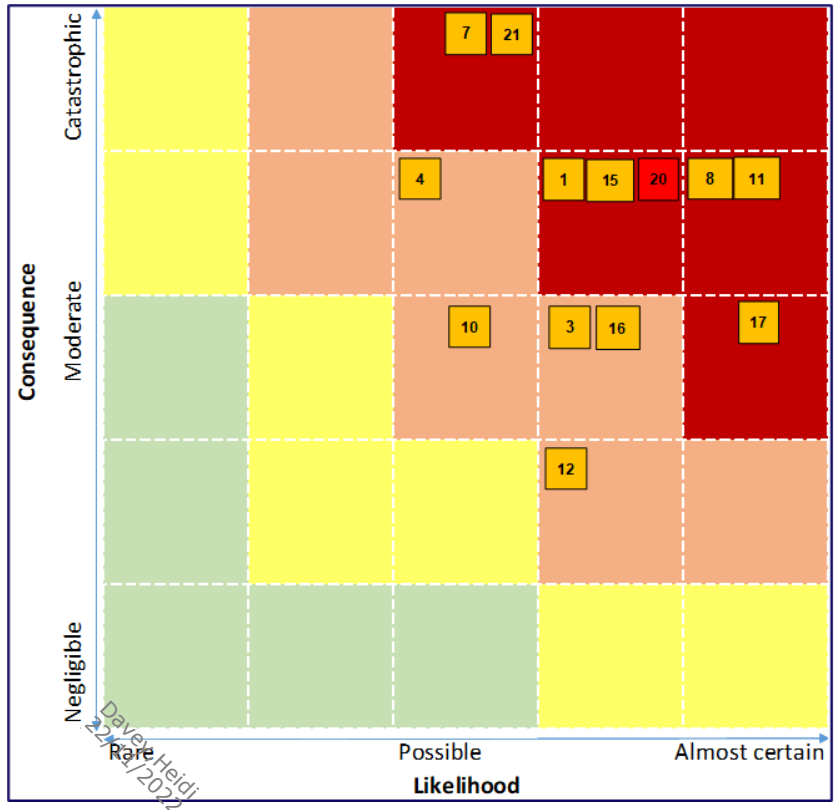
Integrated Care System (ICS)

- The combined ICS has a **year-to-date deficit position of £7.6m**, which is adverse to plan by £5.1m. This is driven by deficits at the JPUH (£3.4m) and QEH (£1.3m) and NNUH (£0.6m).
- The **ICS FOT** position remains at **break-even**, in line with the plan submission on 20th June.

2. ICB Strategic Financial Risks

This risk dashboard categorises the key financial strategic risks by their impact and likelihood:

Key: = Worsening Risk = Stable risk = Improving risk



Financial Strategic Risks	Ref.	Details	Risk appetite	Aug-22	Sep-22	Oct-22	Nov-22
Achievement of Financial plan	1	Achieve the 2022/23 financial plan **(BAF 11)**	8	16	16	16	16
	3	Transition following end of HDP top up allocations	6	9	9	12	12
	12	Personal Health Budgets (PHB)	4	8	8	8	8
	15	Underlying deficit position **(BAF 11A)**	12	20	20	20	20
	16	Capita - Primary Care payments	9	12	12	12	12
	17	Inflationary pressures	9	15	15	15	15
	19	ISP patient choice	9				
	20	Impact of new prescribing guidance	8	12	12	12	16
	21	Impact of Direct Commissioing transfer		15	15	15	15
Demand and capacity	4	Capacity increases in response to COVID continue	8	12	12	12	12
	5	System approach to service redesign	9				
	7	Continuing Health Care demand growth	6	15	15	15	15
	9	Acute demand management	8				
	10	Treatment breaks / cancelled operations	6	9	9	9	9
	11	RTT backlog and Acute demand management	10	20	20	20	20
	18	Care Home capacity	12				
Efficiency	8	Efficiency, transformation development/delivery	8	16	16	20	20

There has been an increase in one risk in month, relating to the increased costs arising in Risk 20 – Impact of new prescribing guidance. The ICB has seen £0.87m year-to-date expenditure relating to Diabetic Glucose Monitoring which has not been funded.

Of the thirteen open risks eight are rated as extreme (score of between 15 and 25):

- Five specifically relating to the Achievement of the Financial Plan risks;
- Two specifically relating to Demand and Capacity risks; and
- One relating to Efficiency delivery risks.

None of the open risks are currently at their tolerated risk appetite and ongoing management actions are in place to monitor and mitigate the impact of these risks.

3. ICB Statement of Financial Position (SOFP)

The Statement of Financial Position presents the aggregate closing position of the ICB as at 31st October 2022.

Non Current assets: IFRS16 was implemented in April 2022, this resulted in the inclusion of right of use assets relating to the lease of the premises in King's Lynn. A corresponding entry is also included in Lease Liabilities.

Current assets: Total current assets have decreased since year end, driven principally by aged debtors and cash. The £8.5m balance is made up of aged debtors of £7.2m (including HEE £3m, NCC £1.8m and North West London ICB £0.9m), net of a provision against this balance of £3.1m, together with prepayments and accrued income of £4.4m. Trade debtors are subject to a quarterly review of bad debt for provision or write off, which are presented to the Audit Committee.

Current liabilities: Total current liabilities have decreased by £28m since year end driven principally by ICB and system invoice accrual timing. The £165m balance is made up of trade creditors of £5m, Prescription Pricing Authority accruals of £17m, payroll costs including GP pensions of £3m, deferred income of £10m, prior year accruals of £63m and ICB and system invoice accruals of £67m. Provisions have increased since year end and include legal, staffing, estates costs, prescribing and elective recovery claw-back for 2021/22.

Long Term liabilities: This balance is the deferred income relating to research & development programmes which are funded in advance.

Taxpayers equity: The ICB is directly funded by NHSE with cash allocated on a monthly basis. Any future commitments to balance the general fund shortfall will be supported by the next months cash request from NHSE. This will however continue to remain negative as the NHSE principle is that cash should only be drawn based upon one months commitment at a time.

NHS NORFOLK & WAVENEY ICB STATEMENT OF FINANCIAL POSITION	Position as at 31/03/22	Position as at 30/09/22	Position as at 31/10/22
ASSETS EMPLOYED			
Non-Current assets			
Right-of-use-Assets	0	66	66
Accumulated Depreciation	0	(27)	(31)
Total non-current assets	0	39	35
Current assets			
Trade and Other Receivables	9,552	4,172	8,502
Cash and Cash Equivalents (less Cash in Hand)	1,481	426	457
Cash in Hand	0	0	0
Total current assets	11,033	4,598	8,959
Current liabilities			
Trade and Other Payables	(195,365)	(170,217)	(164,860)
Lease Liabilities	0	(53)	(40)
Provisions for liabilities and charges (including non-current)	(5,194)	(7,473)	(7,285)
Total current liabilities	(200,559)	(177,743)	(172,185)
Long Term liabilities			
Non-Current Payables	(612)	(612)	(612)
Total non-current liabilities	(612)	(612)	(612)
Net assets employed	(190,138)	(173,718)	(163,803)
FINANCED BY TAXPAYERS EQUITY			
General fund	(190,138)	(173,718)	(163,803)
Total taxpayers equity	(190,138)	(173,718)	(163,803)

4. Operational Risks and Mitigations

The table opposite identifies the significant Financial risks the ICB is experiencing, including the impact that has crystalised in the year-to-date position, of £7.6m ❶; together with the risk that is included within the year end forecast position (FOT), £16.8m ❷ (£11.9m M06).

FOT risk includes £5.2m of risk identified within the planning submission relating to CHC excess inflation (£2.4m ❸) and ERF income (£2.8m ❹).

In addition, the ICB has identified a net potential uncrystallised unmitigated risk of £13.3m ❺ (M06 = £17.7m), of this, £3.6m ❻ relates to system risk that is being "held" by the ICB. The reduction in risk not in the FOT is predominately due to the crystalisation of the system Back Office staff efficiency scheme not delivering, this has been offset by non-recurrent mitigations.

BAF Reference	Risk Ref.	Risk Details	Risk Score	Prior Month	YTD Crystalised £m	Crystalised in FOT £m	Not in FOT £m
N/a	1	**If** Prescribing for Mental Health continues to reduce **then** further Investment will be needed to ensure delivery of the Mental Health Investment Standard which will exceed the ICBs budget.	3 x 4 = 12	3 x 4 = 12	0.0	1.0	0.0
FINCOM19	2	**If** the Independent Sector Acute activity for Ophthalmology increases **then** the ICB will exceed the Acute budgets.	4 x 3 = 12	4 x 3 = 12	1.3	3.5	0.3
N/a	3	**If** the Integrated Community Equipment Store Prices and Volume increase **then** the ICB will exceed the Community budgets.	4 x 3 = 12	4 x 3 = 12	0.3	0.5	0.0
FINCOM08	4	**If** the ICB does not deliver the Efficiency plans embedded in its forecast **then** the ICB will exceed the budgeted spend (Schemes identified as High or Medium Risk)	4 x 4 = 16	4 x 4 = 16	0.0	1.6	1.6
FINCOM20	5	**If** the uptake of the Continued Glucose Monitoring Testing and Drugs is undertaken following NICE guidance **then** the ICB will exceed the GP Prescribing budgets.	3 x 4 = 12	3 x 4 = 12	0.0	0.0	3.6
FINCOM07	6	**If** the Continuing Health Care Non-NHS market Price Rises exceed the forecasted 11% rise overall **then** the ICS will exceed the budget.	3 x 5 = 15	3 x 5 = 15	1.5	2.4 ❸	0.7
FINCOM11	7	If additional ERF activity is not achieved then this causes a full year financial adverse variance.	5 x 4 = 20	5 x 4 = 20	1.6	2.8 ❹	0.0
N/a	8	**If** the ICS System partners do not achieve the Efficiency Savings in relation to the Back Office Staff **then** the ICB who hold the gross £(5)m budget will exceed the budget.	5 x 4 = 20	5 x 4 = 20	2.9	5.0	0.0 ❻
N/a	9	**If** the ICS do not defer the System Development Fund projects **then** the slippage assumed in the plan will not be achieved and the ICB will exceed the budget.	3 x 4 = 12	3 x 4 = 12	0.0	0.0	3.6 ❻
N/a	10	Aggregated other smaller Risks across all portfolios	2 x 3 = 6	2 x 3 = 6	0.0	0.0	6.9
		Total Risks			❶ **7.6**	❷ **16.8**	**16.7**
N/a	1	Aggregated other smaller Mitigations across all portfolios	2 x 3 = 6	2 x 3 = 6	(7.6)	(16.8)	(3.4)
		Total Mitigations			**(7.6)**	**(16.8)**	**(3.4)**
FINCOM01		**Total Financial Impact of assessed risk less identified mitigations**	4 x 4 = 16	4 x 4 = 16	**0.0**	**0.0**	**13.3** ❺

5. ICS Financial summary (1 of 2)

Revenue position: The system financial performance is extracted from the month 7 (October) "heads up" draft NHSE/I submissions.

The position M7 YTD is a £7.6m deficit, £5.1m adverse to plan.

The most significant variances are as follows:

- JPUH: activity performance achieves the 104%, which achieves baseline Elective Recovery Fund targets but not the additional income over and above this in the plan, in addition, costs have increased due to additional bedded capacity.
- QEH: in line with previous months, driven by high temporary pay costs.
- NNUH: adverse variance resulting from timing of Cost Improvement Plans (CIP) and the additional costs of delivering the significant additional open capacity due to patient volumes with no right to reside.

All system organisations are reporting a break even forecast outturn.

Capital position (Capital Delegated Expenditure Limit – CDEL): Year-to-date the system CDEL expenditure as at October was £37.4m, £12.6m lower than below plan.

All organisations had an underspend on core projects mainly due to delays in project roll out.

The full year forecast remains in line with full year planned levels, however, there are technical overspends at QEH due to the re-categorisation of funding source for digital maturity expenditure and at NNUH resulting from the mandated accounting treatment for capitalised leased assets under IFRS 16.

Revenue surplus/(deficit)	M7 YTD			Forecast Outturn		
Organisation	Plan	Actual	Variance Fav/ (Adv)	Plan	Actual	Variance Fav/ (Adv)
	£m	£m	£m	£m	£m	£m
JPH	(2.2)	(5.6)	(3.4)	0.0	(0.0)	(0.0)
NNUH	1.3	0.7	(0.6)	0.0	(0.0)	(0.0)
QEH	(2.2)	(3.5)	(1.3)	0.0	0.0	0.0
NSFT	0.0	0.0	0.0	0.0	0.0	0.0
NCH&C	0.6	0.8	0.2	0.0	0.0	0.0
Provider Subtotal	**(2.5)**	**(7.6)**	**(5.1)**	**0.0**	**0.0**	**0.0**
ICB	0.0	0.0	0.0	0.0	0.0	0.0
N&W System Total	**(2.5)**	**(7.6)**	**(5.1)**	**0.0**	**0.0**	**0.0**

System CDEL	M7 YTD			Forecast Outturn		
Organisation	Plan	Actual	Variance (Under)/ Over	Plan	Actual	Variance (Under)/ Over
JPH	8.7	4.6	(4.0)	24.6	24.6	(0.0)
NNUH	12.7	11.5	(1.2)	17.9	19.5	1.6
QEH	17.5	15.1	(2.4)	40.5	42.5	1.9
NSFT	7.3	4.1	(3.2)	9.8	9.8	(0.0)
NCH&C	4.0	2.1	(1.8)	6.0	6.0	0.0
N&W System Total	**50.1**	**37.4**	**(12.6)**	**98.9**	**102.4**	**3.5**

5. ICS Financial summary (2 of 2)

Protocol for change to an in-year financial forecast:

- On 7th November 2022, NHSE/I released the above guidance - mandates the steps and additional controls that will be imposes for both systems and individual organisation prior to moving away from a break-even year-end forecast out-turn (FOT).

- ***Timing:*** the protocol notes that changes would not be expected in the early months of the year and that changes in the final quarter will be looked on as a sign of very poor financial control likely to attract further scrutiny, therefore, changes if any are anticipated to be made in month 8 or 9.

- ***Pre-conditions***: As a pre-condition to invoking the protocol, the system must evidence that all the actions detailed in the operational planning round letter dated 20 May 2022 from Julian Kelly (NHSE/I National CFO) have been completed, these include evidencing key lines of enquiry produced for plans / establishing processes to monitor agency, bank and consultancy spend usage controls / bridge workforce from pre-pandemic workforce showing where additional staff have been deployed / Compliance with the “Getting the basics right” check list and action plans thereafter.

- ***Conditions and associated consequences:*** these are split into two categories

  1. Where an **NHS Provider** (or more than one) wishes to report a forecast deterioration to plan which the system can absorb, the system will oversee the conditions, which include: Complete variance analysis presented to system leaders explaining underlying causes / A recovery plan showing steps taken and to be taken / Evidence of sign-off by the whole executive team of the Provider and the Board / Independent review by a neighbouring provider. With a summary of these actions submitted to NHSE/I regional team.

  The consequences will be an implementation of a “double-lock sign off” process for any revenue investments greater than £50k, by organisation and system / complete workforce review / additional financial and reporting requirements may be imposed on the provider by the system.

  2. Where an **ICB and/or system** wishes to forecast as deficit position the NHSE/I regional team will oversee the meeting of the conditions above.

  The consequences will be an implementation of a “triple-lock sign off” process for any revenue investments greater than £100k, by organisation and system and NHSE/I / NHSE/I Regional Director of Finance will attend the system Finance Committee / additional financial and reporting requirements may be imposed on the system by NHSE/I / efforts to reduce pay costs / formal review of capital allocations .

Glossary of terms (1)

Term	Description
BCF: Better Care Fund	A programme which supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers.
BPPC: Better Payment Practice Code	The NHS national payments code for good practice with associated mandated reporting. Sets a target of 95% compliance of paying suppliers within 30 days.
Cat M: Category M drugs	Part of the Drug Tariff which is used to set the reimbursement prices of over 500 medicines. It is the principal price adjustment mechanism to ensure delivery of the retained margin guaranteed as part of the contractual framework, using information gathered from manufacturers on volumes and prices of products sold plus information from the Pricing Authority on dispensing volumes to set prices each quarter.
CIP: Cost Improvement Programme	A provider measure of Efficiency and Productivity.
CHC: Continuing Health Care	A package of care for adults aged 18 or over which is arranged and funded solely by the NHS. In order to receive funding individuals have to be assessed according to a legally prescribed decision making process to determine whether the individual has a ‘primary health need’.
GIRFT: Get It Right First Time	A national programme designed to improve the treatment and care of patients by reviewing health services. The programme undertakes clinically-led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.
GMS: General Medical Services	Contract which forms the basis of the relationship between the NHS and its GP contractors. The current contract came into force on 1 April 2004 and has been negotiated and updated annually between NHS Employers and the British Medical Association (BMA) since then. It is based upon a multi facetted formula which identifies spend and applies specific ratios resulting in an overall annual percentage pay award for each practice.
GPFV: General Practice Forward View	National development programme of investment in workforce, technology and estates designed to speed up transformation of General Practice services.
HDP: Hospital Discharge Programme	National funding stream to enable earlier discharge increasing flow in the system and release capacity in the acute hospitals.
LCS / LES: Locally Commissioned Services or Locally Enhanced Services	Services provided by GP practices that are either enhanced or additional to the core services offered. These are generally commissioned to meet a local need based on either deprivation or proximity to existing services. Includes services such as phlebotomy, anti-coagulation, atrial fibrillation and care homes. They can reduce onward referrals to Acute settings and funding is separate to practices core contracts.
Model Hospital	An NHS digital information service designed to help the NHS improve productivity, quality and efficiency. Enables health systems and trusts to compare their productivity and quality, and identify opportunities to improve.

Glossary of terms (2)

Term	Description
MHIS: Mental Health Investment Standard	The nationally set requirement for ICBs to increase investment in Mental Health services in line with their overall increase in allocation each year. This is subject to separate external audit on an annual basis to confirm compliance.
NCSO: No Cheaper Stock Obtainable	Items for which in the opinion of the Secretary of State for Health there is no product available to contractors at the price in Part VIII of the Drug Tariff, generally resulting in a higher priced product having to be used.
PHM: Population Health Management	An approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population by focusing on the wider determinants of health by using data to design new models of proactive care and deliver improvements in health and wellbeing which make best use of the collective resources.
PLICS: Patient Level Information and Costing Systems	Costing system which brings together healthcare activity information with financial information in one place. PLICS provides detailed information about how resources are used at patient-level, for example, staff, drugs, and diagnostic tests and combined with other data sources, provides trusts with a rich source of information to help understand their patients and their services.
PMS: Personal Medical Services	Voluntary option for GPs and other NHS staff to enter into locally negotiated contracts. PMS contracts offer local flexibility compared to the nationally negotiated GMS contracts by offering variation in the range of services which may be provided by the practice, the financial arrangements for those services and the provider structure (who can hold a contract).
QIPP: Quality, Innovation, Productivity and Prevention	The collective measure of system transformation efficiencies and productivity.
QOF: Quality and Outcomes Framework payments	This is a voluntary annual reward and incentive programme for all GP practices in England, detailing practice achievement results. It is not about performance management but resourcing and rewarding good practice.
Rightcare	Teams who work locally with systems to present a diagnosis of data and evidence across that population, working collaboratively with systems to look at the evidence to identify opportunities and potential threats. They use nationally collected robust data to complete delivery plans on a continuous basis, to evaluate the system and establish a base plan to maximise opportunities and turnaround issues.
Running costs / Programme costs	Running costs represent the costs of administering the ICB and the work it carries out / Programme costs represent the costs of services commissioned by the ICB.
s.117: Section 117 of Mental Health Act 1983	Entitlement to free after-care if a patient has been in hospital under specific sections of the Mental Health Act 1983. It meets the needs that a patient has because of the mental health condition that caused them to be detained and is designed to reduce the chance of the condition getting worse so avoiding a return to hospital.

Norfolk and Waveney
Integrated Care Board

Agenda item: 12

Subject:	**Month 7 (October) ICB Finance Report**
Presented by:	**Jason Hollidge, Director of Commissioning Finance**
Prepared by:	**ICB Finance Team**
Submitted to:	**ICB Board**
Date:	**22 November 2022**

Purpose of paper:

To review the financial performance and financial risk of the Norfolk and Waveney Integrated Care Board, as a statutory organisation.

Executive Summary:

Integrated Care Board (ICB) statutory organization has reported a year-to-date break-even position, which is in line with the plan submission.

The ICB forecast out-turn (FOT) position is also a break-even position, in line with the plan submission on 20th June (as part of the system plan).

The full value of potential risks to the full year position amount to £13.4m (M05 £16.3m) – these are items which have not yet crystalised but have been identified as having the possibility of producing a financial issue.

The combined Integrated Care System (ICS) has a year-to-date deficit position of £7.6m, which is adverse to plan by £5.1m.

This is driven by deficits at the JPUH (£3.4m) and QEH (£1.3m) and NNUH (£0.6m).

The ICS FOT position remains at break-even, in line with the plan submission on 20th June.

Report

As attached

Recommendation to the Finance Committee:

This report is presented for information.

Key Risks	
Clinical and Quality:	None
Finance and Performance:	Achievement of Financial plan
Impact Assessment (environmental and equalities):	None
Reputation:	The achievement of the plan impacts the CCGs reputation with NHSE/I.
Legal:	None
Information Governance:	None
Resource Required:	None
Reference document(s):	NHSE/I guidance and communications
NHS Constitution:	None
Conflicts of Interest:	None
Reference to relevant risk on the Board Assurance Framework	None

Governance

Process/Committee approval with date(s) (as appropriate)	N/a

NHS
Norfolk and Waveney
Integrated Care Board

Agenda item: 13

Subject:	**Board Assurance Framework (BAF)**
Presented by:	**Karen Barker, Director Corporate Affairs and ICS Development NHS Norfolk and Waveney ICB**
Prepared by:	**Martyn Fitt, Corporate Affairs Manager NHS Norfolk and Waveney ICB**
Submitted to:	**ICB Board**
Date:	**22 November 2022**

Purpose of paper:

To present the Board with a copy of the ICB's Board Assurance Framework (BAF)

Executive Summary:

The Board is presented with a copy of the ICB's Board Assurance Framework (BAF) and associated risk visual (below.)

Effective risk management is an essential part of the ICB's system of internal control and supports the provision of a fair and well-illustrated Annual Governance Statement

Since the ICB's last Board meeting on 27 September 2022 the BAF has been reviewed in full by the Executive Directors. Accordingly, the Board is asked to note the following updates:

- **BAF05b Barriers to full delivery of the mental health transformation programme (CYP)**. Following a comprehensive review of the actions and delivery against these targets, the mitigated risk has increased to 4x4=16. Full updates have been provided to support the increase in risk.

- **BAF18 Transition and delegation of primary care services**. This is a new risk which has been added to the BAF and is in respect of risks associated with the ICB's responsibility regarding delegated primary care services. Full updates have been provided to support the rationale for the risk being added to the BAF

- **BAF19 Discharge from inpatient settings**. This is a new risk which has been added to the BAF and is regarding the impact on the system caused by patients no longer meeting "criteria to reside". Full updates have been provided to support the rationale for the risk being added to the BAF.

- **BAF20 Industrial Action.** This is a new risk which has been added to the BAF and is in respect of risks associated with the recent strike ballot. Full updates have been provided to support the rationale for the risk being added to the BAF.

Progress on actions recorded at Board
An action was noted at the last Board on 27 September 2022 seeking that ICB's risk appetite be further worked on and inviting the ICB to re-look at a small number of risks which have been scored 'catastrophic' (rating 5) as a consequence.

Accordingly, these matters were discussed and considered at EMT on 10 October 2022, resulting in the change to BAF05b as noted in the above updates. Further, in respect of the other risks associated with a consequence rating of 5 these were considered by the relevant committees. In particular, the ICB's Finance Committee reviewed matters relating to BAF risk 07 and the ICB's Audit and Risk Committee considered matters relating to BAF risks 12 and 13.

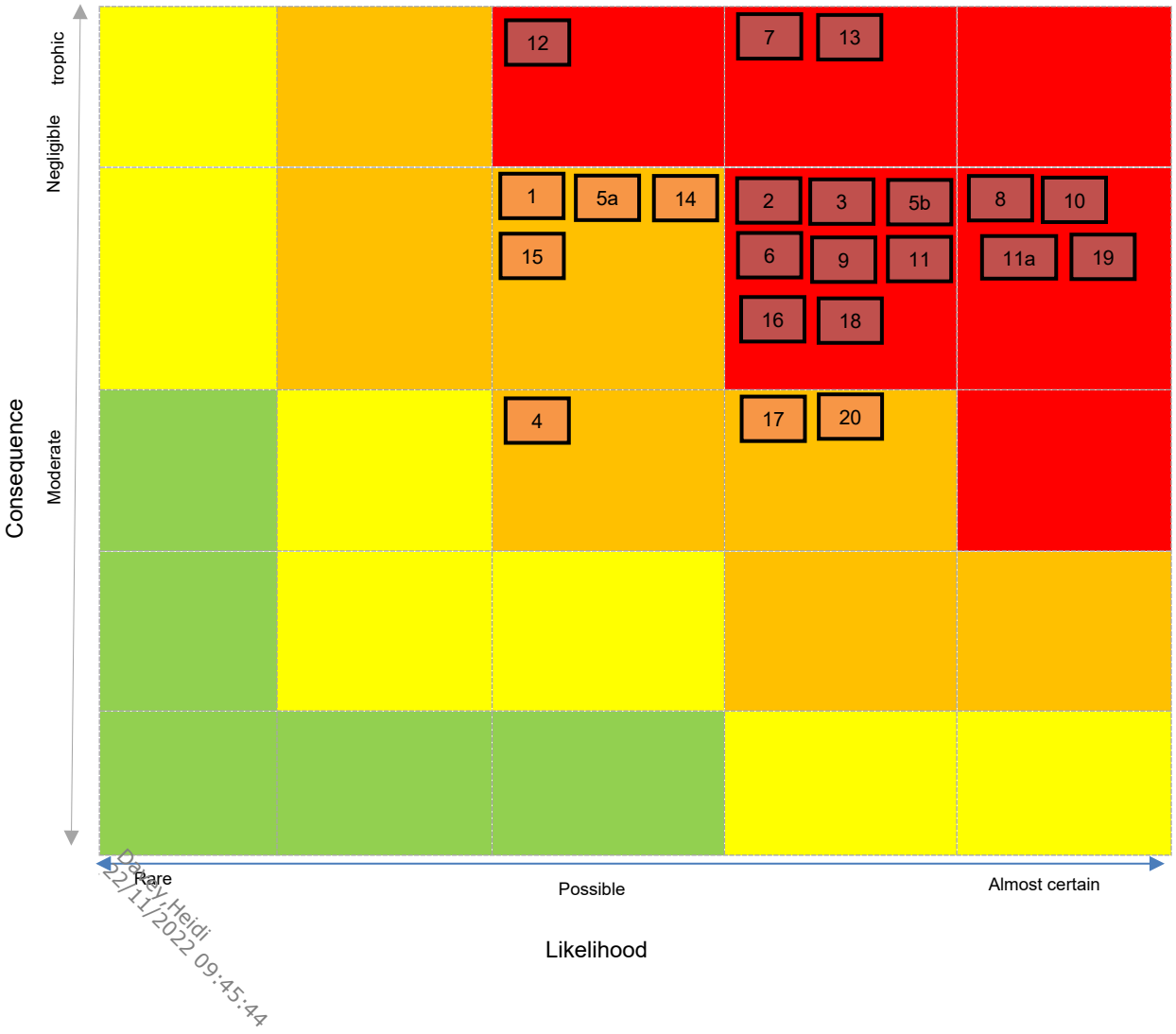
Recommendation to Board:

The Board is asked to:

1. To receive and review the risks presented on the Board Assurance Framework.

Key Risks	
Clinical and Quality:	None
Finance and Performance:	None
Impact Assessment (environmental and equalities):	None
Reputation:	It is important the Board is apprised of the key risks in the organisation currently.
Legal:	N/A
Information Governance:	N/A
Resource Required:	Corporate Affairs risk management resource
Reference document(s):	None
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	See table.

Risk visual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NHS Norfolk and Waveney ICB – Board Assurance Framework (BAF)

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

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

Summary of risks

Ref.	Risk Title	2022-2023 Monthly Risk Rating											
		1	2	3	4	5	6	7	8	9	10	11	12
BAF 01	Living with COVID-19				12	12	12	12	12				
BAF 02	System Urgent & Emergency Care				16	16	16	20	20				
BAF 03	Providers in CQC 'Inadequate' Special Measures (NSFT)				16	16	16	16	16				
BAF 04	Cancer Diagnosis and Treatment				9	9	9	9	9				
BAF 05a	Barriers to Full Delivery of the Mental Health Transformation Programme (Adult)				12	12	12	12	12				
BAF 05b	Barriers to Full Delivery of the Mental Health Transformation Programme (CYP)				12	12	12	16	16				
BAF 06	Health Inequalities				12	12	16	16	16				
BAF 07	RAAC Planks				20	20	20	20	20				
BAF 08	Elective Recovery				20	20	20	20	20				
BAF 09	NHS Continuing Healthcare				16	16	16	16	16				
BAF 10	EEAST Response Time and Patient Harms				16	20	20	20	20				
BAF 11	Achieve the 2022/23 Financial Plan				16	16	16	16	16				
BAF 11a	Underlying Deficit Position				20	20	20	20	20				
BAF 19	Discharge from impatient settings												

BAF01	
Risk Title	Living with COVID-19
Risk Description	There is continued risk that new variants may contribute to increase in transmission and alter severity of illness. The local healthcare system is currently going through a period of high system pressure set against recovery, and compliance with robust Infection Prevention and Control Measures.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Tricia D'Orsi	Quality & Safety	Karen Watts	01/07/2022	31/03/2023

Risk Scores

Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	3	15	4	3	12	2	3	6

Controls	Assurances on controls
• Local testing options reflect national guidance. • A system approach to managing positive and asymptomatic patients has been agreed reflecting national guidance with local risk assessment as required. • The vaccination programme has been accelerated and is delivering against national plan. September booster programme for COVID-19 and Flu has commenced. • Vaccination sites are managing their capacity against need. There is a mixed model of vaccination delivery that is inclusive of harder to reach groups and wherever possible, Flu vaccinations have been co-administered. • Protect NoW is focusing on health inequalities and outreaching to vulnerable groups. • System has collaborated on the approach to planned visits to inpatient areas and local risk assessments regarding national guidance around testing and use of face coverings.	**Internal:** Vaccination Programme Board, Daily Operational Touchpoint, Clinical Directors Meeting, ICB Executive Management Team (EMT), System EMT, Quality & Safety Committee, ICB Board. **External**: Regional Vaccination Operational Cell, Regional COVID-19 and Flu Operational Group, NHSE regional and national oversight.

Gaps in controls or assurances

- Numbers of COVID-19 positive patients circulating in the community are not fully understood due to changes in testing.
- Retention of workforce continues to be the key risk to delivery. Staff wellbeing and resilience continues to be impacted. Pension abatement guidance is awaited pending 'end date' of national extension. This will impact on the availability of experienced reservists.
- Prevalence of COVID-19 inpatient admissions has decreased; however, planning must take place to be prepared by further waves and seasonal pressures.

Updates on actions and progress

Date Opened	Action / Update	BRAG	Target Completion
17/06/22	Continue to utilise local and regional outbreak surveillance to enable risk assessment and response.		31/03/23
25/08/22	Delivery of the COVID-19 September booster programme is on target to begin, in conjunction with Flu		28/02/23
04/11/22	Dedicated system-wide red capacity in development by NCH&C		30/11/22

Visual Risk Score Tracker – 2022/23

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

BAF02	
Risk Title	System / Urgent & Emergency Care (UEC) Pressures
Risk Description	There continues to be a risk that the Norfolk and Waveney health and social care system does not have sufficient resilience or capacity to meet the urgent and emergency care needs of the population whenever a need arises. This can result in longer than acceptable response times to receive treatment and as a result potentially poorer outcomes for our patients with associated clinical harms. The above risk manifests itself as an increasing number of patients remaining in hospital, when they no longer meet the nationally prescribed 'criteria to reside', with the associated increase in longer lengths of stay and higher occupancy levels in all acute and community hospitals. The higher occupancy levels result in delays in admitting patients from our emergency departments (EDs) into a bed this in turn congests the EDs slowing down ambulance handover leading to more crews outside hospital who are unable to respond to 999 calls.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Mark Burgis	Quality and Safety	Ross Collett & Karen Watts	01/07/2022	31/03/2023

Risk Scores

Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	5	20	4	5	20	3	4	12

Controls	Assurances on controls
• UEC System Transformation Steering Group is overseeing a system wide transformation programme to improve Urgent and Emergency Care pathways. • A seven-day System Resilience Team and East of England Ambulance Service (EEAST) System Oversight Cell (SOC) are in place, working together to coordinate and smooth operational flow across sites. • All Trusts, including community, 111 and primary care have business continuity plans in place to manage peaks in demand. Specific controls to reduce emergency care demand: • IC24 Clinical Advice Service (CAS) reduce ambulance demand by validating ambulance dispositions and utilising a range of urgent care pathways as an alternative to conveyance. • Low acuity 999 calls are transferred to IC24 or other urgent community services to reduce delays for low acuity patients. • GP Streaming is in place at all acutes to manage lower acuity pts and reduce footfall through Emergency Departments (ED). • EEAST enact Intelligent Conveyancing to manage and even out the ambulance demand profile across acute sites. Specific controls to create surge capacity: • A range of cohorting measures are available at acutes to provide ED surge capacity and reduce waiting to handover at hospital.	**Internal:** ICB Executive Management Team; Norfolk and Waveney UEC System Transformation Steering Group (STSG); 3 x Acute led Locality Boards SORTs (System, Operations, Resilience and Transformation), ICB Quality and Safety Committee. **External**: Trust Boards; System Executive Management Group; UEC System Serious Incident Tactical Group System Gold Command Group, set up as required using Operational Pressure and Escalation Levels (OPEL). NHSE UEC Board Assurance Framework being implemented from September 2022.

• Hospital Ambulance Liaison Officers (HALOs) manage effective offload plans for all vehicles on site and support patient and staff welfare. • Arrangements in each ED enable a limited number of additional rapid ambulance handovers to release waiting ambulance crews to attend very urgent community calls where there is an extreme risk of adverse clinical outcome from delay. • Use of surge beds across acute and community inpatient units provides limited additional capacity to support flow and alleviate pressure on EDs. • A System Discharge Dashboard is in place to track discharge delays across organisations. • All acute hospitals have ambulance handover plans to improve handover performance and accommodate surges in demand. Specific controls to improve discharge: • Discharge Director is ensuring best practice is in place via a 30,60,90-day plan and 100-day discharge challenge. • Capacity and Demand modelling work has taken place and funding made available to support an increase in capacity equivalent to 250 acute inpatient beds.	

Gaps in controls or assurances

- Measures to reduce demand arriving at ED have been effective but progress in improving flow through reducing the volume of patients that are awaiting discharge from hospital (i.e.no longer meet the Criteria to Reside) has not been sustained.
- Lack of available care market workforce may compromise additional capacity and delay improvements in discharge flow.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
20/06/22	Funding has been made available to support an uplift in capacity across a range of care settings, equivalent to an increase of 250 acute hospital beds.		
20/06/22	Ambulance handover plans are in place at each acute hospital site with a range of actions to reduce handover times to below 60 minutes by October 2022, however, despite a range of new initiatives being implemented ambulance handover within 60 minutes is not being achieved. New national guidance with escalation plans received.		31/12/22
03/10/22	Critical incident declared on 03/10/22, including five core incident management pillars: 1. 999/111 Response and Admission Avoidance 2. Community and Mental Health 3. Acute Hospital Response 4. Primary Care Response 5. Discharge		31/03/23
04/11/22	Winter Director seconded and in post.		31/10/22

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				16	16	16	20	20				
change				New	→	→	↑	→				

BAF03	
Risk Title	Providers in CQC 'Inadequate' Special Measures (NSFT)
Risk Description	There is a risk that services provided by Norfolk & Suffolk Foundation Trust (NSFT) do not meet the required standards in a timely and responsive way. If this happens, people who use our services will not receive access to services and care that meets the required quality standard. This may lead to clinical harm, poor patient experience and delays in treatment or services.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Tricia D'Orsi	Quality & Safety	Karen Watts	01/07/2022	31/12/2023

Risk Scores

Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	4	4	16	2	4	8

Controls	Assurances on controls
• The report published on 28/04/22 gave an overall reduced rating of inadequate. The Trust was able to provide adequate assurance to mitigate the need for a Section 31 enforcement notice during the inspection. • The Trust's Improvement Plan is over seen by an Improvement Board with a focus on the areas set out in the section 29a letter and Must Do's issued in April 2022. Stakeholder engagement has been strengthened. Evidence Assurance Panel established with attendance by ICB MD and DoN. • Regular NHSE/I Oversight, and Assurance Group in place. Dedicated senior NHSE/I and ICB support has been taken up. • Staff engagement events have taken place across Trust sites and staff groups, with support from the Norfolk & Waveney and Suffolk ICBs. • Weekly internal Performance Board is driving progress. NHSE and ICB are working collaboratively to support the Trust. • Transformation plans continue to progress alongside Quality Improvement. • Strengthened leadership to support key clinical areas. • The ICB MH Strategic Commissioning Team are attending 'pillar' meetings around Culture, Leadership & Governance, Safety, Demand & Capacity and Service Offer. Each pillar is led by an NSFT Executive SRO, supported by an external consultant supporting delivery of the overarching improvement plan. ICB staff are participating in working groups. • ICB supporting Trust with data validation, completion of dashboard and South Norfolk community capacity pilot. • ICB attending Trust Quality and Safety Reviews (QSR) with frontline teams and working closely with NHSE on a governance review.	**Internal:** Clinical Governance Meetings, Quality and Safety Committee, ICB Executive Management Team (EMT), System EMT, and ICB Board. **External**: ICB attendance at Key Trust Meetings, Care Quality Commission, System Quality Group, Norfolk and Suffolk Healthwatch organisations, NHSE/I Oversight and Assurance Group, NSFT Quality Improvement Board, NSFT Quality Pillars and NSFT Quality Committee.

Gaps in controls or assurances
• There is an increase in people presenting with Mental Health problems without previous history, as well as those already engaged with services, as a result of the pandemic. High levels of patient acuity are being reported. Capacity is not currently able to meet demand. • There is variation in clinical governance processes across the Trust, which means that some service areas are less sighted on their levels of risk to care quality than others. • Workforce pressures. Staff sickness and absence combined with unfilled vacancies and difficulties recruiting to key posts. Impact of 'inadequate' rating on staff wellbeing and morale. • 12hr 'decision to admit' breaches reported for patients presenting to hospital Emergency Departments, who require a Mental Health bed, which requires a systemwide health and social care solution. • There is a risk that progress may be delayed or diluted if Norfolk and Suffolk commissioners are not aligned in their transformation programme, where relevant.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
03/11/21	Progress on the Trust's Integrated Quality Improvement Plan is reported into the weekly internal Improvement Board and to the external Overview and Assurance Group. Ongoing transformation of current pathways for both adults and children to improve access to services.		31/03/23
17/12/21	Additional programme governance has been put in place around 12Hr ED breaches in order to meet the requirement for SOF 4 recovery. This brings together commissioners, service providers and other key stakeholders to implement a system recovery plan looking at early intervention and crisis support, front and back door hospital processes and the 'flow' between these areas.		31/03/23
03/11/22	The ICB supports multidisciplinary meetings for complex patients, where there are difficulties accessing ongoing care for example patients with eating or disorder eating		31/03/23
13/05/22	Quality Service Improvement Review visits supported by ICB continue to all inpatient areas, revisiting where required. Reviews extended to include community teams.		31/03/23
13/05/22	Staff engagement visits have been undertaken across sites, supported by the Norfolk and Waveney and Suffolk ICBs.		31/03/23
13/05/22	Large scale recruitment events have continued with successful recruitment of support workers.		31/03/23
17/06/22	Trust in dialogue with NHSE regarding SOF 4 exit criteria, agreed.		31/03/23
17/06/22	Staff engagement with CYPM Team to support quality initiatives.		31/03/23
25/08/22	Trust reported 80% completion of Must Do's as of end of July 2022. Evidence Panel has been set up to review compliance with Section 29a.		31/03/23
25/08/22	CQC re-inspection of Section 29a completed, Well-led to take place in November 2022.		31/12/22

Visual Risk Score Tracker – 2022/23

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

BAF04	
Risk Title	Cancer diagnosis and treatment
Risk Description	There is a risk that patients with cancer will not be diagnosed and treated as early as possible due to the multiple impacts of the pandemic. Delayed diagnosis and treatment can lead to poorer long term outcomes for cancer patients as well as significant psychological distress to those waiting for treatment. Clinical risk to patients on 62 day cancer pathway and other elective waiting lists with last minute cancellations to their surgery

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Dr Frankie Swords	Quality & Safety	Dr Mark Lim	01/07/2022	31/03/2023

Risk Scores								
Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	3	12	3	3	9	2	3	6

Controls	Assurances on controls
• Prioritisation of planned care recovery alongside system response to COVID-19 and urgent and emergency care pressures. • The elective recovery board is overseeing significant work to expand the capacity of out patient clinics and elective surgery across the system to address the backlog as quickly and as fairly as possible. • The diagnostics board is overseeing work to transform how diagnostics are performed and organised to increase access to diagnostics for people with confirmed or suspected cancer to accelerate their diagnosis and treatment. • The Cancer Programme Board continues to work in close partnership with regional cancer screening and North EOE Cancer Alliance, supporting work to expand capacity and to transform how care is delivered to increase speed and efficiency of care and elective recovery. Transformation projects are focused on streamlining the 2ww pathways to improve effectiveness and efficiency. • Unified prioritisation and harm review process of reviewing patients on waiting lists for possible harm, to ensure that elective capacity is used to deliver care to patients in order of clinical priority in place at all acute trusts. • There is an ongoing review of 2ww documentation to support more appropriate and complete referrals into the 2ww pathways. • Dedicated capacity for care co-ordination in Primary Care is also being piloted. • Norfolk & Waveney Cancer Programme working with Public Health England to support improved local screening uptake in partnership with local Primary Care Networks. • A new breast screening network has also been set up to specifically address delays in the recovery of that pathway. • Additional educational webinars to Primary Care provided, to support the early recognition of possible cancers, and to reinforce NICE criteria for suspected cancer referrals.	**Internal:** • Monthly reports on elective capacity, waiting times, waiting list size, and recovery against pre COVID care delivery to Elective Recovery Board, reporting to Transformation Board. • Monthly reports on diagnostics capacity, waiting times and backlog to Diagnostics board, reporting to Transformation Board. • Quarterly reports to Cancer Programme Board on screening backlogs. • Oversight of all performance metrics to come to ICB Performance Committee and individual trust data also overseen by NHSEI performance oversight meetings. • All trusts using rolling programme of clinical prioritisation using national definitions to ensure that patients at highest risk of harm are prioritised. • All harms identified subject to duty of candour and incident investigation process and overseen through ICB quality and safety committee. **External**: PHE, NHSE/I, Regional Cancer Network

• A local communication plan is in place to educate patients on worrying symptoms and encourage presentation to Primary Care. • Cancer rapid diagnostic service now operational across the system to support review of patients with nonspecific symptoms which may be suggestive of cancer • Multiple pilots in place to target early diagnosis of specific cancers eg targeted lung health checks from August 22, for people in GY identified to be at high risk of lung cancer before they develop any symptoms. • National Grail trial has included Norfolk and Waveney targeting deprived populations to recruit local residents to access a new biomarker for cancers. Any residents with a positive result are directed onto a 2ww pathway.	

Gaps in controls or assurances

- COVID-19 has had a significant impact on public behaviour in attending screening / seeking support & advice for worrying symptoms. This led to a fall in people coming forward during the pandemic and has in turn led to an increase in people with delayed presentations post the initial peaks.
- It is not possible to define the possible harm on these patients due to delays in their diagnosis until they have been detected and treated but this may be contributing to excess deaths both nationally and within our system.
- The EOE Cancer Alliances are quantifying this risk, with the current estimate of approx 600 missed cancer diagnoses in Norfolk and Waveney over the COVID period.
- Environmental challenge of providing services during continued COVID surges continue in particular re the safe delivery of diagnostic tests and treatments to comply with infection control guidance.
- Staffing resilience due to challenge of operational pressures, self-isolation and sickness
- Availability of capacity and human resources to meet the demand of the backlog, new and follow-up patients and 52 week wait recovery in a timely way whilst managing COVID-19 response
- Significant pressure on breast, colorectal and prostate cancer diagnostic pathways and treatment capacity at the local cancer centre.
- Additional requirement to safely manage backlog and waiting lists across cancer, elective care and diagnostics is leading to increased pressure on administrative personnel and processes which could impact upon appropriate progression of patient pathways, and ability to progress transformative list management
- There remain significant pressures on Cancer Services across the system due to surges in two week wait (2ww) demand with variable performance across providers and pathways. This is putting pressure on Breast, Colorectal and prostate diagnostic pathways and exacerbating long term issues with system cancer waiting time performance. Screening, diagnostic and treatment backlogs continue to be monitored via the system Cancer Programme Board
  A formal plan for the recovery of the NNUH breast cancer pathway is being reviewed internally at present. Operational delivery of the system mutual aid policy/SOP is challenging for the cancer pathways across the trusts as there is little spare capacity and the complex surgery is provided by the NNUH as cancer centre.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
08/04/22	Operational and staffing pressures beginning to ease but still significant. Continued focus on recovering 2ww pathways. Screening, diagnostic and treatment backlogs continue to be monitored via the system cancer programme board.		Ongoing

Visual Risk Score Tracker – 2022/23

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

BAF05A - Adults	
Risk Title	Barriers to full delivery of the Mental health transformation programme
Risk Description	There is a risk that during a period of unprecedented mental health demand and acuity of need current system capacity and models of care are not sufficient to meet the need If this happens individual need will not be met at the earliest opportunity, by the right service or by the most appropriate person and need will escalate. This may lead to worsening inequality and health outcomes, increased demand on other services and reputational risk

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Tricia D'Orsi	Quality & Safety	Jo Yellon	01/07/2022	31/03/2023

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	2	4	8

Controls	Assurances on controls
• System wide governance framework (currently under review by N&W ICB MH Partnership Board aiming to develop System Collaborative) • Acting Director of Mental Health Transformation appointed to lead development of system collaborative, working closely with stakeholders and MH SRO • 22/23 N&W Planning submission agreed by NHS England & Improvement • Finance working group meets monthly to drive robust financial arrangements Working group and process in place to manage financial slippage and deliver planned MHIS investment • System commitment to increase knowledge skills and expertise and develop additional capacity through use of digital • MH Workforce Lead and Programme Manager working with system partners to implement the N&W MH workforce strategy/ transformation • Ongoing work with Population health management team to proactively contact and offer support/ physical health assessment and vaccination • Co-developed eating disorder strategy to direct implementation of national ambitions	**Internal:** SMT, EMT, Viard **External**: N&W ICB MH Partnership Board, HWBs Norfolk and Suffolk, NW Health and Care partnership MH Forum, HOSC, Norfolk and Suffolk NHSE/I Regional MH Board and subgroups, NHSEI System Improvement and Assurance Group

Gaps in controls or assurances

- Impact of pandemic and cost of living crisis on mental health and well-being of population leading to increased need for support and adding to capacity pressures and resilience of providers
- Impact of continued CQC rating of inadequate for NSFT following CQC visit in November 21, and revisit September 22. Currently awaiting publication of report. NB Associated negative MH publicity
- Cultural shift required as a system to enable successful transformation and ensure mental health is better understood and regarded as 'everyone's business'
- Cultural, digital and operational collaboration to enable access and easily navigable mental health services, is at an early stage of development
- Conflicting priorities across complex system transformation agenda
- Intra-system Electronic Patient Record connectivity, especially at the interface of primary/secondary/social care and third sector provision, remains a challenge and priority to address
- Ability to recruit, retain and train a viable number of staff to enable service expansion and meet the MH and well-being needs of the N&W population

- Limited influence on alternative provision within a tightly prescribed IAPT model – National NHSEI and HEE guidance is restrictive and does not allow local flexibility

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**
29/04/22	Increased programme management support (ICB and NSFT), to support operational and clinical leads to plan and deliver transformation. Near to full recruitment in current structure.		31/03/23
29/04/22	Joint approach between ICB and NSFT to support response to CQC concerns and joining up the transformation programme plan to deliver sustainable change. Awaiting CQC response following September 22 visit and planned Well-led visit in November to determine next steps.		31/03/23
21/10/22	Proposed governance framework to oversee work on collaboration in progress. Agreement with the MH Partnership Board to amend the terms of reference to include oversight and support to/of the collaborative discussion. A task and finish group to design and implement an engagement strategy met 20/10/22. The engagement will initially focus on revisiting the themes of 2019 mental health strategies for continued relevance (delivery due date April 23). A further task and finish group looking at legislative arrangements and models of collaboration will be set up in due course (delivery due date October 23).		31/03/23
29/04/22	Continuing work to develop effective partnerships and system ownership of the N&W MH Transformation Programme Plan. Co-production with Experts by Experience and Reference Group is central to initiating and sustaining positive change. Programme Assurance Group purpose and structure under review as part of current governance review and transition to System Collaborative by October 2023. Proposing an overarching Transformation Delivery group instead to report into MH Partnership Board.		31/03/23
29/04/22	Collaborative annual planning process supported by regular (i.e., monthly) review of priority areas, ensuring governance structure and oversight are effectively managing inter-dependencies and risk. Rated amber as NHSE 23/24 planning guidance is delayed following national period of mourning and political upheaval. Work underway to ensure readiness for issue of planning guidance.		31/03/23
24/08/21	MH Digital Working Group established, co-led by ICB and Provider Leads, involving partners to scope and identify solutions which align to MH Digital priorities. Rated amber as some work has stalled, currently reviewing priorities in context of operational demands.		31/03/23
29/04/22	MH Workforce lead driving development of workforce dashboard, and transformation programme. Working with system partners, to set up 4 focused work groups that will implement the N&W MH workforce strategy. Temporarily stepped down Workforce Board until January 2023 due to lack of SRO and Lead capacity resulting in non-attendance. Becoming clear that transformation focus needs to be matched by BAU/ operational focus – plan to meet and discuss with MH SRO. Rated amber to reflect this.		31/03/24
29/04/22	IAPT N&W System leads working with Regional NHSEI and HEE leads, in conjunction with EofE system leads to work up a proposal to influence a revised approach to IAPT training provision at national level. IAPT currently operating within a 24-month tender waiver which expires on 31st August 2024. EMT paper in development to decide next steps to secure future service.		31/03/23
29/04/22	Developed Recovery Improvement Plans with support from NHSEI to work towards recovery of trajectories for the following: increasing Physical Health Checks for people with Severe Mental Illness,		31/03/23

	improving Dementia Diagnosis and reducing Out of Area Placement OAP). All negatively impacted by the pandemic which has increased demand and limited opportunity for early intervention. This will enhance support for areas of activity where N&W do not yet meet the national standard. Rated amber to reflect difficulties reducing use of OAP beds and eradicating 12-hour breaches during a time of extraordinary demand and pathway pressures. Joint planning of the Pre-assessment Unit is progressing within the 12-hour DTA working group with the MH SRO supporting partnership discussion.		
20/10/22	Community Transformation: Working with North Norfolk and Norwich locality leads and practices who are keen to act as pilot sites for the 'MH Integrated Care Interface'. This is a working title for the newly forming primary care-based MH Multi-disciplinary team, a group of professionals from different organisations (NSFT, NCC, VCSE and primary care) that will work together to assess and direct people to the most beneficial service according to their need.		31/03/23

Visual Risk Score Tracker

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

BAF05B - CYP	
Risk Title	Barriers to full delivery of the Mental health transformation programme
Risk Description	There is a risk that during a period of unprecedented mental health demand and acuity of need current system capacity and models of care are not sufficient to meet demand. If this happens individual need will not be met at the earliest opportunity, by the right service or by the most appropriate person and need will escalate. This may lead to worsening inequality and health outcomes, increased demand on other services and reputational risk

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Tricia D'Orsi	Quality & Safety	Rebecca Hulme	01/07/2022	31/03/2023

Risk Scores

Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	4	4	16	2	4	8

Controls	Assurances on controls
• Dedicated CYP strategic commissioning team now in place • Effective System wide governance framework • Collaboration with system partners to understand demand and capacity has begun and the shared resource is better understood. • Development of robust understanding of the financial envelope available to drive the transformation, and investment necessary, including appropriate measures to reconcile these is still in process. • System approach to increasing knowledge skills and expertise across agencies and developing additional capacity through use of digital. Greatly assisted by digital appointing a digital lead. Digital workstream initiated • Financial slippage is being mitigated against protecting our ability to maintain MHIS investment Implementation of system wide transformation programme	**Internal:** SMT, EMT, Integrated Care Board, Finance Committee, Quality Committee, **External**: CYPMH Executive Management Group, CYP Strategic Alliance Board, HWBs Norfolk and Suffolk, NW Health and Care partnership MH Board, NHSE/I Regional MH Board and subgroups, HOSC Norfolk and Suffolk, System Improvement and Assurance Group

Gaps in controls or assurances

- Capacity and commitment within providers to support transformation and collaboration impacted by increased demand and historical backlog
- Capacity within the substantive CYP integrated commissioning team to deliver on the scale of transformation required.
- Conflicting priorities across complex system transformation agenda
  Intra-system Electronic Patient Record connectivity, especially at the interface of primary/secondary/social care and third sector provision, remains a challenge and priority to address.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
23/12/21	Schemes for £800K Winter funding to support Urgent and Emergency Care and discharge put forward. Region keen for schemes to continue next year if successful using SDF and MHIS		31/12/22
23/12/21	CYP Senior Programme Manager now in post to lead on the development and mobilisation of the CYP Integrated Front Door which will improve efficiencies and flow through the system		30/06/22

23/12/21	Continued work to address significant historical CYP waits across providers Current system waits for treatment circa 2500 reduced from 3500 March 2021		31/03/22
02/05/22	Six out of ten CYP Integrated Commissioning Team posts are now substantive. Remaining four are fixed term and will be reviewed once Community transformation work is completed		31/03/23
02/05/22	Intensive Day Support for CYP with eating disorders is due to open this month for 5 CYP and their families on a six month test & learn basis before expanding support offer to 12 CYP.		30/11/23
02/05/22	CYP team secured £800K in slippage to support system wide waiting list initiatives, enhanced support for 18-25 and trauma informed training		31/03/22
02/05/22	£180K of winter funding secured to support CYP on acute paediatric wards, development of an integrated practice model and respite for CYP with NDD and their families		31/06/22
02/05/22	Development of Integrated Front Door progressing well, dedicated team in place to develop model, ensure pathways and capacity sitting behind front door will meet the need, procurement process has begun with an expected go live date early 2023. Talking Therapies collaborative being developed as part of model to increase capacity		31/03/23
02/05/22	Mobilisation of three focussed waiting list initiatives to support circa 1000 CYP on waiting lists.		31/12/22
02/05/22	Working alongside adult commissioning team to enhance support offer for 18-25 year olds in wellbeing hubs. Task and finish group set up to improve IAPT offer for 16-25 to improve access, engagement and outcomes.		31/03/23
02/05/22	Increased funding to CYP Crisis team to increase capacity, expand skill mix and increase level of seniority. Scoping out options to meet 24/7 crisis assessment and support offer, in line with NHS Long Term Plan ambition		31/03/23
06/11/22	Recruitment remains challenging in core secondary care services. New staff in post but staff leavers nullifying effect. Requirement to address urgent presentations and increased community acuity reducing routine capacity to reduce waiting times.		31/03/23
06/11/22	Some mitigations through expansion of VCSE provision, successful procurement of Integrated Front Door Provider, new provider for Mental Health Support Teams and talking Therapies Collaborative – now mobilising in advance of 2023 planned start		31/03/23
06/11/22	Current uncertainty following CQC visit, and imminent Well Lead review impacting on capacity and focus to deliver transformation		31/03.23

Visual Risk Score Tracker – 2022/23

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

GBAF06	
Risk Title	Health inequalities and Population health Management
Risk Description	The combined long-term impact of the COVID pandemic and recent rapid increases in economic pressures that are impacting on the cost of living and the number of Norfolk & Waveney residents living in absolute poverty further exacerbate health inequalities whilst placing increasing pressure on our health system.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Dr Frankie Swords	Quality and Safety	Dr Frankie Swords	01/07/2022	31/03/2023

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	4	4	16	1	4	4

Controls	Assurances on controls

• NHSE/I 5 Action areas to address inequalities, are embedded into all N&W system recovery plans, 5 year strategy development & operational plans. Progress against key national delivery timelines are regularly reported on via appropriate governance structures.
• Whole system approach to reducing inequalities in development through emerging governance structures.
• Monthly ICS Health Inequalities Oversight Group established and taking place monthly with clear objectives identified to be presented to Exec. Cross-system representation, key workstreams identified, including:
  ○ Data and insight – alignment of system resources to provide clear data picture of need & issues at System & Place level
  ○ Vaccine Inequalities – oversight of approaches to reduce vaccination inequalities & implementation of Wellbeing on Wheels approach.
  ○ Core20+5 – scoping and development of system approach.
  ○ Community engagement – development of Norfolk & Waveney Community Voices programme to respond to People & Communities guidance and provide insights to inform strategy and planning.
  ○ Inclusion health – supporting access to healthcare for underserved communities, including development of roving model.
  ○ NHS Anchors – development of strategic framework to support NHS anchors approaches to tackle wider determinants of health.
  ○ Population health management – alignment of HIOG with new PHM Board in Sept 22 & development of
	Internal: Health Inequalities Oversight Group (HIOG), Health Improvement Transformation Group (HITG), Inclusion Health Group, Integration & Partnership team, Protect NoW/PHM team
	
	External: Integrated Care Board, Health & Wellbeing Partnerships, Place Boards, Clinical and Operational steering groups

PHM roadmap in conjunction with developing digital strategy ○ Mental health inequalities – supporting mental health transformation agenda and the alignment of resources to reduce MH inequalities. • System Health Improvement Transformation Group (HITG) established with developing work programmes in response to key priorities: ○ Development of system strategy for health improvement & prevention ○ Reduction in smoking ○ Reduction in physical inactivity rates • Development of VCSE Assembly to support integration of VCSE into ICS governance arrangements, which will support a reduction in inequalities and enable preventative approaches. • Elective care recovery – draft EQIA in development Place Health & Wellbeing Partnerships, along with the Integrated Care Partnership, have recognised the reduction of health inequalities as one of their key priorities, and will be developing localised plans in response.	

Gaps in controls or assurances

- Further development, coordination and oversight of actionable projects to mitigate against risk, respond to gaps and maximise resources, now that governance structures are clearly defined
- Alignment of governance and approaches into overarching ICS HI strategy, informed by foundations developed through HIOG. The aggregation of Place-based projects to ensure we avoid duplication of effort and the maximisation of system resources.
- Development of ICS 5 year strategy – disconnect between strategy development and existing programmes of work/teams.
- System-wide strategy for inequalities and impending cost of living crisis, that will likely affect system pressures – acknowledge this will form part of Place-led strategy through HWB Partnerships.
- Development of BAF/risk log and corresponding work programme & reporting.
- Connectivity between Place Boards/Health & Wellbeing Partnerships and system governance structures, such as HIOG & HITG – opportunity for these structures to 'own' system priorities.
- Duplication of effort, energy and resources at Place level – lack of coordination/sharing of learning between Partnerships.
- Duplication of effort – alignment between ICS governance structures such as HITG/HIOG/ECRB
- Capacity – lack of programme oversight of health inequalities across the system, particularly with reference to Core20+5 & VCSE integration agenda, resources in wider system (i.e. local government) to support agenda, and lack of integration with Public Health
- Resources – ring-fenced resources to support emerging work programmes and respond to system priorities, non-recurrent funding arrangements for existing workstreams, prioritisation of prevention in resourcing strategies

Evaluation methodology for key work programmes – support required to ensure impact measurement

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
23/12/21	N&W VCSE Assembly is supporting the development of VCSE place-level networks/forums to ensure effective VCSE participation in the place-led discussions, where tackling health inequalities will be a significant priority.		30/08/22
23/12/21	Core20Plus5, health inequalities initiative has been produced by NHSE which will help to galvanise ICS action to tackling health inequalities		31/03/23

31/08/22	Development of ICS 5 year strategy – embedding of HI priorities		31/03/23
31/08/22	Development of clear actionable plans linked to each of the HIOG/HITG workstreams		31/03/23
31/08/22	Development of system & place HI data packs to inform prioritisation & strategy development through HIOG and HWP Partnerships		31/03/23
31/08/22	Development of insights reporting process aligned to Norfolk & Waveney Community Voices programme		31/03/23
31/08/22	Development of PHM strategy, building on learning identified through Protect NoW, Optum & PDP programmes		31/03/23
31/08/22	Inclusion health, population health LCS		31/03/23
31/08/22	Working group to develop and manage system HI risk log, NHSE reporting and update GBAF		31/03/23
31/08/22	Opportunities for further resourcing of Core 20 approach, including EAHSN funding, Core20 Connectors, Core20 Ambassadors & GP fellows programmes and the development of a Core20 Strategy		31/03/23

Visual Risk Score Tracker – 2022/23

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

BAF07	
Risk Title	RAAC Planks
Risk Description	There is a risk of failure of the current roofing structures at two Norfolk and Waveney Acute Trusts due to their composition with RAAC Planks which are now significantly beyond their initial intended lifespan. This could affect the safety of patients, visitors and staff. The rolling programme of inspections and remedial work to detect and mitigate this also presents a risk to the system through the requirement to close areas for remedial work, further impacting patient and staff experience as well as the ability to deliver timely urgent, emergency and elective care to our patients.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Steven Course	Board/Finance Committee	Steven Course	01/07/2022	31/03/2023

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	5	25	4	5	20	3	5	15

Controls	Assurances on controls
• Trusts have robust plans in place to manage a possible incident; however these only cover immediate evacuation and not reprovision • Regional RAAC response plan is established • Regular surveys and assessments are being carried out to determine the severity of the issue and to identify and address signs of deterioration. • Region-wide scoping piece commissioned to look at ongoing service transition and recovery. • Current work ongoing to address issues found on inspection as issues identified. Each issue is separately risk assessed using NHSE led guidelines for 'Best Buy' hospitals and a RAACter Scale used to assess level of issue. • Legal position and recommendations provided by Browne Jacobson on ICB responsibilities should there be a catastrophic failure at either acute.	**Internal:** SMT, EMT, ICB Board **External**: ICS Boards, Estates, NHSE/I, Individual trust boards RAAC related exercises have been undertaken to provide assurance of plans and procedures in responding to an evacuation of a RAAC impacted trust. • Feb 22 - Exercise Farthing • Jun 22 – Exercise Walker • Nov 22 – Exercise Fox EPRR Core Standards incorporated a Deep Dive on health providers Evacuation and Shelter arrangements specifically due to the RAAC risk

Gaps in controls or assurances
• QEH not currently in line for HIP2 support

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**
16/02/22	Scoping piece to assess service transition and recovery post RAAC failure to be concluded		ongoing

Visual Risk Score Tracker												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				20	20	20	20	20				
change				New	→	→	→	→				

BAF08	
Risk Title	Elective recovery
Risk Description	There is a risk that the number of patients waiting for elective treatment in Norfolk and Waveney, which has grown significantly during the pandemic, cannot be reduced quickly enough to a level that meets NHS Constitutional commitments and which protects patients from the risk of clinical harm. If this happens, it will contribute to a poor patient experience, failure to meet Constitutional requirements and may lead to an increased risk of clinical harm for individual patients resulting from prolonged waits for treatment.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Dr Frankie Swords	Quality & Safety	Dr Mark Lim	01/07/2022	31/03/2023

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	5	4	20	3	4	12

Controls	Assurances on controls
• he Elective Recovery Cell was upgraded to an Elective Recovery Board meeting bi-weekly. • Each Provider has undertaken a waiting list clinical validation process. • Workstreams are in place to expand capacity where possible, maximise efficiency of current services, to reduce variation in waiting times between different providers and to transform care pathways to accelerate elective recovery, each led by a chief operating officer or medical director. • A unified process of clinical harm review and prioritisation in line with national guidance is now in place across all providers to ensure that patients' care is undertaken in order ot clinical priority and to prevent harm where this is identified as a risk. • Local data have ben uploaded onto the new national patient resource to allow patients to identify average waiting times and to provide additional information to support people to improve their health and wellbeing whle awaiting care https://www.myplannedcare.nhs.uk/ A more detailed local patient information site has also been established: https://norfolkandwaveneyICB.nhs.uk/while-you-wait	**The initial focus to clear all patients waiting 104 weeks or more across our system by 1 July 2022 was met with data confirmed by NHSEI.** **Internal:** Weekly and monthly performance metrics for each workstream scrutinised at biweekly elective recovery board. **External**: Trust Board Governance processes and returns to NHSEI, National contract monitoring by NHSEI and Elective Recovery Board.

Gaps in controls or assurances

- The situation around patients waiting over 78 weeks remains challenging and is the specific focus of a summit meeting.
- Ongoing staffing challenges, as well as the operational impact of RAAC plank issues has led to a fall in performance against trajectory since July 2022.
- The digital infrastructure remains a concern. Although a system for managing patients on a single waiting list has been developed, due to competing priorities relatively little support has been available for outpatient transformation.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion

16/05/22	The situation around patients waiting over 78 or 104 weeks remains challenging and is the specific focus of a summit meeting.		31/03/23

Visual Risk Score Tracker – 2022/23												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				20	20	20	20	20				
change				New	→	→	→	→				

BAF09				
Risk Title	NHS Continuing Healthcare			
Risk Description	There is a risk that NHS Continuing Healthcare (CHC) funded packages will not be filled by the provider either due to the complexity of the care required and/or their capacity or the proposed cost of care. If this happens significant pressures will be placed on the CHC nurses to source a package of care. Staff vacancies and absences may increase and the infrastructure to support provision of safe and effective care packages will be compromised. This may lead to increased financial cost to secure a care package, could impact on hospital discharges and admissions and poor outcomes for people requiring NHS funded care in the community.			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Tricia D'Orsi	Quality & Safety	Dawn Newman	01/07/2022	31/03/2023

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	4	4	16	3	3	9

Controls	Assurances on controls
• Recruiting to vacant posts within the CHC team to support assessments and care sourcing. • Commence work with finance team and contract team in NWICB and Local Authorities (LAs) to work to stabilise the market. • Link with Local Authority (LA) workforce teams to support care providers in additional training and support required. • Regular financial updates to Finance Committee and Executive Management Team (EMT) to monitor impact of cost of care packages. • Monthly operational finance meetings for Quality in Care (QiC) team. • Monitoring of time taken to secure complex care packages and escalation process for CHC team if unable to source. • Attendance at regional meetings to support feedback and sharing of good practice and innovation. • CHC Business Intelligence (BI) has developed relevant pictorial data sets for analysis which are included in the monthly QiC Quality report for the Quality & Safety Committee. • Weekly meetings held with Norfolk and Suffolk NHS Foundation Trust (NSFT) and NCC to improve communication and partnership working around discharge planning. Complex discharges from acute mental health hospital beds are progressively delayed by lack of suitable complex care in the local provider market. • Contracting, Finance and CHC teams collaborating to share relevant information regarding uplifts.	**Internal:** Senior Management Team (SMT); EMT; Quality & Safety Committee; Finance Committee; Board **External**: NHS England/Improvement; Regional CHC Team, Joint Collaborative Forum (Norfolk County Council (NCC)), Care Market Cell (Suffolk County Council), System partners

Gaps in controls or assurances
• Ability to source and retain suitable workforce for either the NWICB CHC team or care provider market • Lack of a whole system Care Workforce Strategy

- Ability to stabilise the care market post Covid-19 and EU Exit
- Capacity of CHC team to source or revise care packages
- From 30/06/22, funded Discharge to Assess pathway 3 ceases. CHC team does not have staff resources to manage the extent of workload that will require progressing.
  Following the CHC contract procurement in October 2022, as at 02/09/22, there are 125 CHC eligible individuals with ICB commissioned care who do not have a provider with a current NHS contract. We currently continue to commission new packages of care with some of these providers. Full details are within Quality and Safety risk QiC-CHC-027 'Care providers without contracts'.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
11/02/22	Active recruitment into newly established roles to enhance the team's capacity and maximise clinical functionality of the team. Eight new commissioning support officers and two nurses.		30/09/22
14/04/22	NSFT Discharge to Assess model to continue. £100K available to continue this scheme.		30/09/22

Visual Risk Score Tracker

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

BAF10	
Risk Title	EEAST Response Time and Patient Harms
Risk Description	Clinical risks to patients awaiting ambulances in community – C1 and C2 response times including inability to undertake rapid release of ambulances. System-wide pressures continue affecting ambulance handover and inter-facility transfers resulting in patient harms.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Tricia D'Orsi / Mark Burgis	Quality & Safety	Karen Watts	01/07/2022	31/03/2023

Risk Scores

Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	5	4	20	3	3	9

Controls	Assurances on controls
• Daily sit-rep ensures ICB is sighted on real-time demand and resource. • HALO role across all Acute sites to support Emergency Departments (ED). • 999 / 111 multi-disciplinary approach via CAS at IC24 to manage some ambulance calls and dispositions • Pre-alert and 'drop and go' processes in place with safety netting for patients waiting to be seen. Ambulance revalidations embedded. • Proactive public comms to promote appropriate use of NHS service options. This is reinforced across seasonal campaigns. • UEC Tactical Group continues to review system-wide SIs and identify trends / themes.	**Internal:** EMT, N&Q Senior Team, ICB Clinical Lead for UEC and UEC Commissioning Team, ICB Quality and Safety Committee, ICB Board, Provider Governance Forum. **External**: Regional Commissioning Consortium, NHSE Regional Team, OAG and CQC.

Gaps in controls or assurances

- The Trust has seen prolonged periods of high activity which continues to fluctuate from REAP Level 4 and Surge Levels 2 to 4. System-wide pressures impact on the ability of ambulances to handover patients at Emergency Departments (ED) and release to respond to new calls in a timely way. Incidents have been reported by Primary Care, where Health Care Professionals have assessed the need for an ambulance and experienced a significant delay in response. Incidents have also occurred where inter-facility transfers e.g., from local acute hospitals to tertiary centres for specialist care have been delayed.
- Patient harms increased in July 2022, which triggered an increase in risk rating.
- Discharge pressures, with high numbers of patients with no criteria to reside, impacting on patient flow through the acute hospitals.
- Significant challenge in social care re: capacity and workforce required to support packages of care in the community.
- EEAST continues to experience workforce challenges in relation to recruitment, retention, wellbeing and morale. System pressures are compounding this leading to significant risk to the resilience of teams and moral injury.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
21/09/22	Monitoring of Serious Incidents and associated harms. System-wide operational meetings in place daily with on-call arrangements to manage system pressures. System-wide focus on handover delays due to risk of harm to patients. UEC Tactical Group in place to enable systemwide learning and solutions. Critical incident declared on 03/10/22 and daily rhythm of Gold Command meetings in place.		31/03/23

17/11/21	Commissioners are sighted on the change to paediatric conveyance threshold and are working with the Trust and system partners to review the potential impact of this change on clinical quality and patient safety.		31/07/22
17/06/22	'Perfect Week' planned for July 2022.		31/08/22
04/11/22	Five core management pillars (cross-reference BAF02).		31/03/23

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				16	20	20	20	20				
change				New	↑	→	→	→				

BAF11	
Risk Title	Achieve the 2022/23 financial plan
Risk Description	If the ICB does not deliver the 2022/23 Financial Plan of a break-even position, then the ICB may not be able to maintain spending on current levels of service, or to continue with plans for further investment. This may lead to a reduction in the levels of services available to patients

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Steve Course	Finance	Jason Hollidge	01/07/2022	31/03/2023

Risk Scores

Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	4	4	16	2	4	8

Controls	Assurances on controls
• Monthly monitoring of risks and mitigations, reported to NHSE/I. • Detailed plan for 2022/23 approved by Board and submitted to NHSE/I as part of the break-even system plan. • Monthly Finance Report presented to Finance Committee and Board.	**Internal:** Board Reports and Minutes, Audit Committee reports and Internal Audit work plan, Finance Committee reports, Budget manager review. **External**: ICB assurance process, early flagging of risk with NHSE/I.

Gaps in controls or assurances

- Identification of risks and associated mitigations reviewed on a monthly basis;
- Escalation to EMT, Finance Committee and Board if appropriate, should total unmitigated risks crytalise;
- No contingency reserve in plan;
- £5.4m of unmitigated risk in the plan.
- £XXm of uncrystallised net risks identified

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
12/10/22	Review of M6 year to date performance and assess forecast out-turn evaluated risks and mitigations.		Ongoing
12/10/22	Monitor the NHSE guidance which is due to be released (by the end of October) to ascertain the process for moving away from a break-even forecast out-turn position		31/10/22

Visual Risk Score Tracker – 2022/23

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

BAF11A	
Risk Title	Underlying deficit position
Risk Description	If the ICB underpins its financial position via non-recurrent funding, then, this provides a risk to future years financial sustainability due to lower allocations based on historic expenditure.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Steve Course	Finance	Jason Hollidge	01/07/2022	31/03/2023

Risk Scores

Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	5	4	20	3	4	12

Controls	Assurances on controls
• Analysis and understanding of underlying recurrent position, including drivers of the deficit. • ICS Medium Term Financial Model has been developed that suggests an improving position over future years	**Internal:** Board Reports and Minutes, Audit Committee reports and Internal Audit work plan, Finance Committee reports. **External:** ICB assurance process, early flagging of risk with NHSEI.

Gaps in controls or assurances

- ICB has an underlying deficit position of c£38m with no plan at present to bring to a break even position in the short term.
  Development and approval of Medium Term Financial Plan is not yet complete, however, first draft has been prepared to represent a baseline position.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
06/09/22	Develop ICS (and ICB) medium term financial strategy to assess achievability of a break-even position. This requires significant levels of efficiencies to be delivered over a continuous time frame.		31/11/22
08/09/22	Understanding of the key drivers of the underlying deficit identified and work continues to attempt to reduce this position.		Complete

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				20	20	20	20	20				
change				New	→	→	→	→				

BAF19	
Risk Title	Discharge from inpatient settings
Risk Description	There is increased risks to patients no longer meeting the “Criteria to Reside” in both acute and community hospitals. The causes are many including significant vacancies in discharge hubs; variation in the quality of discharge documentation; a 40% shortfall in the availability of Pathway 1 domiciliary care services; insufficient resources on wards to keep people active; and insufficient pathway 2 & 3 beds. These delays leaving hospital lead to a syndrome of deconditioning as people significantly reduce their activity (less than 400 steps a day) leading to reduced functional ability, muscle wasting etc as well as worsening cognition and mood negatively impacting on the activities of daily living.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Tricia D’Orsi	Quality and Patient Safety Committee	Mark Shepperd	25/10/22	31/03/23

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	3	15	5	3	15	2	3	6

Controls	Assurances on controls
• Daily review in provider of discharges • Escalation process for problems • Creation of additional capacity 240 additional beds or bed equivalents • Winter plan • Discharge Director promoting best practice via 30-60-90 day plans, and the Acute Hospital Discharge programme Key Lines of Enquiry • End of PJ paralysis programme • Tour de East of England • Reconditioning the nation programme	**Internal:** ICB Executive Management Team; UEC Board; Discharge Programme Board; Discharge Steering Group; ICB Quality and Safety Committee; Bi weekly discharge touchpoint meeting. **External:** Trust Boards; 3 x Acute System Operations, Resilience and Transformation Boards; Serious Incident Gold Group; Serious Incident Tactical Group; NHSE Board Assurance Framework.

Gaps in controls or assurances

- Single agreed system dashboard
- Insufficient capacity within existing care market
- Transfer of Care form and processes
- Patient Transport
- Workforce pressures. Staff sickness and absence combined with unfilled vacancies and difficulties recruiting to key posts.
- Criteria led discharge
- Identifying complex discharge early
- 7-day working
- Managing workforce capacity in community settings to meet changes in demand and surges

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
1/11/22	All wards to participate in Recondition national initiative		31/3/2023
1/11/22	Secure permanent funding for discharge hubs		30/11/22
1/11/22	Deep dive into hubs their systems and processes		31/12/22
1/11/22	Deep dive into fast-track process for end of life patients		31/12/22
1/11/22	Deep dive into Pathway 1 discharges		31/12/22

9/11/22	Roll out of criteria lead discharge to all wards		31/03/23
9/11/22	Establish task and finish group to explore strengthening the role and contribution the VCSE sector can make to discharge		31/12/22

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

Norfolk and Waveney ICB aim: To make sure that you only have to tell your story once

Principal risk: That people in Norfolk will have their time wasted due to lack of integration and poor data sharing between different providers of health and care. This could lead to frustration for patients and staff, and introduce errors due to multiple handovers of information

Summary of risks

Ref	Risk description	Month risk rating											
		1	2	3	4	5	6	7	8	9	10	11	12
BAF12	Cyber Security				15	15	15	15	15				
BAF13	Personal data				20	20	20	20	20				

BAF12	
Risk Title	Impact on Business Continuity in the event of a Successful Ransomware Cyber Attack
Risk Description	Current heightened risk of hostile cyber attack affecting the UK may, via a ransomware attack, impact on the ICB's ability to maintain business continuity, if access to data stored within Office 365 on the national NHS tenant, is compromised or prohibited (by data getting onto and corrupting the local network via Ransomware)
ICB priority	To make sure that people can live as healthy a life as possible

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Andrew Palmer	Board	Anne Heath	01/07/2022	31/03/2023

Risk Scores

Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	3	5	15	2	3	6

Controls	Assurances on controls
• ICB and CSU are already signed up to receive CareCERT alerts. Remedial action is implemented where necessary • Windows 10, Threat Protection and MDE are in place for ICB and Primary Care devices • Secure boundary protection is in place • Ivanti patching process to prevent Ransomware getting on the network The process for accessing the out of hours support provided by NHS Digital to resolve major incidents will be established	**Internal:** Cyber Security Assurance Manager, Head of Digital, IG Working Group, NWICB N365 Technical Workstream Delivery Group **External**: National Cyber Security Operations Centre, NHS Digital, AGEM CSU, MTI Technology Limited (technical partner to NHS Digital)

Gaps in controls or assurances

- An organisation's staff are the first line of defence in preventing a ransomware attack so can be a control and a risk. The threat posed by Ransom Cyber Attacks is greatly driven by user's behaviour. Greater Cyber Security awareness provides better prevention. A lack of awareness in users to recognize Phishing emails increases the risk of a successful Ransomware Attack happening. Good awareness can help prevent them. A new campaign will be launched for winter.
- Staff passwords may not follow best practice as the most recent advice has not been communicated – an awareness campaign has been run and will be part of a new campaign for winter.
- Staff may not be aware that their online presence on social media, whether work or personal, may reveal details that can be used to access their account – a digital footprint awareness campaign will be run in the autumn.
- A protocol informing staff of how to act in the event that they do become the victim of a phishing attack needs to be put together and made available to all staff in a prominent location, this should include details of "first aid" actions a user can take as well as how to notify the service desk and how to escalate the issue if they feel the response is not adequate.
- A source of resources and information for staff on how to prevent and report a phishing or ransomware attack has been put in place and is available on the intranet.
- Advice and guidance for staff on how to activate MFA is currently being developed. NHS Digital have provided specific advice that this is rolled out first to finance teams.
- Starter and leaver processes for NHS mail accounts are not standardized either within the ICB or Primary Care – users need to be made aware how important it is that all leavers have their NHS Mail accounts disabled – this guidance is currently being developed.
- The ICB is asked to provide NHS Mail accounts for non ICB or Primary Care staff – current cyber awareness training does not include these groups and they therefore pose a greater threat. NHS Digital advice is that organisations must meet DSPT standards.
- There is no out of hours cyber process for on-call managers to follow
- Out of hours cyber support from the commissioned IT provider is on a goodwill basis only
- There is no out of hours cyber support for Primary Care staff
- Microsoft 365 works on a system of retention rather than traditional backup. DSPT requires evidence of backup.

- Currently unable to test how support from the national Office 365 team will support the ICB to recover data in the event of a cyber attack .
- There is no regional Cyber Security Operations Centre (CSOC) available to provide expert technical resource to support business continuity, data recovery and cyber breach remediation – although there is evidence of NHS Digital providing this function to other organisations.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
16/05/22	Cyber security behaviour change support and awareness package with clear guidance being developed to include: • how to spot and report a phishing email • how to get help if you have fallen for a phishing email • campaign to improve password security • campaign to raise awareness of giving your data away on social media • campaign to encourage self-enrolment for MFA • provision of a channel dedicated to cyber awareness and information making MFA mandatory for non ICB or Primary Care staff provided with an NHS Mail address		Complete – further campaign for autumn planned
16/05/22	Guidance has now been provided which includes a central Data Security helpline where all incidents can be reported and the nhs.net helpdesk should be contacted for the recovery of data.		Unknown
16/05/22	Details of CSU point of contact for cyber security issues will be made available to silver and gold on-call directors via EPRR lead		31/07/22
16/05/22	Assurance has now been provided by NHS Digital both nationally and regionally to a level that meets DSPT requirements.		Complete
16/05/22	Digital Team currently testing implementation of InTune with mobile device management. Before scoping and agreeing rollout to staff using ICB issued and personal devices to access NHS Mail and MS Teams to be implemented as part of transfer to new IT provider		31/10/2022
16/05/22	A feasibility including costed plan for the implementation of MFA for all staff across both the ICB and Primary Care is being developed and will be presented to the ICB's September IG Working Group.		30/09/2022

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				15	15	15	15	15				
change				New	→	→	→	→				

BAF013	
Risk Title	Personal data
Risk Description	There is a risk that the ICB's constitution and statutory / delegated functions will not permit it to process personal data without consent, once the protection of the current COPI Notice ceases on 30 June 2022; particularly functions that have been stood up during the pandemic. This also includes the risk to the CEfF (the access to controlled financial data pertaining Patient Identifiable Data). The ICB has not as yet been given legal right to access personal confidential data
ICB priority	To make sure that people can live as healthy a life as possible

Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Andrew Palmer	Audit and Risk	Anne Heath	01/07/2022	31/03/2023

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	5	20	4	5	20	3	3	9

Controls	**Assurances on controls**
• Guidance from the ICS Establishment CoP suggests that all functions currently conducted by a CCG can transition to an ICB Constitution for NHS Norfolk and Waveney ICB allows for the transition of all functions delivered by the CCG	**External:** ICS Establishment COP and EOE IG ICB Transition Group **External**: IG Working Group and Population Health and Care Operational Delivery Group

Gaps in controls or assurances

- Functions established under the COPI Notice, which the ICB wishes to continue will need to move to BAU with supporting Data Sharing or Data Processing Agreements
- Buy in from GP Practices to enable the ICB to continue to use primary care data for functions such as the Virtual Support Team, after the COPI Notice has expired

Updates on actions and progress

Date	**Action**	**RAG**	**Target completion**
10/06/22	A review of services has been conducted using COPI registers and the outcome has identified the areas that require to continue to process data.		complete
10/06/22	A data processing contract was agreed with Kafico and has been disseminated to General Practice to support areas which have been identified as BAU for the ICB and would need to continue. PHM team collating update of signed agreement.		complete
10/06/22	Letter from director of Data and Information Management systems of NHSE provided on 28th June 2022 detailing the CAG approval of the amendment from CCG to ICB for the existing section 251 agreements in place for invoice validation and risk stratification.		complete
23/08/22	PHM team are engaged with practices for signatures of agreements. IG team are seeking regular updates for assurance that agreements are being signed.		

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				20	20	20	20	20				
change				New	→	→	→	→				

Norfolk and Waveney ICB aim: To make Norfolk and Waveney the best place to work in health and care

Principal risk: That people will not want to work in health and care in Norfolk and Waveney leading to difficulties recruiting and retaining staff. This could lead to difficulties in providing our services

Summary of risks

Ref	Risk description	Month risk rating											
		1	2	3	4	5	6	7	8	9	10	11	12
BAF14	#WeCareTogether People Plan				12	12	12	12	12				
BAF15	Staff Burnout				12	12	12	12	12				
BAF16	Primary Care resilience				12	12	16	16	16				
BAF17	Financial Wellbeing						12	12	12				
BAF18	Transition and delegation of primary care services								16				
BAF20	Industrial action								12				

BAF14	
Risk Title	#WeCareTogether People Plan
Risk Description	There is a risk that there is failure in the implementation of our *#WeCareTogether* People Plan in respect to improving health and wellbeing, creating new opportunities, maximising skills of our staff and creating a positive and inclusive culture at work. If this happens then we will not achieve our goal to be the 'best place to work'. This may lead to increased sickness and turnover, high vacancies and poor patient care, and our people may experience bullying and discrimination.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Ema Ojiako	People and Culture	Emma Wakelin	01/07/2022	01/04/24

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	1	3	3

Controls	Assurances on controls
ICB controls • Staff Involvement group in place provides forum for reps from the ICB to discuss internal topics relating to our people • SMT – review of ToR for this group to ensure the role and remit aligins to requirements of ICB, this will include oversight and management of some people functions • OD plan implementation – Plan has been running for 24 months but would benefit from enhanced resource to address all elements of people within an effective organisation • Director of People has commenced in post and will continue to progress work with ICB DoN and MD to collaborate on workforce transformation • Director of people to Chair ICB People Board and Remuneration, people & Culture Committee for oversight and assurance System Alignment • Monthly Health and Wellbeing Board Systems Leads meeting to respond to the emerging needs and issues in place. • Bi weekly Workforce Workshops commenced which showcase workforce transformation activity and allow our staff across ICB and ICS to attend to hear more, ask questions, and collaborate on the #WCT programme • Monthly Workforce Governance meetings in place to steer discussions on: growing our own; up skilling staff. *#WeCareTogether* People Plan has over40 key projects to help us achieve our goal. • Inclusive Culture: Monthly EDI Systems Inclusions meeting to; develop a system plan to shape and support an inclusive and just culture; respond to any emerging needs and issues; support focus groups to enable staff to have a voice in shaping this work. *#WeCareTogether* system wide People Plan in place since August 2020.	**Internal:** EMT, SMT, SIG

Gaps in controls or assurances
• Lack of clarity for People Function within ICB – People Director or Director of Governance portfolios to be agreed. Insufficient internal people resource to deliver requirements of people function to ensure the ICB is a healthy and effective organisation. Review of statutory people functions and those required to transform the ICB is underway which will include key risks and mitigations for EMT to review. • Greater focus on internal staff communication and engagement is required • Change in roles for Health and Wellbeing, EDI, and Freedom to Speak up Guardians represents a risk until we identify replacements • Lack of dedicated resource to effectively analyse our 'people data'; a 'people dashboard; that is reviewed and considered with the same scrutiny as operational and financial performance • Lack of significant and consistent progress/focus on WRES standards. • Lack of sight on impact of retention, wellbeing as a result of Covid retirement flight risk, burnout, might undermine our grow, attract and retain strategy. Increasing sickness levels against historic picture. High vacancies and sickness levels.

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**
26/12/21	• We now have 4 workstreams (system recruitment, reducing sickness, bank & agency, e-rostering) mapped to our SOF 4 plan for workforce. These workstreams will be monitored at the monthly system finance meetings and the WDG. These themes will reduce workforce risks on implementation. **November 22 update** • System pressures and conflicting priorities for organisations have impacted on the delivery of these programmes resulting in delays and a lack of decision making on core elements of the programmes. • Newton Europe diagnostic work will support plans for a review of HR process and practice with strategic input from Director of People. **Director of People has commenced in post and is working with Director of Governance to realign portfolio's**		31/3/23
30/03/22	Workforce Dashboard to monitor high level milestones and assess progress in place.		31/03/23
01/04/22	EDI lead commenced in role to support focus on WRES and Inclusion across the system.		31/03/23
19/08/22	ICS people plan #WeCareTogether will be refreshed (national mandate) – resource secured to lead this work which will ensure ICB staff are included		Ongoing
14/11/22	Refresh continues with c250 people engaged since August to review progress since 2020 and consider where updates are required for the #WCT People Plan. Refresh launch planned for early 2023 alongside updated #WCT platform which will develop over time to be a single point of access for people seeking support to join N&W ICS and to reach their potential working with us		March 2023

Visual Risk Score Tracker

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

BAF15	
Risk Title	Staff burnout
Risk Description	Burnout is measured by three elements. • Exhaustion - an imbalance between work demands and individual resources. • Individual strain - an emotional response of exhaustion and anxiety, which is heightened by not feeling effective • Defensive coping - changes in attitudes and behaviour, such as greater cynicism System pressures (increasing activity, workforce vacancies, sickness, and resilience) have increased the risk of fatigue and exhaustion. We are seeing increases in poor physical and mental wellbeing, low morale and motivation. The transition from CCG to ICB also presents a risk of staff feeling unsettling and anxious in line with a change process which will require focussed support to lead people. The narrative that we are failing to meet targets (clinical and financial) is constant. Individuals need to feel they are making a difference. This could lead to an increase in staff absence rates (short and longer term), retention and most worryingly significant mental and physical issues. If this happens this could have a significant impact on the services that they deliver.
ICB priority	To make Norfolk and Waveney the best place to work in health and care

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Ema Ojiako	People and Culture	Jo Catlin	01/07/2022	31/03/23

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	1	4	4

Controls	Assurances on controls
• We are seeing an increase in ICB staff requesting support from System Workforce Team – in particular line management culture change, new ways of working, developing teams. • The Staff Involvement Group and Senior Management Team continue to flag issues regarding economic and cost of living rises – agreement to add as a new risk to ICB corporate risk register as the impact of lifestyle pressures will impact on peoples resilience and increase likelihood of burnout • Discussion at future EMT regarding the Internal People function is tabled, the incoming People Director is a HR professional and we will seek their guidance on future form and function Despite the 2022 pay increase, with the pension contribution changes some of our staff will be worse off. Add this to the cost-of-living pressures (see BAF17) this could further demotivate	**Internal:** SMT, EMT, ICB Board, Staff Involvement Group, Wellbeing Guardian **External**: ICS Boards, NHSE/I

Gaps in controls or assurances
• Changes in NHS legislation, increased/additional workload and pressures post pandemic • Issues are not new, they have been enhanced by the pandemic – longer term culture change required to support staff (especially in our appoach to Flexible Working to support our people to obtain a better work/life balance) • Currently no dedicated budget or resource to support health and wellbeing initiatives

- Change in roles for Health and Wellbeing, EDI, and Freedom to Speak up Guardians represents a risk until we identify replacements

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
October 2021	Established H&WB Champions and Steering Group, utilising NHS H&WB Diagnostic and resources to shape actions and approach **November update** • H&WB summit held in September to commence ICS H&WB strategy • Continued support at organisation and system level to support staff wellbeing, this includes a focus on financial wellbeing, and our CV19 Resilience hub for health and social care staff • Presentation at Clinical Director and through Medical Director briefings highlighted H&WB offers in place for Primary Care Workforce, this will also be captured in medical Director Blog in November for a wider audience Business case for ICB to implement Vivup, Employee benefit scheme to be proposed to ICB SMT on 17/11. Other Trusts in ICS already use or are implementing the use of Vivup so this will enable ICB to level up and offer equitable support for our staff		31/01/23
May 2022	In response to NSS results, pilot new approach to wellbeing conversations, incorporating available resources and support. Fully implement in July 2022		Complete
May 2022	Communications and engagement review has now completed with findings to be presented to EMT in August/September		Complete
May 2022	Refocussed Extended Senior Leadership agenda to focus on the People Promise values and to include regular updates and opportunities to receive updates, share information, and collaborate on the change process for the ICB. Meetings now held face to face to encourage collaboration and enhance relationships **November 22 update** ICB Leadership Summit to be held 16/11 with EMT and Senior members of the ICB as a starting point in a redesign and development of how EMT and Snr leads work together in the ICB		September 2022

Visual Risk Score Tracker – 2022/23

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

BAF16	
Risk Title	The resilience of general practice
Risk Description	There is a risk to the resilience of general practice due to several factors including the ongoing Covid-19 pandemic, workforce pressures and increasing workload. There is also evidence of increasing poor behaviour from patients towards practice staff. Individual practices could see their ability to deliver care to patients impacted through lack of capacity and the infrastructure to provide safe and responsive services will be compromised. This will have a wider impact as neighbouring practices and other health services take on additional workload which in turn affects their resilience. This may lead to delays in accessing care, increased clinical harm because of delays in accessing services, failure to deliver the recovery of services adversely affected, and poor outcomes for patients due to pressured general practice services.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Mark Burgis	Primary Care	Sadie Parker	01/07/2022	31/03/2023

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	4	4	16	3	4	12

Controls	Assurances on controls
• Locality teams and strategic primary care teams prioritised around supporting the resilience of general practice, dedicated resource to support the Covid vaccination programme. All practices have been supported to review business continuity plans • PCN ARRS (additional roles reimbursement scheme) funding has increased again in 2022/23 • Primary care workforce and training team working closely with locality teams to identify clinical and volunteer workforce and to ensure training available to support practices and PCNs in setting up and maintaining services Resilience funding process has been completed earlier this year (Q2) to provide practices with more opportunity to bid and respond	**Internal:** EMT, Strategic Command, SMT, workforce steering group, primary care cell **External**: Primary Care Commissioning Committee, NHS England via delegation agreement, Health Education England, Norfolk and Waveney Local Medical Committee

Gaps in controls or assurances

- Practice visit programme, CQC inspections focused on where there is a significant risk or concern
- Unplanned risk associated with outbreaks or positive cases
- Impact of ambulance delays diverting practice teams from routine and urgent care to respond to emergencies
- Continued reports of poor patient behaviour across practices, decrease in patient satisfaction with general practice through GP patient survey, consistent with national position

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
01/09/22	This risk (resilience impact due to Covid-19 pandemic) has been combined with an additional primary care risk (general practice resilience) following agreement at the primary care commissioning committee in July.		30/11/22

	Resilience funding process has been completed with practices invoicing where funding has been awarded. It is expected there will be national funding for general practice for winter – discussions are taking place to determine how to invest this funding for best impact. There has been an unplanned influx of asylum seekers into our system in August and September, with several local hotels being procured as contingency accommodation. This is having an impact on practices local to the hotels, as well as on wider health and care partners. Work is underway to support both an immediate response and a longer-term system approach to the needs of asylum seekers. There are currently four practices rated as inadequate by the CQC, requiring increased support and development from multiple teams in the ICB, as well as the increased work and focus for the teams in the practices to respond. Training and learning are being shared with all practices on an ongoing basis.		
31/10/22	Winter funding letter for general practice now published, winter fund being created from funding already allocated to PCNs, but available to draw down sooner. Workforce team is working with localities and PCNs to finalise ARRS forecasts. Currently investigating if any underspends can be identified for investing in practices through the winter, subject to discussion with LMC. A further practice has been rated as inadequate by the CQC, ICB teams are supporting.		30/11/22

Visual Risk Score Tracker

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

BAF17	
Risk Title	Financial wellbeing
Risk Description	There is a risk that in the current climate staff will become increasingly under pressure to maintain cost of living. As well as financial wellbeing, this will also impact on peoples physical, mental and social wellbeing – which is likely to impact on resilience and productivity at work. People may also consider alternative employment which offers more flexibility or increased income, take on secondary jobs, or access other avenues outside of workspace to increase financial wellbeing. We also anticipate this will affect working arrangements – for example, reluctance to attend f2f meetings because of fuel or parking costs, or an increase in requests for office working in the winter to reduce personal heating bills which will affect the space available at our sites (eg NCC).
ICB priority	To make Norfolk and Waveney the best place to work in health and care

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Ema Ojiako	People and Culture	Emma Wakelin	01/08/2022	ongoing

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	4	3	12	4	4	12

Controls	Assurances on controls
• Monthly Staff Involvement Group Meetings in place with representation from all Directorates provides a safe space to highlight risks and issues for staff wellbeing that can be responded to • Weekly staff briefings will have regular inputs from SIG members with information and guidance for support and to demonstrate that we hear and are doing what we can to support staff needs • Recognition that financial wellbeing can affect any member of staff regardless of salary – SMT and EMT to recognise this to ensure compassionate and mindfulness to all staff • Identification of an Employee Reward and Benefit Programme. Many other organisations in our system offer this but the ICB does not have anything in place. They also offer an integrated Employee Assistance Programme (EAP) to support wellbeing and advice on financial management. We do have an EAP which we currently pay for, but sits in isolation under HR. Perhaps not utilised as much as it could be. Plans will include potential alignment to ICS Partner organisations to maximise offer for our system workforce. • Close working with ICS partner organisations coordinated through the ICB System Associate Director of Workforce Transformation and HRD network. This includes a T&F group for financial wellbeing with reps from NHS Providers, LA, and ICB.	**Internal:** SMT, EMT, ICB Board, Staff Involvement Group, Remuneration People & Culture Chair **External**: HRDs, N&W People Board

• EoE Regional Teams (HEE/NHSEI) also provide support, resources and regular updates on national responses.	

Gaps in controls or assurances

- This is a macro issue, relatively outside of our control. The country's economic climate shows no sign of easing
- Currently no dedicated budget or resource to support health and wellbeing initiatives nor a dedicated Health and Wellbeing Co-ordinator with expertise in all elements of wellbeing. This would be beneficial as we currently rely on volunteer HWB champion roles.
- Change in roles for Health and Wellbeing, EDI, and Freedom to Speak up Guardians represents a risk until we identify replacements

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
14/11/22	Review of financial support offers underway – requested by EoE regional workforce team and DoF Network		18/11/22
Sept 2022	Following a period of engagement and discussions within ICB, business case to implement Vivup – the Employee Benefit Scheme for ICB staff will be presented ICB SMT on 17/11. Other Trusts in ICS already use or are implementing the use of Vivup so this will enable ICB to level up and offer equitable support for our staff. Aim to have this in place for staff to access before 25/12		24/12/22

Visual Risk Score Tracker – 2022/23

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

BAF18	
Risk Title	Transition and delegation of Primary Care Services (Dentistry, Optometry and Community Pharmacy) including complaints service and potential transition of Contact Centre for these areas.
Risk Description	Primary Care Services will become the responsibility of the Integrated Care Board from 1st April 2023, the risk is there will be a lack of additional capacity, resources and finance to effectively commission these services within existing ICB teams (Finance, Complaints, Quality, Workforce, Contracts and Delegated Commissioning) during and following the transition process, leading to a poor patient experience for our local population.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Andrew Palmer	Primary Care	Sadie Parker	31/10/22	31/10/2023

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	4	4	16	3	2	6

Controls	Assurances on controls
• Dental staff to be aligned to ICB's • Single ICB host agreed for the region for community pharmacy and optometry contracting • Pre-delegation assurance framework (PDAF) and safe delegation checklist (SDC) published in draft to support transition work. • Weekly regional task and finish group in place to support the transition and share workload • Regular regional primary care directors and finance directors meetings in place • CSU Medicines Optimisation Team already have working relationships with Community Pharmacies around quality. • Proposal for complaints/Contact Centre transition to be delayed to April 2024.	**Internal:** ICB Task and Finish Group, ICB Finance and Primary Care Directors meetings, EMT, Primary Care Commissioning Committee **External:** NHS England, Norfolk and Waveney LDC

Gaps in controls or assurances

- Visibility, decision and agreement on transfer of budget from regional team to ICB.
- Alignment of staff members from region to ICB to be agreed, with focus on contracting only.
- Pharmacy and Optometry services to be aligned to ICB's hosted by HWE ICB
- Lack of resource to support management of finance.
- The level of the unmet need for Dentistry and the associated financial consequence of this once addressed (if possible) given the transfer for funds are to be based on 2022-23 current expenditure which per NHSEI forecasts are also below budget (suggesting a growing unmet need). Non-clinical financial pressures are also likely to arise in relation to resourcing costs given the loss of the economies of scale held in the current model for which the ICB are not funded adding pressure to their Running Costs control target.
- Concern around the financial consequences due to Dental contracts currently being returned or removed from providers, resulting in temporary and more expensive contracts with reduced activity and higher UDA (Unit of Dental Activity).
- Lack of resource to support management of clinical quality, safety and patient experience for these services and for the governance of these functions i.e. managing complaints quality visits and specialist advice and support for providers.
- Access to NHS dentistry services has consistently been an area of quality concern that the local system has escalated to NHSE. This impacts on some of our most vulnerable patient groups.
- Significant workforce shortfalls across dentistry, optometry and community pharmacy.
- Hosting arrangements for pharmacy and optometry services are not yet confirmed, drafting of memorandum of understanding is underway.
- Final versions of PDAF and SDC not yet available.

- The ICB has not been provided with sufficient information to fully complete the PDAF and SDC prior to submission of initial draft in September.
- No confirmation yet as to whether NHSE Contact Centre work/staff to be transferred to ICBs and no data as to staff numbers/workload this would bring. Concern break-up of regional/national team will lead to inefficiencies, remove economies of working to scale and concern there will not be team resilience due to small numbers of staff transferred.
- No data on the complaints service such as numbers of staff and activity levels for complaints work leaving little time to ensure an effective transition of services.
- Unclear decision-making process for transition of complaints with infrequent regional meetings and currently no access to the project group who will be making the recommendation for transfer of complaints service to December Board for approval.

Updates on actions and progress

Date opened	Action / Update	BRAG	Target completion
25/08/22	Governance submission programme and timelines have been agreed, commencing with initial draft submission of pre-delegation assurance framework to region on 9th and 16th September 2022, with safe delegation checklist sign off by February 2023.		28/02/23
25/08/22	Transitional Delegation Task and Finish Group established, with an inaugural meeting in August 2022.		28/02/23

Visual Risk Score Tracker – 2022/23

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

BAF20	
Risk Title	Industrial Action (IA)
Risk Description	The Royal College of Nursing (RCN) have announced the outcome of their strike ballot on 09/11/2022 for their members. The NMC recognises that 'nurses, midwives and nursing associates have the right to take part in lawful industrial action, including strike action, Trade Unions representing NHS staff have advised the Secretary of State for health and Social Care that they are in dispute over the 2022/23 pay award. The RCN ballot outcome for Norfolk and Waveney (N&W) is in favour of strike action affecting the following organisations. • NHS N &W Integrated Care Board (ICB) • Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUHFT) • Norfolk and Suffolk NHS Foundation Trust (NSFT) • Norfolk Community Health and Care (NCH&C) The strike action in England must take place within six months of the close of industrial strike action strike ballot. Action could be either continuous strike action, which is when two or more strike days occur consecutively, with no working days in between or discontinuous strike action which is when strike days are not consecutive.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Ema Ojiako	Quality and Safety	Karen Watts & Emma Wakelin	14/11/2022	31/03/2023

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	4	3	12	2	3	6

Controls	Assurances on controls
• Ballot and any strike action that follows must comply with specific legal requirements. There are structured thresholds that need to be met before industrial action can be taken, at least 50% of all members eligible to vote needs to be met before industrial action can be taken. • Only members of a union who have balloted members and received support for strike action in accordance with legal requirements can strike, those who are employed on Agenda for Change terms by an NHS employer. • Only members of a union who are on duty for an employer on strike can strike, employees who are on long-term sick or maternity leave cannot strike. • Employee protection, any employee who takes part in lawful industrial action is protected against unfair dismissal. • NHSE have started negotiations at a national and local level, with established lines of communication with Trade Unions (TU) to manage the impact of any action. • N&W Task and Finish Group for coordination has been set up with strategic oversight of Directors of Nursing (DoNs) and HRD. • Multi-agency exercise planned for ICB and system partners to test emergency preparedness, week beginning 14/11/22. • Communication plan through the national team to ICB Comms Lead in progress. • ICB have reviewed clinical staff for potential redeployment.	**Internal:** N&W Task and Finish Group, ICB Executive Management Team (EMT), System EMT, Quality & Safety Committee, ICB Board. Emergency Planning and Preparedness meetings. **External**: NHSE regional and national oversight. Directors of Nursing (DoNs) and HRD networks

Gaps in controls or assurances
• Full impact on work force and business continuity difficult to ascertain as unknown how many staff will take up the option to strike. • Loss of ICB staff to support providers to manage BAU. • Duration of strike period and implementation dates.

Updates on actions and progress			
Date Opened	**Action / Update**	**BRAG**	**Target Completion**
14/11/22	NHS England has provided the ICB with advice and guidance on preparations to plan for minimal disruption to patient care, emergency services can operate as normal.		31/03/23
14/11/22	Negotiations have commenced at a national and local level to gain a clearer picture on how services will operate on days of strike action to ensure patient safety is not compromised		31/03/23
14/11/22	ICB will support Trusts to be prepared by, • Consolidating completion of Trust's self-assessment templates for return in the event of IA. • Set up a N&W Task and Finish Group for coordination with a rhythm of meetings. • Strategic oversight by Directors of Nursing (DoNs) and HRD		30/11/22
14/11/22	ICB will share information on confirmed industrial action, including information on derogations across the system. • ICB will work with system comms teams and our HRD and DoN networks to ensure information and system planning is consistent across the system including with TUs to manage impact of any action.		31/03/23
14/11/22	Testing system preparedness will be coordinated with wider winter planning. Exercise Artic Willow planned for week commencing 14/11/22.		21/11/22
14/11/22	Communications will be through ICB Comms Lead content provided by National team including messaging for the public commenced. Guidance and support for decision making around operational delivery and engagement with staff taking industrial action will be shared by the Comms Team.		30/11/22
14/11/22	ICB have reviewed clinical staff for potential deployment. • Face to face clinical skills training commenced for ICB staff		31.12.22

Visual Risk Score Tracker – 2022/23

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

Norfolk and Waveney
Integrated Care Board

Agenda item: TBC

Subject:	**Quality and Safety Committee Report**
Presented by:	Cathy Armor, Quality and Safety Committee Chair (Interim) Tricia D'Orsi, Chief Nurse ICB
Prepared by:	Evelyn Kelly, Quality Governance & Delivery Manager
Submitted to:	Integrated Care Board Meeting
Date:	22 November 2022

Purpose of paper:

To provide the Board with an update on the work of the Quality and Safety Committee for the period of 01 September 2022 to 22 November 2022.

Committee:	Quality and Safety
Committee Chair:	Cathy Armor (Interim)
Meetings since the previous update on 27 September 2022	**06 October 2022,15:00 – 17:00** **03 November 2022, 15:00 – 17:00**
Overall objectives of the committee:	Development of the Committee objectives will come out of the recent review of Terms of Reference and will be reported in full, within the next report to Board. In the meantime, objectives are driven by risk as reported below.
Main purpose of meeting:	**06 October 2022** Regular meeting of the Committee covering all standing items plus the following: • Risk focus on Ambulance Response Times • Quarterly Serious Incident Report • 'Joanna, Jon and Ben' Safeguarding Review Progress • Local Maternity and Neonatal System (LMNS) Update • Monitoring of Adult and CYP LD&A Inpatient Cohort Members were also briefed on the Norfolk Safeguarding Children Partnership Annual Report (2021-22) and the ICB Research and Evaluation Annual Report (2021-22).

	03 November 2022 Regular meeting of the Committee covering all standing items plus the following: • Risk focus on Ambulance Response Times • Risk focus on Neurodevelopmental Pathway • Infection, Prevention and Control Update • Monitoring of Adult and CYP LD&A Inpatient Cohort Members were also briefed on the East of England Ambulance Service Trust Strategy and the Norfolk and Suffolk Child Death Overview Panel Annual Report (2021-22).
BAF and any significant risks relevant / aligned to this Committee:	**Quality and Safety Committee BAF risks:** BAF01: Living with COVID-19 BAF02: System Urgent & Emergency Care BAF03: Providers in CQC 'Inadequate' Special Measures BAF04: Cancer Diagnosis and Treatment BAF05a: Mental Health Transformation Programme (Adult) BAF05b: Mental Health Transformation Programme (CYP) BAF06: Health Inequalities BAF08: Elective Recovery BAF09: NHS Continuing Healthcare BAF10: EEAST Response Time and Patient Harms BAF18: Emergency Preparedness, Resilience and Response BAF19: Discharge from Inpatient Settings Other risks aligned to the Committee are currently being reviewed against the new ICB Risk Management Matrix, which is based on guidance issued by the National Patient Safety Agency. Risks currently exceeding 15 are all aligned to the BAF as noted above, except for those noted below: • Deprivation of Liberty Safeguard Standards • LD & Autism Residential and Transition Provision • Community Paediatrics (Neurodevelopmental Pathway and Central Norfolk Paediatric) • Digital infrastructure for Maternity Services (Electronic Patient Record / Shared Care Record) An update on associated risks will be reported within the next Board paper, according to reviewed and agreed risk ratings.
Key items for assurance/noting:	**06 October 2022** Members were briefed on the declaration of a critical incident, in relation to system pressures and sustained periods of surge-level activity. Escalation was agreed

	from Committee to the Urgent and Emergency Care Improvement Programme Board recommending further development of the community-based 999 Call Stack Allocation project which is identifying appropriate out of hospital care and support to improve patient experience and avoid avoidable conveyances to hospital. The ICB Quality in Care Team highlighted the increasing activity in the Neurological Rehabilitation Pathway and the challenge around discharge, with blocks in specialist provision. Commissioners are working with stakeholders around alternative pathways. Members received assurance that the NNUH Insulin Pump Initiation cap had been reviewed and increased to support uptake, as well as steps taken to recommission the Norfolk and Waveney Community Dermatology Service in response to a deterioration in waiting times. Members discussed the recent communication received from Claire Murdoch, National Director for Mental Health, in relation to the quality and safety of mental health and LD&A inpatient services and reflected on the mechanisms in place in the Norfolk and Waveney area to ensure there is robust oversight of the LD&A cohort. Work is also taking place with NSFT to ensure the same oversight in relation to mental health, particularly in relation to the management of restrictive interventions. The ICB will be leading a gap analysis against these recommendations, as they pertain to our other providers. The ICB's progress with 'Learning from Lives and Deaths of People with a Learning Disability and Autistic People' was commended; this has moved forward significantly with the six-month backlog managed. The Norfolk and Waveney system is currently just over the transforming care trajectory for inpatients who are ICB funded. Individual discharge planning for this complex group of patients is reliant on social care provision and housing developments. Current care planning is focused on finding placements as close to home as possible, to maintain family connections and keep inpatient admissions as short as possible. Members received assurance that mitigations are being put in place around CAMHS waiting lists, focused on safety netting patients waiting to be seen and scoping new support services with VCSE engagement. The CYP Eating Disorder Day Centre service has begun to have impact and the teams are seeing fewer acutely unwell young people.

	Committee were asked to note the work undertaken by the LMNS to deliver the Maternity Transformation Programme; its role in quality and safety oversight and response to the national Ockenden Report and local programme risks and mitigating actions. **03 November 2022** The ICB Medical Director provided an update around pandemic impact and recovery of cancer care. Diagnostic rates in Norfolk and Waveney remained static from the 18 months preceding the pandemic, up to April 2020 when there was a dramatic fall in the diagnosis rate, which took until January 2021 to fully recover. Overall, Norfolk and Waveney saw an 8% reduction in patients diagnosed with cancer in comparison to what would have been expected. Haematological, colorectal, prostate and other urology cancers appear to have been impacted most significantly and later stage presentations have increased by around 10%, which potentially illustrates the impact of the pandemic on patient confidence in coming forward for assessment of early symptoms, due to concerns around COVID-19. Committee were updated on the transformation work around the neurodevelopmental pathway and discussed the impact of delays for assessment and diagnosis, on children and their families. Members reflected that while formal diagnosis can be very important to individuals and their families, in terms of understanding and celebrating their neurodiversity, it is important that support is based on presenting need and is not delayed. Committee supported the priority around improving the collaborative systemwide response to meeting children and young people's needs across health, social care and education during the diagnostic process and the expansion of interventions designed to reduce waits, into and beyond 2023. The ICB Quality in Care Team highlighted annual health check performance for people with learning disabilities, with Norfolk and Waveney achieving well above national average in access and uptake. Work around 'length of stay' reviews for people with LD&A in inpatient care, was also commended. Committee noted the impact of the cost-of-living crisis on families who have children with significant health needs and a pack has been put together to help signposting to helpful resources and support.

	Committee were briefed on the East of England Ambulance Service Trust Clinical Strategy, which has been developed in partnership with their patients, employees and partners. Committee received an update on system Infection Prevention & Control (IP&C) priorities, covering COVID-19 Avian Flu, Tuberculosis and a recent Group A Streptococcal outbreak in the community. Quality improvement workstreams around hydration and Urinary Tract Infection prevention, and overuse of gloves in healthcare settings, were highlighted. Committee were updated on the engagement plan for the system Quality Strategy, which has been proposed for review and approval at the January Board Meeting.
Items for escalation to Board:	No additional items requiring Board approval during this reporting period. Risks are captured above.
Items requiring approval:	No items requiring Board approval during this reporting period.
Confirmation that the meeting was quorate:	***Quoracy (as per Governance Handbook):*** *there will be a minimum of one Non-Executive Member, plus at least the Director of Nursing or Medical Director.* On 06 October 2022 and 03 November 2022, the meeting was quorate, as defined above.

Key Risks	
Clinical and Quality:	This report highlights clinical quality and patient safety risks and mitigating actions.
Finance and Performance:	Finance and performance are intrinsically linked to quality, in relation to safe, effective, and sustainable commissioned services.
Impact Assessment (environmental and equalities):	N/A
Reputation:	See above.
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	The report supports the clinical quality and patient safety elements of the NHS Constitution.
Conflicts of Interest:	Committee member's interests are documented and managed according to ICB policy.

Norfolk and Waveney
Integrated Care Board

Agenda item: 15

Subject:	**Primary Care Commissioning Committee Report**
Presented by:	**James Bullion, Local Authority Member**
Prepared by:	**Sadie Parker, Associate Director of Primary Care**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**22 November 2022**

Purpose of paper:

To provide the Board with an update on the work of the Primary Care Commissioning Committee for the period September to November 2022.

Committee:	Primary Care Commissioning Committee
Committee Chair:	James Bullion, Local Authority Member
Meetings since the previous update on 27 September 2022	13 September 11 October 8 November
Overall objectives of the committee:	The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.
Main purpose of meeting:	To contribute to the overall delivery of the ICB's objectives to create opportunities for the benefit of local residents, to support Health and Wellbeing, to bring care closer to home and to improve and transform services by providing oversight and assurance to the ICB Board on the exercise of the ICB's delegated primary care commissioning functions and any resources received for investment in primary care.
BAF and any significant risks relevant / aligned to this Committee:	BAF16 – the resilience of general practice Current mitigated score – 4x4=16 There is a risk to the resilience of general practice due to several factors including the ongoing Covid-19

	pandemic, workforce pressures and increasing workload. There is also evidence of increasing poor behaviour from patients towards practice staff. Individual practices could see their ability to deliver care to patients impacted through lack of capacity and the infrastructure to provide safe and responsive services will be compromised. This will have a wider impact as neighbouring practices and other health services take on additional workload which in turn affects their resilience. This may lead to delays in accessing care, increased clinical harm because of delays in accessing services, failure to deliver the recovery of services adversely affected, and poor outcomes for patients due to pressured general practice services.
Key items for assurance/noting:	<u>September</u> Note this meeting was not held in public due to the death of the Queen, urgent items only were considered. <u>October</u> • Risk register • Resilience funding • Learning Disability Health Checks • Care Quality Commission Report on Andaman Surgery, Lowestoft • Prescribing report • Finance report <u>November</u> • Risk register • Learning Disability Health Checks • Severe Mental Illness Health Checks • Digital update • Estates update • Restoring routine care for Diabetes • CQC reports for Bacon Road and Taverham Surgeries in Norwich • Prescribing report • Finance report
Items for escalation to Board:	The resilience of general practice, summarised in BAF16 continues to be of concern in the system, despite the significant activity being undertaken (575,000 appointments in September, 38% on the day and 73.4% face to face).
Items requiring approval:	<u>September</u> Note this meeting was not held in public due to the death of the Queen, urgent items only were considered. • Branch closures advice note

	• Primary Care Network overview and update and progress on the Additional Roles Reimbursement Scheme • Enhanced Access services <u>October</u> • GP Patient Survey <u>November</u> • None
Confirmation that the meeting was quorate:	Yes

Key Risks	
Clinical and Quality:	Care Quality Commission inspection reports are brought to committee meetings
Finance and Performance:	Finance reports are noted monthly
Impact Assessment (environmental and equalities):	N/A
Reputation:	The committee meeting is held monthly in public and includes membership from the Local Medical Committee, Healthwatch Norfolk and Suffolk and the Health and Wellbeing Boards in Norfolk and Suffolk
Legal:	Terms of reference, primary medical services contracts, premises directions and policy guidance manual
Information Governance:	Any confidential or sensitive information is heard in private
Resource Required:	Primary care commissioning team
Reference document(s):	Primary medical services regulations, statement of financial entitlements, premises directions and policy guidance manual
NHS Constitution:	N/A
Conflicts of Interest:	Arrangements are in place to manage conflicts of interest

Norfolk and Waveney
Integrated Care Board

Agenda item: 16

Subject:	**Finance Committee Report**
Presented by:	**Hein van den Wildenberg, Non-executive Member, Finance Committee Chair**
Prepared by:	**Jason Hollidge, Director of Commissioning Finance**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**22 November 2022**

Purpose of paper:

To provide the Board with an update on the work of the Finance Committee for the period 27 September 2022 to 11 November 2022.

Committee:	Finance Committee
Committee Chair:	Hein van den Wildenberg
Meetings since the previous update on 27 September 2022	25 October 2022 – 1:30 – 4:00
Overall objectives of the committee:	The objective of the committee is to contribute to the overall delivery of the ICS objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan and strategy, consistent with the ICS Strategic Plan and its operational deliverables.
Main purpose of meeting:	To gain assurance on the financial position of the ICS and ICB.
BAF and any significant risks relevant / aligned to this Committee:	BAF 11 – Achieve the 2022/23 financial plan BAF 11A – Underlying deficit position
Key items for assurance/noting:	The following items were discussed at the Finance Committee on 25 October 2022: **Part 1 - ICS** *Month 06 (September) System Finance Report* The system financial position was discussed in detail, looking at year-to-date and full year forecast out-turn (FOT) positions for both revenue and capital. This highlighted the significant levels of uncrystalised financial risk in the systems break-even FOT position (net £32.8m after identified mitigations) and this makes it difficult

	to be assured of the achievement of this break-even position, noting the implications that would bring. The committee took note that the potential claw back as a result of underperforming against the Elective Recovery Fund may not be applied. This formed half of the unmitigated risk at the time of plan approval. The committee noted the expected spend on agency staff for the year to be well in excess of plan. Discussion ensued to gain a more detailed understanding of this in future meetings, including the range of likely outcomes, understanding of what the mitigating items are and how these mitigations are planned to be delivered. The committee took note of the FOT for the financial year for the system to be Break Even for revenue. Given the risk profile and expected winter pressures, the committee was not assured at this point in time, that a system break even position would be achieved. The committee noted that the reliance on non-recurring mitigations, both in the original plan, and to deal with further pressures, meant that the financial challenge for next year would be compounded. *Month 05 (August) System Activity Report* This report focused on the acute activity and increases in waiting lists. *Management Information (MI) reporting pack* The proposed structure and content of future MI reporting to the committee was presented and agreed to utilize PowerBI as the delivery method in line with other committees. *Joint Forward Plan (JFP) update* Presented the timeline and requirements of the systems JFP for noting. *Spotlight: James Paget University Hospital NHS Foundation Trust (JPUH) Finances* Details of the JPUH financial position were presented by its CFO, who highlighted the key risks and issues. This was consistent with wider system financial risks discussed earlier in the meeting. This included the risk surrounding the forecast out-turn break-even position and the significant non-recurrent efficiency delivery which will translate into an increased challenge for 2023/24. In its meetings since July 2022, the committee has engaged with the CFOs of the ICB, Queen Elizabeth Hospital King's Lynn, and James Paget University Hospital, respectively, as part of a rolling financial update to the committee from NHS providers and the ICB. *Spotlight on Elective Recovery Fund (ERF)* A report was presented showing the system performance of ERF against the 104% (of 2019/20 activity) target. The system is significantly below this target showing actual delivery of 91.96% year to date.

	NHSEI have confirmed there will be no clawback of the funding for the first half of the year relating to this underperformance. This discussion linked back to the risks associated with the year-end forecast outturn and the delivery assumptions made within the 2022/23 plan. In its meetings since July 2022, the committee has engaged with stakeholders through spotlights on Mental Health Investment Standard, Discharge to Assess, Continuing Health Care, and Elective Recovery Fund, and its financial implications. **Part 2 – ICB** *Month 06 (September) ICB Finance Report* The ICB's organisational position was reviewed in detail, showing a break-even year to date and forecast full year out-turn, the delivery of which is significantly under-pinned by non-recurrent mitigations. The report also highlighted the net £17.7m of uncrystalised financial risk within the ICB, of which £9.1m relates to system risk being "held" by the ICB. *Prescribing rebates (standing item)* One prescribing rebate was presented for approval. *Spotlight on Mental Health Investment Standard (MHIS)* A detailed report showing the forecast achievement of MHIS for the year 2022/23 was presented, together with the potential risks and mitigations to this position. The Committee was given assurance that the MHIS target will be achieved. *Spotlight on ICB WTE and Pay cost analysis* This item was deferred to the following meeting. *In view of the reporting timeline, the next Finance Committee will be on 29 November 2022, and consider the Month 07 (October) financial position.*
Items for escalation to Board:	The significant levels of uncrystalised financial risk in the systems break-even FOT position (net £32.8m after identified mitigations) making it difficult to be assured of the achievement of the full year break-even position.
Items requiring approval:	None
Confirmation that the meeting was quorate:	Confirmed the meeting was quorate.

Key Risks	
Clinical and Quality:	Not applicable
Finance and Performance:	It is important that there is scrutiny of financial management of the ICB and this function is performed by the Finance Committee.

Impact Assessment (environmental and equalities):	Not applicable
Reputation:	Ensuring effective committees and order of business essential for maintaining the reputation of the ICB
Legal:	Finance Committee is a statutory committee of the ICB.
Information Governance:	Not applicable.
Resource Required:	None.
Reference document(s):	Not applicable.
NHS Constitution:	Not applicable.
Conflicts of Interest:	Not applicable.

Norfolk and Waveney
Integrated Care Board

Agenda item:

Subject:	**Audit and Risk Committee Report**
Presented by:	**David Holt**
Prepared by:	**Amanda Brown, Head of Corporate Governance**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**22 November 2022**

Purpose of paper:

To provide the Board with an update on the work of the Audit and Risk Committee for the period 27 September 2022 to11 October 2022.

Committee:	Audit and Risk Committee
Committee Chair:	David Holt, Non-executive Member
Meetings since the previous update on 27 September 2022	• 11 October 2022
Overall objectives of the committee:	This Committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.
Main purpose of meeting:	The main purpose of the meeting: • **Deep dive discussion and review of BAF 12 and 13** BAF 12 Cyber Security & BAF 13 Personal Data were presented to the committee by Andrew Palmer, the lead Director and Associate Director leads Anne Heath and Howard Martin. Key actions from the discussion include splitting BAF12 rewording the narrative for the risk to give a more accurate description of the risk, review of risk scoring and splitting the

	risk into wider cyber attack concerns and risk of individual cyber attack e.g. phishing emails. BAF 13 – further discussion on risk to look at incentive for practices to share data. • **Internal Audit Plan approved** The plan was approved with proviso it returns to the committee meeting in December to confirm the audits that are achievable in year. ICB Transition Governance audit received 'substantial' assurance. • **Anti-Crime Plan approved, and Anti-Crime Progress Report noted** • **Information Governance Work Group terms of reference approved and update of IG policies noted** • **Losses and Special Payments – no new items for write off**
BAF and any significant risks relevant / aligned to this Committee:	The Committee has responsibility for oversight of the ICB risk management process and the whole Board Assurance Framework.
Key items for assurance/noting:	Deep dive review of BAF 12 and 13
Items for escalation to Board:	None
Items requiring approval:	No items for approval.
Confirmation that the meeting was quorate:	Yes

Key Risks	
Clinical and Quality:	Internal audit reports provide assurance on internal control processes
Finance and Performance:	The Committee monitors the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance.
Impact Assessment (environmental and equalities):	None

Reputation:	The Committee supports the ICB reputation by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.
Legal:	
Information Governance:	This Committee provides assurance to the Board that there is an effective framework in place for the management of risks associated with IG.
Resource Required:	None
Reference document(s):	None
NHS Constitution:	N/A
Conflicts of Interest:	The Committee is responsible for satisfying itself that the ICB's policy, systems and processes for the management of conflicts (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.