Meeting of the Board of Norfolk and Waveney Integrated Care Board ICB

Tue 30 May 2023, 13:30 - 15:30

Agenda

13:30 - 13:30
0 min

Meeting Agenda

00. 2023.05.30 NW ICB Public Meeting Agenda.pdf (4 pages)

13:30 - 13:30
0 min

1. Welcome and introductions - Apologies for absence

13:30 - 13:30
0 min

2. Minutes from previous meeting and matters arising

02. DRAFT NW ICB Board Part 1 Minutes 28032023.pdf (7 pages)

13:30 - 13:30
0 min

3. Declarations of interest

03. Board Register of Interests.pdf (4 pages)

13:30 - 13:30
0 min

4. Chair’s Action Log

13:30 - 13:30
0 min

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

05. ICB Board Action Log May 2023.pdf (1 pages)

13:30 - 13:30
0 min

6. Chair and Chief Executive’s Report

06. Chair and Chief Executive's ICB Board report - Final.pdf (8 pages)

13:30 - 13:30
0 min

7. Learning from people, staff, and communities

13:30 - 13:30
0 min

Items for Sharing and Board Consideration

13:30 - 13:30
0 min

8. Norwich Walk in Centre re outcomes and approvals

08. Norwich Walk In Centre Consultation_final.pdf (11 pages)

13:30 - 13:30
0 min

9. Joint Forward Plan Review

- 09. ICB Board Report 30 May 2023 - Final.pdf (4 pages)
- 09. NW First Draft JFP Part 1 - v0.5 17-05-2023.pdf (100 pages)
- 09. NW First Draft Part 1 (Appendix 1) 17-05-2023 V0.5.pdf (15 pages)
- 09. NW First Draft Part 2 legal duties 15-05-2023.pdf (49 pages)

13:30 - 13:30
0 min

Finance and Corporate Affairs

13:30 - 13:30
0 min

10. Financial Report for Month 12

- 10. ICB Finance Report - Month 12 - Board.pdf (8 pages)

13:30 - 13:30
0 min

11. Additional Review of the Governance Handbook

- 11. Governance Handbook refresh May 2023.pdf (2 pages)
- 11.1 APPENDIX D- v1.5 track changes.pdf (9 pages)
- 11.2 APPENDIX H Performance TORv2 April 2023 + tracked changes V3.pdf (8 pages)

13:30 - 13:30
0 min

12. Board Assurance Framework

- 12. BAF Cover Paper.pdf (3 pages)
- 12.1 Board Assurance Framework (BAF) Risk Register.pdf (51 pages)

13:30 - 13:30
0 min

13. IFR Drugs Policy Approval and IFR Non-Drugs Policy Approval

- 13. ICB Board IFR updated cover sheet May 23 v4.pdf (3 pages)
- 13.1 IFR-Drugs Panel Policy - May 2023 - FINAL.pdf (26 pages)
- 13.2 Non-Drugs IFR Policy May 2023 FINAL.pdf (23 pages)

13:30 - 13:30
0 min

Committees Updates and Questions from the public

13:30 - 13:30
0 min

14. Report from the Quality and Safety Committee

- 14. Quality and Safety Committee Report to Board v2.0.pdf (7 pages)

13:30 - 13:30
0 min

15. Report from the Finance Committee

- 15. ICB Fin Com Chair Report to Board.pdf (4 pages)

13:30 - 13:30
0 min

16. Report from the Primary Care Commissioning Committee

- 16. PCCC for ICB Board.pdf (5 pages)

13:30 - 13:30
0 min

17. Report from the Performance Committee

17. Performance Committee Report to Board - May 2023.pdf (3 pages)

13:30 - 13:30
0 min

18. Report from Patients and Communities

18. ICB Board - Patients and Communities Committee Update May 2023 (1).pdf (6 pages)

13:30 - 13:30
0 min

19. Report from the Audit and Risk Committee

19. 20223.05.11-ARC Report to Board.pdf (6 pages)

13:30 - 13:30
0 min

20. Report from the Remuneration, People and Culture Committee

20. REMCO Committee Report to Board template - May 2023.pdf (5 pages)

13:30 - 13:30
0 min

21. Report from the Conflicts of Interest Committee

21. COI Committee Report to Board.pdf (2 pages)

13:30 - 13:30
0 min

22. Questions from the Public. Where questions in advance relate to items on the agenda.

13:30 - 13:30
0 min

23. Any other business

NHS
Norfolk and Waveney
Integrated Care Board

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

Tuesday, 30 May 2023, 1.30pm – 3.30pm

(In Public)

Meeting virtually via Microsoft teams

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.		**Chair's Action Log** To receive an update from the Chair on actions taken since the last meeting. There are no Chairs Action to report at this meeting.	Chair
5.	1.35	**Action log – things we have said we will do** To make sure the ICB completes all the actions it agrees are needed.	Chair
6.	2.05	**Chair and Chief Executive's 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.	1.40	Involving the voice of people who use and deliver services, as well as unpaid Carers, in our Board meetings held in public is a powerful commitment from our Board that our people and communities are at the heart of service design and decision-making. It is important that this learning drives change, so this item will revisit our first four learning sessions to find out what has changed as a result of what we were told.	Tricia D'Orsi
		Items for Sharing and Board Consideration	
8.	1.55	**Norwich Walk in Centre re outcomes and approvals** To update Board members on the final report summarising the Norwich Walk-in Centre consultation and recommendation for approval.	Mark Burgis/Sadie Parker
9.	2.15	**Joint Forward Plan Review** To receive a copy of the draft Joint Forward Plan.	Andrew Palmer
		Finance and Corporate Affairs	
10.	2.45	**Financial Report for Month 12** To receive a summary of the financial position as at month 12	Steven Course
11.	2.55	**Additional Review of the Governance Handbook** To share details of amendments to two committee terms of reference for Board approval.	Karen Barker
12.	3.00	**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
13.	3.05	**IFR Drugs Policy Approval and IFR Non-Drugs Policy Approval** To approve the revised Non - Drugs Individual Funding Request Policy and the Drugs Individual Funding Request Policy.	Karen Barker
		Committees Update and Questions from the public	
14.	3.10	**Report from the Quality and Safety Committee**	Aliona Derrett
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**	Dr Hilary Byrne

Item	Time	Agenda Item	Lead
18.		**Report from Patients and Communities**	Aliona Derrett
19.		**Report from the Audit and Risk Committee**	David Holt
20.		**Report from the Remuneration, People and Culture Committee**	Cathy Armor
21.		**Report from the Conflicts of Interest Committee**	David Holt
22.	3.20	**Questions from the Public.** Where questions in advance relate to items on the agenda.	Chair
23.		**Any other business**	Chair
Date, time and venue of next meeting: **Tuesday, 18 July 2023 Norwich Research Park (Quadram Institute, Rosalind Franklin Road, Norwich Research Park, Norwich, Norfolk, NR4 7UQ); - Rooms 55b and 55c**			
Any queries or items for the next agenda please contact: **nwccg.corporateaffairs@nhs.net**			

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, 28 March 2023

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 (SCou), 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
- Aliona Derrett (AD), Non-Executive Member, NHS Norfolk and Waveney ICB
- Cllr Bill Borett (BB), Chair, Norfolk Health and Wellbeing Board, and Chair, Norfolk and Waveney ICP (joined via MS Teams)
- Dr Hilary Byrne (HB), Partner Member – NHS Primary Medical Services
- Jonathan Barber (JBa), Partner Member – NHS Trusts (Acutes)
- Stephen Collman (SCol), Partner Member – NHS Trusts (Mental Health and Community Services)
- James Bullion (JBu), Local Authority Partner Member (joined via MS Teams)
- Sue Cook (SCoo), 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
- Andrew Palmer (AP), Director of Performance, Transformation and Strategy, NHS Norfolk and Waveney ICB
- Ema Ojiako (EO), Director of People, NHS Norfolk and Waveney ICB
- Ian Riley (IR), Director of Digital and Data, NHS Norfolk and Waveney ICB
- Judith Sharpe (JS), Deputy Chief Executive, Healthwatch Norfolk

Attending to support the meeting:

- Chris Williams (CW), Senior Support Manager, NHS Norfolk and Waveney ICB (Minutes)
- Kieren Davies (KD), Support Worker, REST King's Lynn (for item 7)
- Sara Tough (ST), Executive Director for Children's Services, Norfolk County Council (for item 9)

1.	**Welcome and introductions – apologies for absence**	
	The Chair welcomed everyone to the meeting. There were no apologies from Board members.	
2.	**Minutes from previous meeting and matters arising**	
	Agreed: The draft minutes from the meeting held on 24 January 2023 were approved as an accurate record of the meeting.	
3.	**Declarations of interest**	
	The Chair noted that declarations of interest are kept up-to-date and are available on the ICS's website.	
4.	**Chair's action log**	
	The Chair explained that there were no actions to report at the meeting.	
5.	**Action log**	
	The report was noted.	
6.	**Chair and Chief Executive's Report**	
	The Chair introduced the item and noted that the Hewitt Review would be published shortly and then shared with the Board. Questions and comments from Board members: • DH asked how long the additional capacity introduced using winter funding would be available for and what the risks are of it no longer being funded. TB explained that the funding did have a cut off of 31 March, but that we are looking at longer term solutions, including the workforce needs, so that we avoid putting-in short-term additional capacity next winter. The report was noted.	
	Learning from people, staff and communities	
7.	**Learning from people, staff and communities**	
	PD'O introduced the item, which focused on how people with lived experience of mental ill health are being supported to manage their mental health and live well in the community. KD introduced the Wellbeing Hubs and set-out the services they offer to adults experiencing mental health crisis. He explained that word of mouth is really important for referrals and that there is now close working with local partners, including the Police, adding that good communications between partners is helping to provide more continuity of care. **Action: CW to share the video of the wellbeing hub service users with the Board.**	

	Items for sharing and Board consideration	
8.	**Quality Strategy approval**	
	PD'O introduced the item by explaining that the draft strategy had been pulled together by partners from across the whole system, including the voluntary, community, faith and social enterprise (VCFSE) sector. She noted that the strategy is a statement of intent about what we need to do to improve the quality of care in Norfolk and Waveney, and that the next step would be to develop an implementation plan with partners. Questions and comments from Board members: • JBa supported the broad aims of the strategy and having one strategy for the system, and highlighted that we will need to identify quality metrics which are cascaded through all the provider organisations and linked to what place needs to deliver. • ER commented that in terms of data and evidence, the VCFSE sector has lots to offer and that it would be good to acknowledge this in the strategy. • JBu welcomed the strategy and its focus on both quality and equalities, and the committment to being person-centred. He noted that as we implement it, he would welcome a focus on the care market and a stronger link to the Integrated Care Strategy too. • TD'O explained that there will be workshops regarding metrics and measurements, and that she will ensure there is a reference to the VCFSE sector's data and evidence in the strategy. She added that she knows the care market is challenged and is committed to strengthening the availability of services. She also explained she would welcome further discussions about how the link with the Integrated Care Strategy could be strengthened. • FS thanked TD'O for the approach taken to co-produce the document and that she was pleased to see research and evidence embedded as one of the six pillars, as this is how we work in Norfolk and Waveney. **Agreed:** The ICB Board agreed to: • Approve the ICS Quality Strategy (2022-2025) for publication. • Support the next steps in relation to pre-publication design and the approach to development of a supporting implementation plan, as detailed in the paper.	
9.	**Mental Health Collaborative approval**	
	JP introduced the item by highlighting key points from the paper. ST joined the meeting for this item and outlined the opportunities for children and young people. JBu expressed his support for the work and noted there's great scope for change. He also acknowledged the role the Mental Health Programme Board had played in this work. Questions and comments from Board members:	

	• HB welcomed the development of the collaboratives and asked when we will see outcomes and start making a tangible difference. • JP explained that the collaboratives would start in April, looking at the opportunity for change and making detailed plans that could be brought back to the Board. • SCoo noted she had been involved in the development of the collaboratives. She explained that Suffolk is working to the same timescales, which is helpful, and welcomed the flexibility of Board around children's services. • AD asked if any information could be shared about the impact of the FLOURISH strategy. • ER suggested the VCSE Assembly could be involved to strengthen the sector's involvement in the collaboratives. • ST noted that the VCSE sector is involved in the Alliance. She highlighted that one of the successes of FLOURISH is that it has asked each of our agencies to ask what they are doing for children and young people. She explained that there is a performance framework. **Agreed:** The ICB Board agreed to: • Establish the adult mental health system collaborative and a children and young people's system collaborative from April 2023. • Endorse the direction of travel set out in the paper. **Action: CW to add an update on the FLOURISH strategy and its impact to the Board's forward plan.**	
10.	**Maternity overview and updates**	
	PD'O introduced the item by highlighting key points from the paper. Questions and comments from Board members: • SCol supported the report, particularly the conclusion of having a single delivery plan. He added that maternity can't be seen in isolation and that the lessons from East Kent should be implemented with other services too. • HB asked if there had been a reduction in provision of Entonox for our paitents, and if so, are we assured that we have the appropriate pain management strategies in place. • CA explained she was pleased to see that there would be more permanent members of staff in place to support the Local Maternity and Neonatal System, and asked if the numbers of staff would remain the same. • TD'O explained that the Quality and Safety Committee and the System Quality Group would share the learning across different groups. She noted that there are plans afoot with NHS England regarding Entonox and that we are in line with all the	

	recommendations coming forward at the moment. We are also ensuring risk assessments are being undertaken in a timely way with regards to Entonox. She explained that we have seen over recent months an improvement in the number of maternity support workers and midwives working in all the units, although we still have improvements to make in terms of recruitment and retention, which we are working with local partners, NHS England, the University of East Anglia and the University of Suffolk on. **Agreed:** The ICB Board agreed to: • Note the work undertaken by the Local Maternity and Neonatal System (LMNS) to deliver the Maternity Transformation Programme. • Note the LMNS role in Quality and Safety Oversight and response to Ockenden and East Kent.	
	Finance and Corporate Affairs	
11.	**Financial Report for Month 11**	
	SCou introduced the item, noting that the forecast outurn position for the ICB for the year remained a break-even position in line with our plan. He explained that the forecast outurn position for the Integrated Care System was a £20m deficit. Questions and comments from Board members: • DH asked for more information about the variances and where it puts the ICB in terms of risk for the next financial year. SCou noted that some underspends had been used as one-off, non-recurrent savings, which does provide some risk in our plans for 2023/24. The report was noted.	
12.	**Review of the Governance Handbook**	
	KB introduced the item by highlighting key points from the paper and noting that we would be undertaking a larger governance review later in the year. Questions and comments from Board members: • AD suggested that independent providers should be added to the graphic on page two of the handbook. • JBa asked if the larger review later in the year will give further consideration as to how the provider collaboratives fit into the system. • ER suggested that the sentence on p65, point 5, be changed to “continue to invest in the VCSE Assembly”, rather than “build relationships with the VCSE Assembly”. • BB noted that the primary care representation on the ICP has been increased by adding the chairs of the place boards to the membership.	

	• KB explained that how the provider collaboratives fit into the system would be given further consideration in the governance review, and committed to making the changes suggested by AD and ER. **Agreed:** The ICB Board	
13.	**Board Assurance Framework**	
	KB introduced the item by highlighting key points from the report. Questions and comments from Board members: • HvWB commented that the dates for the risks don't all have to finish at the end of the financial year and that for each risk we should ask the risk owners when we think we will be at our tolerated risk level. • BB commented that if we think risks are going to take longer than the end of the financial year, we should say so. • SCol suggested that further consideration is given to how the ICB's Board Assurance Framework is linked with and translates into individual trust and organisational equivalents. • DH commented that the risks the Board might be most concerned with are the ones that have catastrophic consequences. He explained he would be meeting again with KB to discuss how this is managed going forward, but that there might be value in giving more thought to how the Board are kept informed of these when we are operating above our risk threshold or appetite. • KB noted that we do tend to work on a yearly basis for the dates for the risks, but that there are no rules about this and we can review it. She added that in terms of aligning the ICB's Board Assurance Framework with other organisations, we have started to hold meetings of the chairs of the different audit committees and that work is ongoing with the directors of corporate affairs from the trusts too. **Action: DH and KB to give further consideration as to how the Board is kept informed about the ICB's risks that are highlighted as having catastrophic consequences, particularly when we are operating above our risk threshold or appetite.** The report was noted.	
	Committees update and questions from the public	
14.	**Report from the Quality and Safety Committee**	
	The report was noted.	
15.	**Report from the Finance Committee**	
	The report was noted.	
16.	**Report from the Primary Care Commissioning Committee**	

	The report was noted.	
17.	**Report from the Performance Committee**	
	The report was noted.	
18.	**Report from Patients and Communities Committee**	
	The report was noted.	
19.	**Report from the Audit and Risk Committee**	
	The report was noted.	
20.	**Report from the Conflicts of Interest Committee**	
	The report was noted.	
21.	**Questions from the public**	
	There were no questions from the public.	
22.	**Any other business**	
	No other business was raised.	

Date, time, and venue of next meeting:

Tuesday, 30 May 2023, via MS Teams

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				Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		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	Patient at 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 Pension Schemes	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	Broadland St Benedicts			X	Direct	Non-executive Director of Broadland St Benedicts – the property development subsidiary of Broadland housing Group	2020	Present	Although risks are minimal this will always be declared as with Trust Board declaration of interests
		James Paget University Hospitals		X		Direct	Deputy CEO of James Paget University Hospitals NHS FT	2022	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.
		Great Yarmouth & Waveney		X		Direct	GY&W Place Chair	Ongoing		
		Acle GP Partnership			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Tracey Bleakley	Chief Executive Officer, Norfolk and Waveney ICB	Drayton & St Faiths Medical Practice			X	Direct	Patient at 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				Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
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
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	
		South Norfolk PCN				Indirect	Clinical Director of SNHIP Primary Care Network	2022	Present	
Stephen Collman	Partner Member - Mental Health and Community, Norfolk and Waveney ICB	Norfolk Community Health and Care NHS Trust		X			Chief Executive, Norfolk Community Health and Care NHS 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.
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	Executive 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

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				Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
Aliona Derrett	Non-Executive Member, Norfolk and Waveney ICB	Norfolk and Norwich University Hospitals NHS FT				Indirect	My son-in-law, Richard Wharton, is a consultant surgeon at NNUHFT	2004	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Hear for Norfolk	X			Direct	I am the Chief Executive of Hear for Norfolk (Norfolk Deaf Association). The charity holds contracts with the N&W ICB.	2010	Present	
		Derrett Consultancy Ltd	X			Direct	I am the Director of Derrett Consultancy Ltd.	2018	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		Norfolk and Waveney MIND				Indirect	My husband, Robin Derrett, is the HR Director at Norfolk & Waveney MIND. MIND holds contracts with the N&W ICB	2021	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		MoldovaDAR Ltd	X			Direct	I am Director of MoldovaDAR Ltd	Ongoing		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
Patricia D'Orsi	Executive 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	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Department of Work and Pensions	X			Direct	Non-Executive Board Member, Department for Work and Pensions. Chair of the Audit Committee and Chair of the Health Transformation Programme Board	2019	May-23	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			Direct	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 made with the relevant chair to assess the risks. Appropriate action will be taken accordingly.
		Newberry Clinic				Indirect	Wife is Consultant Community Paediatrician, Newberry Clinic (Great Yarmouth)	Ongoing		
Andrew Palmer	Deputy Chief Executive Officer, Norfolk and Waveney ICB	James Paget University Hospitals				Indirect	My wife works at the JPUH, in a non-decision making role	Ongoing		Any decision relating specifically to the JPUH should ideally be made by the ICB's CEO. However, in their absence the

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				Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
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
Dr Frankie Swords	Executive 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	Ad-hoc Clinical Advisor of multiple patient charities - Addison Self Help Group - Pituitary Patient Support Group - Turner syndrome Society	2008	Present	
		Long Stratton Medical Partnership			X	Direct	Patient at 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
		N/A				Indirect	Husband is a counsellor and undertakes voluntary work with 2 VCSE providers in N&W MIND and Emerging Futures	2008	May-23	*Will be removed in Nov 23* Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services
Hein van den Wildenberg	Non-Executive Member, Norfolk and Waveney ICB	Lakenham Surgery			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		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 Action Log Part 1 - Tuesday 30 May 2023							
No:	**Date of Meeting**	**Description**		**RESP**	**Due Date**	**ACTION / UPDATE**	**Status**
3	22-nov-22	Follow up learning from patient experience	TD'O to bring a report back to the meeting of the ICB Board in January 2023 on learning from the patient experience heard in November.	Tricia D'Orsi	30.05.2023	Item moved to May and on agenda.	Propose closure
8	28-mar-23	Wellbeing Hub Video	CW to share the video of the wellbeing hub service users with the Board	Chris Williams	30.05.2023	Video shared with Board.	Propose closure
9	28-mar-23	Flourish Strategy	CW to add an update on the FLOURISH strategy and its impact to the Board's forward plan.	Chris Williams	30.05.2023	Noted on forward planner.	Propose closure
10	28-mar-23	Risk overview and discussion of potential risks and what is rated as catastrophic.	DH and KB to give further consideration as to how the Board is kept informed about the ICB's risks that are highlighted as having catastrophic consequences, particularly when we are operating above our risk threshold or appetite.	Karen Barker	30.05.2023	Audit committee have reviewed risk work - report from the Committee on the agenda today	Propose closure

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:	**30 May 2023**

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
B. Elective recovery
C. Delegation of dental, pharmaceutical and ophthalmology services
D. Operational and financial planning
E. ICB organisational review and restructure
F. 1,000 carers passports
G. Changes to our system leadership
H. Visits

Report

A. System pressures

The pressure on health and care services has reduced compared with the winter period, however we continue to face operational challenges. As a system, we stepped down from Critical Incident level a couple of months ago, but we continue to operate at level three of the Operational Pressures Escalation Levels Framework (OPEL 3).

Since we last met, we've had the four-day Easter weekend, which has historically been a challenging time for our system, and this year that was followed by the junior doctors' industrial action. We conducted a significant amount of planning for this, and while it was challenging, overall, we managed the period reasonably well. There was of course an impact on our elective recovery though.

Key actions we took to manage the situation, informed by the learning from previous rounds of industrial action, included:

- Increased public messaging stressing that our services would be busy and asking people to choose services wisely.
- We ran Multi-Agency Discharge Events to try to create capacity in advance, we had plenty of transport available to support discharge and we had internal transfer teams to support with flow. IC24 again had additional staff to redirect as many patients as possible away from Emergency Departments, where clinically appropriate. There was additional clinical assessment service (CAS) capacity to support NHS 111 and additional vehicles for home visits.
- We planned well ahead. Staff at the acute trusts were fantastic and we were able to fill emergency and inpatient rotas well, including amazing support from pharmacy, digital, operational and nursing teams, as well as consultants and other senior medical staff.

We know from previous rounds of industrial action that the aftermath was a little worse than expected. We had a tired workforce who needed compensatory rest and some time off in lieu, which further affected the elective recovery challenge. There were also challenges with the amount of time and resource needed to contact and reschedule patients. We have been supporting staff to recover – it is vital that we look after our workforce – while also working to reschedule patients needing elective care. We will continue to plan and learn as a system for future rounds of industrial action.

B. Elective recovery

We want to highlight the amazing work done by colleagues across the system. Our target was to clear all the patients waiting 104 weeks by July last year and to maintain it, then to clear all those waiting 78 weeks (18 months) by the end of March 2023.

We had some specific challenges with the specialist workforce in gynaecology, with some patients waiting longer than 78 weeks for that reason. But otherwise, we did

incredibly well – missing the target by just 315 patients across our whole system, despite large numbers of appointments which had to be rescheduled due to the industrial action in March.

This is an incredible achievement. It is down to the real hard work and cooperation across all our hospitals, balancing our ambition to clear our longest waiting patients and at the same time to address the needs of emergency, urgent and cancer patients. We want to thank everyone who has played a role in this. Our next major target is to clear all those waiting 65 weeks by the end of March 2024, and at the same time, push to keep improving our cancer performance.

C. Delegation of dental, pharmaceutical and ophthalmology services

On 1 April 2023, the ICB became responsible for pharmaceutical services, primary care optometry services and dental services (primary, community and secondary care). This covers:

- Contracts with 181 community pharmacies
- 66 optometry contracts
- 102 primary care dental contracts, one Special Care Dental service (community dental) contract, contracts with three secondary care providers and contracts for Level 2 specialist services and the out of hours service for weekends and bank holidays.

This means the ICB is now responsible for all primary care services (we were already responsible for general practice). It provides real opportunities to commission services differently, to join-up services and to focus on improving the health of the population.

Improving access to primary care services is a priority for us, as it is for local people. We have three priorities that will help us to better understand and address the challenges facing all primary care services:

1. **Listen to the views of the different primary care professions** and hear about their concerns regarding the future of services in Norfolk and Waveney and how we can support them.

2. Consider **how we can retain our local workforce** and allow them to develop their skills and expertise, **offer opportunities for them to provide some services in a different way** where possible, and also to **encourage individuals to come and work in our area**.

3. **Listen to our patients** and their lived experience, and to **ensure our local population has access to primary care services** when needed.

Dental services

There are significant challenges with access to dental services in particular. We won't be able to solve all the challenges overnight, but we can make a difference. For example:

- Last year new dental service providers were procured in King's Lynn, Lowestoft and Norwich that are offering services 8am – 8pm every day. All three are now offering their full range of services, however they have reached capacity and are not able to take on any more NHS patients. In total the three services are providing NHS dental care to c6,800 patients (4,343 adults and 2,449 children).
- The University of Suffolk has established a Centre for Dental Development to enhance local education and training opportunities in dental therapy and hygiene, apprentice dental technicians and post graduate dentists. The Centre will sit alongside a community interest company that will be able to bid for future locally commissioned dental services.
- In April we increased investment in domiciliary dental services which treat housebound patients in Norfolk and Waveney by £33,575 for 2023/24.

There are actions we will be able to take relatively quickly that will make a difference. However, sustainable, long-term change will take time to achieve. So, our approach is three-fold:

1. **To take any immediate actions we can to improve services**, such as the investment in domiciliary dental services already made.

2. **To agree a one-year plan by September 2023 for short-term interventions to address the most immediate concerns.** A more flexible commissioning approach will help to deliver services that patients need and can access more easily. It will also help to support our ambition to build relationships with and resilience among dental providers in Norfolk and Waveney.

3. **To develop a dental strategy by March 2024 which sets out our commissioning approach and intentions for the next five years**, how we plan to build resilience into our NHS dental services and improve general dental access, alongside the development of our local workforce plan.

This autumn we will receive a full assessment of Oral Health Needs data from the Consultant in Dental Public Health, which will further inform our planning.

General practice and pharmacies

On 9 May 2023, the Department for Health and Social Care and NHS England published a 'Delivery plan for recovering access to primary care'. The plan sets-out 14 actions to "tackle the 8am rush and reduce the number of people struggling to contact their practice" and to help "patients know on the day they contact their practice how their request will be managed".

Actions include:

- Empowering patients to manage their own health by significantly increasing use of the NHS App and (subject to consultation) enabling community pharmacies to supply prescription only medicines for seven common conditions by the end of 2023.

- Implementing ‘Modern General Practice Access’ by supporting all practices on analogue lines to move to digital telephony, including call back functionality, if they sign up by July 2023.
- Building capacity by increasing funding to employ more staff giving direct patient care, expanding GP specialty training and changing local authority planning guidance this year to raise the priority of primary care facilities when considering how funds from new housing developments are allocated.
- Cutting bureaucracy to give practice teams more time to focus on their patients’ clinical needs.

We welcome the plan, which is the first step towards addressing the access challenge ahead of longer term reforms set out in the Fuller Stocktake. The plan provides us with a blueprint for the steps we need to take in the coming months and we are reviewing it to understand what will be required to implement it.

D. Operational and financial planning

A significant amount of work was done to complete our operational and financial plans for 2023/24. This is always a complex piece of work and we would like to thank colleagues from the ICB and across the system who have worked on this and enabled us to set a break-even budget for the year ahead. We need to live within our budget and work with partners to use all our available resources to achieve the best possible outcomes for our residents.

A huge amount of work has also gone into developing our draft Joint Forward Plan. It sets-out how we want to transform services and people’s care over the next five years, in line with our Integrated Care Strategy. We look forward to a discussion with the Board at the meeting about our ambitions for the future and how as a system we will help people in Norfolk and Waveney to live longer, healthier and happier lives.

E. ICB organisational review and restructure

Work has continued on the ICB’s organisational review and restructure. The restructure is needed for two reasons. Firstly, all ICBs need to make a reduction of c35% to their running costs. Secondly, the current structure was put in place when we were a CCG and we need to review this based on what we have learnt since July and to take account of the organisation’s new functions and role as a convener of the system.

We know this is difficult for our staff. We want to thank them for their constructive approach, with colleagues coming forward with creative ideas and thoughtful suggestions. We are and will continue to support staff through the process. The ICB’s People, Culture and Remuneration Committee, chaired by Cathy Armor, will be playing an active role in the oversight of the programme.

We recently wrote to a wide range of partner organisations to ask for input into the ICB’s restructure and for ideas about how we could work together in future. We are part of one integrated care system and so we don’t want the ICB to make changes to how we work in isolation. There is real scope for us to change how we work together

and to better join-up services. We're keen we use this as an opportunity to explore more joint posts, to look at how our teams work together and to consider whether there would be benefits by bringing colleagues together.

F. 1,000 carers passports

Board members will remember that at our very first meeting on 1 July 2022, we heard about plans to launch a carers passport, to help unpaid carers get the recognition they need to help them to do their caring role. It is really pleasing to hear that over 1,000 passports have now been issued to unpaid carers in Norfolk and Waveney.

The passports were co-produced with local carers in a project funded by the ICB and run in partnership with Carers Voice and Caring Together. If you know of a patient, colleague, or family member who is an unpaid carer they can register for a passport using an online form here on the Carers Voice website: https://www.carersvoice.org/carers-identity-passport/. Anyone who needs support to complete an online form can call 07932 095312.

G. Changes to our system leadership

We want to thank Anna Davidson for everything she has done as Chair of James Paget University Hospitals NHS Foundation Trust and wish her well in her retirement. Under Anna's leadership, the Trust has come to be recognised for the exceptionally caring quality and commitment of its staff, reflected both in CQC ratings and in surveys of staff themselves.

We want to congratulate James Bullion on his appointment as the new interim Chief Inspector of Adult Social Care and Integrated Care for the Care Quality Commission (CQC). James has been a vital member of the senior leadership team of our Integrated Care System for the last six years, not just in his role as Executive Director of Adult Social Services at Norfolk County Council, but also as a member of the Integrated Care Board, Chair of the Board's Primary and Community Care Committee and through all the other work he has done.

We've been fortunate to benefit from his experience and leadership here in Norfolk and Waveney. He is of course also well-respected nationally, for example having been President of the Association of Directors of Adult Social Services during the pandemic. We know he will do an excellent job at the CQC. We are working on appointing a new partner member from local government on the ICB Board and appointing a new Chair of the Primary and Community Care Committee.

Finally, we would like congratulate Dr Andy Griffiths OBE, who has been appointed Deputy Medical Director of the ICB. Andy is currently Deputy Medical Director at Mid and South Essex Integrated Care Board. He is a consultant anaesthetist and senior clinical leader who has served around the world in the Armed Forces. We look forward to him joining us in August.

H. 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:

- I attended a wide range of meetings to finalise and then share the findings of my review.
- I visited the James Paget Hospital to attend a farewell event for Anna Davidson. I also had the opportunity to visit the new Concept Ward while I was there, which is based on single bedded bays with en-suite facilities and large four bedded bays. The new ward will enable remediation of RAAC plank wards while testing working arrangements, construction and running costs of single bedded units. I was very impressed by the innovative approach of both the Trust's estates team and their construction partners, as well as the independent evaluation being carried out with university colleagues. The opening this month is an important milestone in the new hospital, as well as providing vital evidence for the national programme.
- I also visited the Queen Elizabeth Hospital where I had the opportunity to meet the teams responsible for flow through the hospital and discharge, as well as the maternity team who we're celebrating international midwives day. I also saw some of the many ways the hospital estate is being developed (with both new build and extensive refurbishment of old buildings providing excellent facilities for ophthalmology, staff education and the wellbeing service). All this work is part of the planned new hospital that is increasingly urgently needed and, we hope, will be announced soon.
- On my visits to both hospitals, I also had very useful conversations with non-executive and executive board members, as well as other staff. I am hugely grateful to all of them for their time, their excellent work and for arranging my visits.
- Clive Lewis MP organised a really helpful meeting with voluntary organisations involved in the advice sector in Norwich, in part to discuss the walk-in centre, but also the wider work we want to with the sector, particularly to tackle health inequalities and the wider determinants of health. The discussion was really thought provoking and constructive.
- I met Adam Doyle, Chief Executive of Sussex ICB, who has been appointed by Amanda Pritchard to a three-day a week role at NHS England supporting systems. He is doing a deep dive into system architecture, including the operating framework, the oversight framework and arrangements for place. We are in the process of arranging a date for Adam to visit Norfolk and Waveney.
- With Tracey, James Bullion, Stuart Richardson and Mark Burgis, I met with local MPs. We discussed the work the system is doing to improve access to primary care, particularly dentistry and the new national delivery plan mentioned above, as well as mental health services, estates and finances.

- Also with Tracey, I attended the ICB Review Meeting with regional NHS England colleagues, which was an opportunity to discuss our planning for 2023/24, as well as a range of other topics.

As Chief Executive, a significant focus has been on the 2023/24 planning round, as well as the ICB's organisational review, but other meetings and visits have included:

- Clare Panniker, Regional Director for NHS England, visited us. I showed her the Vulnerable Adult's Service and the Network Escalation Avoidance Team in Norwich, while explaining how these services fit into the broader context of how we are working together to care for people.
- I went to a national NHS leadership event for ICB and trust chief executives, which was a good opportunity to share challenges and solutions with peers from across the country.
- I attended a meeting convened by Mencap focused on learning disabilities and autism. I volunteered to be the Senior Responsible Officer for East of England for a programme of work to improve care and services. Locally we are doing really well on health checks for people with learning disabilities and have hit the national target of 75%, but we want to do more, not just on health checks, but in thinking about how we can tackle the disparity in life expectancy and quality of life.

Norfolk and Waveney
Integrated Care Board

Agenda item: 8

Subject:	**Norwich Walk-in Centre consultation report and recommendations**
Presented by:	**Mark Burgis, Executive Director of Patients and Communities** **Sadie Parker, Director of Primary Care**
Prepared by:	**Sadie Parker, Director of Primary Care** **Kristen Hall, Communications and Engagement Manager – Primary Care**
Submitted to:	**NHS Norfolk and Waveney Board**
Date:	**30 May 2023**

Purpose of paper:

To update Board members on the final report summarising the activity of the Norwich Walk-in Centre consultation.

To seek approval for the recommendation to commission a new contract for the Rouen Road GP practice, Walk-in Centre (**WiC**) and Vulnerable Adults Service - Inclusion Health Hub (**VAS**) when the current contract expires in March 2024.

Board members are asked to note that PCCC has considered and supported the above recommendation, and for the decision on this recommendation to be made by Board members at the ICB Board meeting on 30 May.

Board members are additionally asked to note that in response to feedback received from the consultation, the ICB would like to investigate what capacity could potentially be released from the GP practice at Rouen Road to create additional patient capacity at the WiC. This would create additional capacity at the WiC to improve patient access to primary medical services and further support GP resilience. It would require a separate period of data analysis and engagement with patients registered at the Rouen Road GP practice, and Board members are asked to note that PCCC have approved a 3-month extension to the current contract to enable this.

Executive Summary:

The ICB ran a consultation from 24 January – 26 March 2023 (9 weeks) on plans for general practice services in the Norwich area when the contract for the WiC, VAS, and GP Practice at Rouen Road expires in March 2024.

The consultation closed with over 3,000 responses which were received through the online survey and in writing.

A final report summarising the feedback received has been prepared by Engaging People - a third party organisation who also supported with the pre-engagement activities for the WiC consultation in June and November 2022. The report and a summary of the ICB's recommendations were published on the ICS's website on Friday 5 May, which can be read here.

Feedback received from members of the public who completed the survey and the stakeholders potentially affected by the change (including healthcare and local authorities) strongly indicated the desire for the WiC to remain open.

PCCC members reviewed and discussed the report summary in Part 1 of their meeting on 9 May. The Committee supported the recommendation and agreed that the decision to commission a new contract for the WiC, GP practice, and VAS be made at ICB Board on 30 May.

The recommendation has also been shared with the Norfolk Health and Oversight Scrutiny Committee (HOSC) for comment and information and will be discussed publicly at its next meeting in public on 1 June.

In addition, in response to feedback received from the consultation we would like to investigate what capacity could potentially be released from the GP practice at Rouen Road to create additional patient capacity at the Walk-in Centre and further support GP resilience.

The GP practice at Rouen Road currently operates longer hours than other GP practices in Norfolk and Waveney. We would like to explore a potential release of capacity by reducing the practice's current opening hours, which are 8am-8pm, seven days per week, and potentially bringing that in line with the core opening hours of other GP practices, which are 8am-6.30pm, Monday to Friday. The savings made from this reduction could be invested to create additional patient access to primary medical care through the WiC and reduce duplication of services.

This would require a separate period of data analysis and engagement with patients registered at the Rouen Road GP practice, and a 3-month extension to the current contract for this activity to take place. PCCC members approved a 3-month extension to the current contract to enable this at their meeting on 9 May.

Introduction

The ICB ran a consultation from 24 January – 26 March 2023 (9 weeks) on plans for general practice services in the Norwich area when the contract for the WiC, VAS, and GP Practice at Rouen Road expires in March 2024.

This paper aims to provide a summary of the consultation findings, as well as providing recommendations for the Board to consider regarding the future of the WiC.

Background

The options for consultation were developed following two rounds of engagement with the public and stakeholders in 2022.

PCCC members were previously briefed on the initial public engagement that was conducted via online survey in June 2022. The ICB's executive management team (EMT) were briefed on the need to undertake additional pre-engagement work and data analysis in November 2022 into the vulnerable adult and adults with additional needs population and their use of the WiC, and to request a contract extension with the provider, Norwich Practices Ltd, for that work to be undertaken and enable a full consultation to take place.

The findings from both programmes of pre-engagement activity, proposed consultation options, and a request for approval to proceed with a public consultation on the WiC were presented to EMT, HOSC, and the ICB Board in December 2022.

Content of the Consultation

The consultation provided 3 options:

- Reprocure the contract as it currently is (no change)
- Reprocure the GP practice and VAS, and let the WIC contract expire
- Reprocure the GP practice and VAS as they are. Redesign and recommission the resources currently provided at the WIC in a different way to improve health outcomes in underserved communities across the Norwich area

A key aim of this consultation was to encourage people to share their views to help shape what future general practice services could look like. The survey provided free text areas where the public could provide feedback on the three options and provided a space for respondents to provide additional input/thoughts into how services could be provided.

It also included several additional questions to gain public insight into experiences and preferences of GP services that will be useful in helping shape planning for future services.

Summary of the Consultation Engagement Activity

A programme of communications and engagement was planned throughout the consultation period which included:

- An ipad hosted at the WIC for the duration of the consultation period with the survey loaded onto it for patients to complete while at the WIC

- Face-to-face interviews with advocates of underrepresented groups, vulnerable adults, and at-risk adults to ensure voices from across the wider Norwich community are captured as part of this consultation
- Interviewers were on site at the WIC over a number of days throughout the consultation period (inc evenings, mornings and weekends) to speak to patients and support them to complete the survey
- Promotional posters and postcards with a QR code linking to the survey were delivered to practices across Norwich PCN, including to areas outside of Norwich such as Wymondham, Drayton, and Humbleyard practices where data show patients use the WIC in line with Norwich activity levels
- Weekly posts on the ICB social media channels and paid-for Facebook advertising
- Paper copies of the consultation document were provided at the GP Practice on Rouen Road and at the Walk-In Centre.
- A communications toolkit with promotional materials was distributed to all GP practices across Norfolk and Waveney to encourage participation by all patients that might use the WIC.
- Communications were supplied to PPGs, parish councils, and other organisations like Norfolk County Council and Community Action Norfolk to support sharing of the consultation opportunity through their communication channels.
- Advertisements in local newspapers were placed to promote ways that people could receive copies of the consultation documents who weren't online.

How people responded to the consultation

A total of **3,043** survey responses were received. The below breakdown highlights the method of response and requests for materials:

- Completed via survey: **2,986**
- Emailed a completed copy – **16**
- Posted a completed copy – **41**

- Requests for printed copies – **19**

- Requests for alternative formats and translations – **2**
    - 1 x Braille
    - 1 x large format version of the document
- Emails received with comments/feedback – **52**
- Easy Read survey returns – **0**

Overview Report Findings

These findings are based on 3,043 responses received to the survey.

In addition to the survey, feedback was also sought and gained from 14 qualitative 1:1 feedback opportunities with organisations supporting vulnerable adults, at-risk adults, adults with additional needs, and children and young

people.

Independent feedback was also received from 9 organisations during the consultation period, including local councils and healthcare providers.

Part A – Feedback on the Consultation Options

Respondent classification

- 98% of respondents (2,995 people) responded to the survey as 'an individual'.
- 1% (29 people) were staff members working at one of the three services which are the focus of the consultation
- 1% (41 people) were representing someone else.

Feedback about Option 1 (unprompted)

- Unprompted, the overriding sentiment was that Option 1 was the 'best' of the three proposed options, and that the three services (Walk-in Centre, the GP Practice, Vulnerable Adults Service) should continue as they are.
- All three highlighted services were considered 'essential', although the focus of feedback was most focused on the Walk-in Centre.
- Many were responding as past users of the Walk-in Centre, or who knew someone who has used its services, and experiences were typically positive.
- The focus of the consultation document was Central Norwich. However, geographically, the Walk-in Centre serves more than just Norwich residents. Indeed, it has a county-wide reach.
- A city-centre location was deemed important for the Walk-in Centre within the feedback.
- The feedback indicated that patient needs were not currently being met by their GP practices, with widely cited difficulties in getting appointments.
- The Walk-in Centre was perceived to be supporting local GP services by helping to plug 'gaps' in service provision.
- There was concern that, should the Walk-in Centre close, people woudld turn to an already stretched A&E as the 'next port of call'.
- Vulnerable groups, such as people experiencing homelessness, would likely be disadvantaged further by the loss of the Walk-in Centre.

Feedback about Option 2 (unprompted)

- Unprompted, Option 2 was widely and strongly negatively received by respondents.
- It was considered to be 'the worst' of the three options by many, due to the proposed closure of the Walk-in Centre.

- There were questions raised about where users of the Walk-in Centre would go, and how the Walk-in Centre's appointments would be recovered elsewhere, in light of a lack of available appointments at local GP practices.
- There was concern that implementation of Option 2 would put increased pressure on A&E.

Views on Option 3 (unprompted)

- The consultation document states that, '*We believe this is the most appropriate option'* which resulted in some perceived survey bias and a degree of derision amongst respondents.
- The consultation document also states, '*We have not finalised details of how this would operate in practice because feedback from patients, the public, and healthcare professionals is essential at this early stage to shape how services could be delivered to best meet local needs.'* Respondents felt that they were expected to make an uninformed decision on Option 3.
- Concerns were raised about whether local GP practices would be sufficiently equipped to meet increased demand on their services as they are currently considered to be ill-equipped to do so.
- From the feedback, it was clear that the WiC is fulfilling a need for immediate / urgent appointments. There was, therefore, some trepidation about this provision being lost, should Option 3 be taken forwards.
- There was sentiment that vulnerable groups (e.g. people experiencing homelessness / asylum seekers / migrant workers) are likely to be detrimentally affected, due to the loss of a 'walk-in' facility, which they can use without the need to be GP-registered.
- The feedback indicated that the loss of the WiC would be felt county-wide, not just by those living in Central Norwich.

Advantages of Option 3 (unprompted)

- Many respondents were unable to think of any advantages of Option 3.
- There was notable mention that information provided in the consultation document was insufficient for them to make a fully informed decision (details have not been finalised).
- Cost-savings were mentioned by some, sometimes scathingly, in that they will benefit the NHS and not patients.
- Any advantages spontaneously cited were extremely small in number.
- There was some low-level, underlying scepticism as to whether proposals would be (able to be) competently delivered.

Disadvantages of Option 3 (unprompted)

- Opposition to the closure of the Walk-in Centre was strongly voiced here.

- There was some doubt expressed that any alternative plans would actually be implemented, and concerns that any changes might not result in a more efficient service.
- There was significant mention that GP services are unable to meet current patient demand, due to lack of appointments and / or 'out-of-hours' provision.
- And there was an expectation that people would turn to A&E as the next option.
- There was some low-level mention that the healthcare needs of people living outside Norwich have been 'over-looked' by this consultation.

Key themes emerged for requests for input for additional ideas/suggestions as to how the healthcare capacity associated with the Norwich WiC could be managed, so that it offers more equal access for all Norwich residents, helps meet growing local demand for general practice services and supports resilience of general practices in Norwich:

- More funding to be made available
- Expand the Walk-in Centre provision (e.g., more centres / increased capacity at current site / move to larger site in Norwich)
- More staff / GPs / nurses generally
- Increased capacity at local GP practices (e.g., more staff, appointments, out-of-hours provision)
- Extended opening hours (Walk-in Centre and local GP practices)
- Better parking facilities at the Walk-in Centre (e.g., parking concessions / free parking)
- Better triage services

Part B - Helping to shape how health services are delivered locally

Additional questions were included to help shape provision of general practice services in Norwich, and which will provide a useful bank of information to support development of general practice services across Norfolk and Waveney.

How far would you be willing to travel for a pre-booked general practice appointment?

RESPONSE	%
Less than 5 miles	59
5 – 9 miles	25
10 – 14 miles	9
15 – 19 miles	3
20+ miles	4

There are lots of important factors that influence your preference for accessing general practice services. Please choose the top 6 most important factors to you from the list below.

- When asked to choose their 'top six' important factors, **the most important factor was 'being able to book a same day appointment'**, and for the large majority **(86%).**

- Other important factors to most are **'having a face-to-face appointment' (79%), 'being able to walk in without an appointment' (72%) and 'being able to book an appointment in advance' (72%).**

- **Having healthcare services within walking distance** ('close to where I live') was important to just under half of respondents **(46%);** and being **'close to public transport' to 40%.**

What is the most important consideration for you when you need to access general practice services, and why?

- When asked about the most important consideration when needing to access general practice services, key words coming through were '**accessibility' and 'availability'.**

- The key *theme* emerging, and overwhelmingly, was **being able to book an appointment with a healthcare professional (most likely a GP).**

- Specifically, **same day appointments were important to many,** as were **face-to-face appointments** (albeit the latter to a slightly lesser extent).

- **Speed of service was also of notable importance**, with many saying they want to be seen promptly, and urgently if needed

- Also important, albeit to a slightly lesser extent, were **services being conveniently located** (close to home / within walking distance / easily accessible by public transport).

What are the things that make it difficult for you to get the general practice services you need?

Key themes emerging included:

- Most significantly, **a lack of availability of appointments generally**
    - And, specifically, notable mentions of difficulties in getting face-to-face appointments
    - And same day appointments
        - With some frustration vented at having to call at a 'set time', first thing in the morning
    - And appointments outside of working hours (including weekends)

- **Problems getting past the receptionist were cited by many ('gate-keepers')**
    - Some do not like discussing health conditions with / being triaged by receptionists (they are not medically trained)
- **Not enough staff / GPs** (generally and / or at local practice)
- The overriding sentiment emerging was that **GP services are overwhelmed** and struggling to cope with current demand

Conclusions

The overriding feedback from the consultation, both from public responses and organisational feedback received, was for the WiC to remain open to support patient access to primary medical services and to support resilience in GP practices not just across the greater Norwich area, but county-wide. Additional significant concerns were raised around the impact of the closure of the WiC on emergency departments.

The additional information provided by Part B of the survey show the factors that are important to patients focus on availability of appointments within GP practices and being able to access healthcare when needed – whether that's through same day appointments, facility to walk-in, or being able to book appointments in advance for less urgent medical needs.

Recommendations

Taking into account the extensive feedback received from the public, media, health and political stakeholders, the recommendation is to proceed with Option 1 (reprocure the contract for the Rouen Road GP practice, WiC, and the VAS).

The Board is asked to approve the recommendation for the WiC to remain open and for NHS Norfolk and Waveney to commission a new contract for the Rouen Road GP practice, WiC, and the VAS when the current contract expires.

ICB EMT and PCCC have noted and supported the above recommendation for the future of the WiC and approved the recommendation for the paper to go forward to the ICB Board for final decision in May. HOSC have also received the paper in advance of their 1 June meeting and supported the recommendation.

Separately, in response to feedback received from the consultation, we would also like to investigate what capacity could potentially be released from the GP practice at Rouen Road to create additional patient capacity at the WiC and further support GP resilience.

The GP practice at Rouen Road currently operates longer hours than other GP practices in Norfolk and Waveney. We would like to explore a potential release of capacity by reducing the practice's current opening hours (8am-8pm, Monday – Sunday), and bringing that in line with the core opening hours of other GP practices (8am-6.30pm, Monday to Friday). The savings made from this reduction could be

invested to create additional patient access to primary medical care through the WiC and reduce duplication of services.

In order for the required engagement with the registered practice list and data analysis on usage of the GP practice to be undertaken, this would require a short further 3-month extension of the contract, which PCCC has approved.

Following the above activity, a paper summarising the feedback received and recommendations on whether to reduce the opening hours of that practice will be presented to PCCC for a final decision in Summer 2023.

Recommendation to the Board:

Members are invited to consider this report and its findings, taking into account the volume of public and provider feedback received and existing system pressures. Members are asked to approve the recommendation to commission a new contract for the WiC, VAS, and Rouen Road GP practice when the current contract expires in March 2024. Members are lastly asked to note that we would like to review what capacity may be released at the GP practice at Rouen Road to create additional patient access to primary medical care through the WIC, and support general practice resilience. A period of engagement with patients registered at that practice and data analysis will be required to investigate this. PCCC have approved a 3-month extension to enable this. A paper summarising the feedback received and recommendations on whether to reduce the opening hours of that practice will be presented to PCCC for a final decision in Summer 2023.

Key Risks	
Clinical and Quality:	Feedback from the consultation is vital for the stability of services in Norwich and to maintain stability of ED.
Finance and Performance:	Cost envelope to remain the same for the overall service.
Impact Assessment (environmental and equalities):	EIA completed as part of consultation. New EIA required to support proposals
Reputation:	Significant reputational risk attached to this decision
Legal:	Legal advice was sought on the original consultation document. HOSC will consider the ICB's recommendations against the consultation report and determine their next steps.
Information Governance:	None identified at this stage

Resource Required:	Primary care commissioning team, communications and engagement team, Engaging People
Reference document(s):	Not applicable
NHS Constitution:	Not applicable
Conflicts of Interest:	GP practice members are conflicted, therefore they will be excluded from this section of the meeting
Reference to relevant risk on the Board Assurance Framework	Resilience of general practice

Governance

Process/Committee approval with date(s) (as appropriate)	

Norfolk and Waveney
Integrated Care Board

Agenda item: 09

Subject:	**Draft 5-year Joint Forward Plan (JFP)**
Presented by:	**Andrew Palmer, Executive Director of Performance, Transformation and Strategy**
Prepared by:	**Liz Joyce, Head of System Transformation**
Submitted to:	**ICB Board**
Date:	**30 May 2023**

Purpose of paper:

This paper presents the draft JFP for consideration by the ICB Board, to receive comments and feedback ahead of producing the final version in June 2023.

Executive Summary:

This paper builds on the good progress made with partners across the system since the ICB Board meeting on 28 March 2023. A pre-draft was submitted to NHSE on 31 March 2023 that has informed this version.

The draft JFP is in two parts:

1) Part one – the main JFP, with an Appendix to illustrate alignment with partners' plans.
2) Part two – Legal Duties

The draft can be accessed via the ICS website using this link: https://improvinglivesnw.org.uk/norfolk-and-waveney-5-year-forward-joint-forward-plan-draft-documents/

It is a requirement that the JFP includes an opinion from both Suffolk and Norfolk Joint Health and Well-Being Boards. The JFP was considered by the Suffolk Health and Well-Being Board on 18th May and was supported, with an opinion to follow pending sight of the finalised content of the JFP. Norfolk Health and Well-Being Board meets on 21 June 2023.

The JFP will be published by 30th June on the ICB website, designed in ICS colours with infographics and illustrated with case studies.

Producing the JFP is a statutory duty for ICB's, NHS Trusts and NHS Foundation Trusts and each partner will take the JFP through their own Board governance during May and June as required.

1.0 Recap of the current position

Papers have previously been brought to the Board of the ICB on 27 September and 22 November 2022, and 28 February and 28 March 2023. These informed members of requirements, the approach, proposed content, and key dates as our thinking around the Norfolk and Waveney JFP has developed.

At the 28 March meeting of the ICB Board some helpful advice from NHSE was highlighted to ensure that we retain a focus on what the JFP should include. This feedback was particularly clear around length, and that the audience is our local population. This will be our collective system plan for Norfolk and Waveney and to this end the JFP needs to be useful in a practical way, well understood and communicated.

A paper was brought to the Norfolk Health and Well-Being Board on 8 March 2023 which was a broad introduction setting out the requirements as per the Guidance, the eight Ambitions, our ways of working and aligned partners plans.

Health and Well-Being Boards have a specific role to provide an opinion on the JFP, which is then published within the plan itself. The JFP was supported at the Suffolk Health and Well-Being Board on 18th May, with a formal opinion to follow pending sight of the finalised content. The Norfolk Health and Well-Being Board meeting is on 21 June 2023. The Health and Well-Being Boards have a strategic role regarding the JFP because of the requirement to build on their respective Joint Local Health and Well-Being Strategies.

A pre-draft JFP was submitted to NHSE on 31 March which received positive feedback and has shaped this next draft. The JFP can be refreshed in-year if we want to do that and must be refreshed for April 2024, so this is an iterative plan. Progress with achievement of the commitments in the JFP will be published in the ICB's annual plans and in those of our NHS partners where the JFP is a statutory requirement.

The draft JFP was also considered and supported by the Patients and Communities Committee of the ICB in May 2023, with helpful feedback provided.

2.0 Development of the content of the draft JFP during April and May 2023

The JFP that is being shared with members of the ICB Board is a draft, and we are listening to feedback. System partners are sharing within their own organisations, and members of the public who provided contact details during the engagement have been signposted to the feedback report and draft JFP on the ICS website.

There has been an intense period of work to develop the eight ambitions and the supporting objectives with partners and socialise these across the system.

The eight ambitions are unchanged from 28 March 2023 ICB Board paper, and the supporting objectives are now included within Part 1 of the Plan. The objectives are broad ranging and include the development of strategies so we can join up existing work and confirm our vision, and specific pathway improvements.

Each ambition includes who the key partners are that we will be working with. A key principle of the JFP is to demonstrate how we are all working collaboratively as a system towards improvement, and the outcomes that will be delivered. Alignment with other ICS strategies is another key principle to ensure subsidiarity, and this is the purpose of Appendix 1.

Each objective includes measurable trajectories and milestones.

The eight ambitions are set out in the context of the needs of our population, presented in Part 1 of the JFP, setting out the evidence base for why we are focusing in these areas, the associated public engagement, our ways of working and how we will deliver.

Part 2 of the JFP is our response to the 17 Legal Duties and other requirements for ICBs, NHS Trusts and NHS Foundation Trusts, and where there is a link to Part 1 content, we have ensured that is referenced.

3.0 Next steps

The JFP will include local case studies, explanatory infographics and will be designed using ICS branding consistent with other ICS strategies.

The final JFP will be presented to the ICB Board on 27 June 2023 for sign off. It will be published on the ICS website by 30th June 2023. It is planned to then support the launch the JFP as part of the celebrations to mark 75 years of the NHS.

Recommendation to the Board:

1. That the Board of the ICB endorses the draft JFP, including the ambitions and objectives.

2. That the Board of the ICB provides comments and feedback to support the production of the final JFP.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	The JFP content has been triangulated with the developing Medium Term Financial Plan and this is a key requirement prior to submission.
Impact Assessment (environmental and equalities):	It is planned to undertake these impact assessments in due course.

Reputation:	It is important that this plan is realistic, achievable and deliverable
Legal:	This is a statutory requirement for the ICB and NHS Trusts and Foundation Trusts.
Information Governance:	N/A
Resource Required:	There will be a significant time commitment required from ICB members of staff and all the partner organisations. The extension of the publication timeline to 30 June is helpful, but timing is still challenging.
Reference document(s):	Go to England.nhs.uk to read the guidance on developing the joint forward plan.
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)	Extraordinary ICB Board 27 June 2023

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

Norfolk and Waveney Integrated Care System

Joint Forward Plan: 2023-2028

First Draft: 17 May 2023
Version 0.5

Foreword by the Chair and Chief Executive of Norfolk & Waveney ICB

There is nothing more important than our own and our family's health. It's why, as a country, we treasure the NHS and its dedicated staff. But vital though it is, the NHS only accounts for a fraction of our physical and mental health and wellbeing. All the rest depends on other things: genetics, our environment – whether we have decent work, enough money, close family and friends, a warm home, clean air – and our own lifestyles.

The development of our Integrated Care System is a unique opportunity to bring together the many different partners who support the health and wellbeing of Norfolk and Waveney's almost 1.1 million residents: the staff and organisations working in the NHS and social care; local government with its responsibilities for public health, social care, housing, leisure and the environment; the voluntary, community, faith and social enterprise sector; and many others in the public and private sectors.

Of course each of us is the expert in our own lives and we all have a responsibility for our own health and wellbeing. This is why our Integrated Care System has at its heart a constant process of listening to people, learning from their experience and acting on what we hear. We are grateful to all the people and organisations who have helped to shape this plan and told us what matters to them.

Our mission as an Integrated Care System is clear: to help the people of Norfolk and Waveney to lead longer, healthier and happier lives. This plan sets-out how we will work towards this over the next five years. We are not starting from scratch – we will build on what we have achieved over the past few years, including through the COVID-19 pandemic, and the real progress we have made since NHS Norfolk and Waveney and our wider Integrated Care Partnership were established in July 2022.

Over the past year we have tackled the longest waits for planned care and treatments that built-up during the pandemic. We are now providing more preventative care, by using data to identify people who could benefit from a particular course of treatment or support, and then contacting them before problems arise or their condition worsens. And we are reaching out to people though initiatives like our Wellness on Wheels Bus, to make it easier for people to get services, support and information about health conditions and other issues like debt and housing, which really affect people's health and wellbeing.

This plan sets-out our ambitions for the future. It describes how we will make it easier for people to get the care and support they need, when they need it. Whether that is in an emergency, getting an appointment at a GP practice, support in the community, or treatment from a mental health professional. It explains how we will continue our work to tackle waiting lists for planned care and treatments. And it makes clear the actions we will take to improve people's health, wellbeing and care from birth through to later life.

By working together, we can create a healthier Norfolk and Waveney.

Rt Hon. Patricia Hewitt
Chair, NHS Norfolk and Waveney Integrated Care Board

Tracey Bleakley
Chief Executive, NHS Norfolk and Waveney Integrated Care Board

Executive Summary <placeholder for final version>

H&WB Board opinions <placeholder for final version>

Suffolk H&WB Board 18th May
Norfolk H&WB Board 14th June

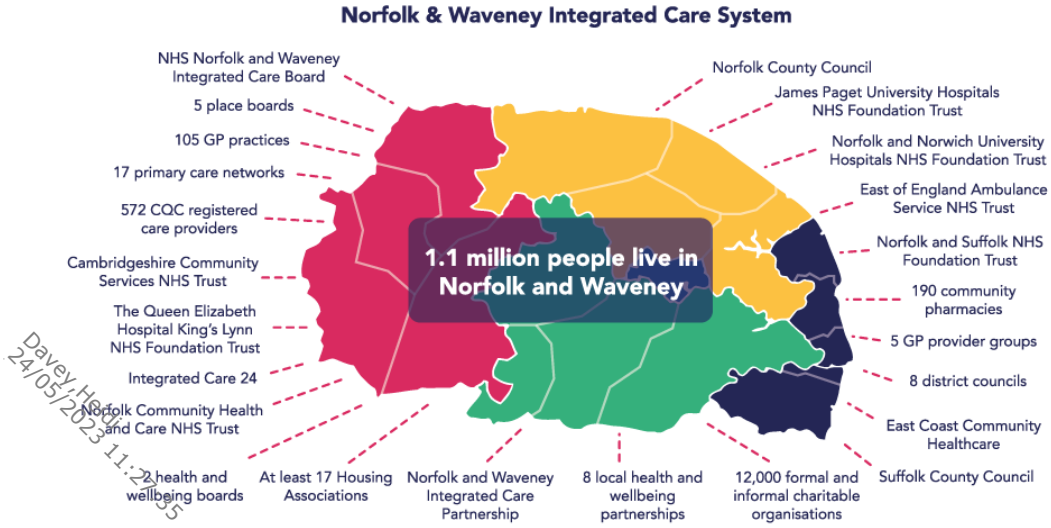
1.0 Scope of the Joint Forward Plan (JFP)

1.1 Introducing the JFP

The Joint Forward Plan is a new requirement set out in the Health and Care Act 2022, for Integrated Care Boards (ICB's) and partner NHS Trusts to describe how they will arrange or provide NHS services for the local population of Norfolk & Waveney. National NHS Guidance (JFP Guidance) confirms what we must include in the plan but first and foremost this document is intended to be a practical plan that the system will deliver, and against which the local population can hold the NHS to account. The needs of our local population are at the heart of this plan, which is ambitious and sets out a number of objectives to improve the quality of our services, as well as ensuring where and how services are provided is informed by local people and our communities.

The JFP describes how we will deliver national NHS commitments such as recovering core services after Covid and improving productivity, as well as transforming care across our eight areas of ambition. The JFP also describes how we will meet our key legal duties, and these are set out in Part 2 of the JFP. A number of these are also referred to within the JFP in relevant sections because they are enablers and will support our improvement and delivery of our eight ambitions which we set out in this plan.

This plan is predominantly about improvements in NHS services but has been developed in collaboration with our ICS partners where services are provided together. This is our first JFP (published in June 2023), and we will update it each year as we set out on a journey of improvement. Progress against the plan will be publicly visible in each NHS partner's annual report, and in the annual report of the ICB.



We will work together in partnership across the Norfolk & Waveney Integrated Care System (ICS).

Our ICS partners are shown in the stakeholder map.

Within Part 2 of our JFP we have also briefly described the health services that are provided within the ICS footprint.

1.2 Links to our transitional Integrated Care Strategy and local Joint Health and Wellbeing Strategies

It is important that our plan is consistent with local Joint Health and Wellbeing Strategies, and we have two of these which cover our ICS – one for Norfolk and one for Suffolk. Helpfully, the Norfolk Health and Wellbeing Strategy is also the Transitional Integrated Care Strategy for Norfolk and Waveney, so we have one strategy that fulfils both those functions. It was designed in this way to bring everything together, looking across both Norfolk and Suffolk and specifically focusing on themes which are not in the remit of a single part of the system but require a collaborative approach to improvement. The JFP builds on that approach, focusing on improvements that will be achieved by working together differently. Within part 2 of our JFP there is a section on **Implementing any local joint health and well-being strategy** which includes a link to both the strategies, and a summary of their priority themes.

1.3 Link to the core purposes of an ICS

The JFP also addresses the four core (national) purposes of an ICS which are:

- Improving outcomes in population health and care
- Tackling inequalities in outcomes, experience and access
- Enhancing productivity and value for money
- Helping the NHS to support broader social and economic development

These core purposes have very good alignment with the Norfolk and Suffolk strategies referred to above. The JFP addresses these through the development of eight areas of ambition, enabled by working differently together and through some key strategic infrastructure which is explained on our strategy map in Section 6.3. Our eight ambitions are:

1. Transforming Mental Health services
2. Improving Urgent and Emergency Care
3. Elective Recovery and Improvement
4. Primary Care Resilience and Transformation
5. Improving Productivity and Efficiency
6. Population Health Management, Reducing Inequalities and Supporting Prevention
7. Improving services for Babies, Children and Young People and developing our Local Maternity and Neonatal System (LMNS)
8. Transforming care in later life

These eight ambitions are described in this plan with underpinning objectives, trajectories, and milestones where these are confirmed at the drafting stage. We want our local population to be able to see what we plan to do, by when, and what difference it will make to them in their lives.

The ambitions are at the centre of our JFP and are set out within Section 4.2.

2.0 Framework for change

2.1 Five-point approach to developing our JFP

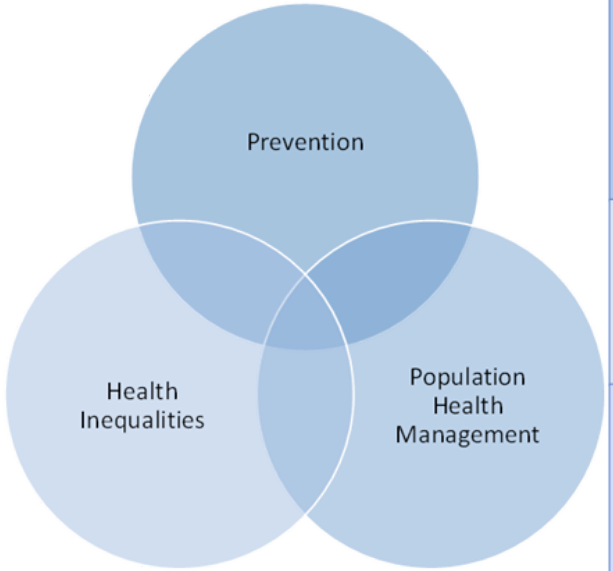
We have adopted a logical approach to developing our JFP, with each step drawing together all the major components of our plan into a coherent vision for improvement over the medium to long term. By doing this, we have carefully considered:

1. **Why** we are doing this – using our ICS Transitional Integrated Care Strategy and the Suffolk Health and Wellbeing Strategy we have set out the needs of our population using evidence, data and public engagement to compile an overall *case for change* to improve the health and outcomes for the people of Norfolk and Waveney. This is section 3.0.
2. **What** our ambitions for improvement are – these are our eight ambitions, with initial objectives identified. This is section 4.0.
3. **When** we expect to deliver – we have created a summary roadmap that illustrates when there will be activity happening on each ambition. This is in section 5.0. Within each objective there are detailed trajectories and milestones for implementation.
4. **How** we are going to work together differently to deliver this – these are the seven ways of working that we have agreed and are set out in section 6.0. This is a really important journey for us to go on as a system, these are our enablers and we have some key areas to focus on – these are equally as vital as the ambitions and objectives themselves.
5. **Commitment** to achievable, measurable and impactful improvements **–** this is how we will know we are achieving our objectives, in our first JFP. Our objectives have been aligned to the NHS Medium-Term Financial Plan to ensure they are affordable, recognising capacity constraints and competing priorities. Working together as system partners is key to our achievement. This is section 7.0.

Each of these five points are set out in more detail in the sections that follow.

3.0 Why we are doing this – the case for change

In this section we talk about Population Health Management (PHM), Health Inequalities (HI) and Prevention so we have explained what we mean by these terms in the picture below. They are interlinked and help us to give us information about what we can do differently, and what will make the most difference to people.



Prevention – 3 levels 1. Primary prevention - taking action to reduce the occurrence of disease and health problems before they arise 2. Secondary prevention - detecting the early stages of disease and intervening before full symptoms develop 3. Tertiary prevention – softening the impact of an ongoing illness. For more information - Prevention | Local Government Association

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them. NHS England » What are healthcare inequalities?

Population Health Management is a way of working, using joined-up local data and information to better understand the health and care needs of our local people and proactively put in place new models of care to deliver improvements in health and wellbeing. For more information - NHS England » Population Health and the Population Health Management Programme

3.1 Summary of health need for Norfolk and Waveney population

In this section we present a summary of our local population and our associated health needs using a population health management and health intelligence approach, which has been led by our public health team. It makes a compelling case for focussing on the ambitions we have chosen, and particularly what we can do now on prevention, to improve our health and well-being for the future. Let's look at some of the key facts about Norfolk and Waveney[1]:

[1] Numbers are rounded

- In 2021 there were 8,750 births and 12,860 deaths[2]
- In June 2022 there were 1,081,700 people registered with a General Practice in Norfolk and Waveney.
- During 2022, patients attended 6,280,000 appointments with General Practice [3] (this means that on average, each person across Norfolk and Waveney attended about 6 appointments), and 75.6% of people have a positive experience of their GP practice
- In June 2022 75,000 children had visited an NHS dentist in the previous 12 months and 309,000 adults visited an NHS dentist in the previous two years[4]
- During 2021/2022
    - 57,000 people in Norfolk and Waveney were in contact with Mental Health, Learning Difficulties or Autism services and 16,000 of these were under 18[5]. This is over 5% of the total population and over 8% of the population under 18
    - A&E and emergency departments saw 298,500 attendances[6] with 101,105 Norfolk and Waveney patients admitted as an emergency[7].
    - There were 1,285,000 hospital outpatient appointments and 165,700 hospital operations – of which 111,650 were operations for people on the waiting list[7]
- 165,000 people in Norfolk and Waveney live in the 20% most deprived communities in England (known as the core20 population)[8]
- As of January 2023, 126,700 people in Norfolk and Waveney have 4 or more diagnosed long term health conditions (LTC's) (physical health and/or mental health conditions)
- In terms of physical health, in 2021/2022 the number of people diagnosed with LTC's include 176,900 with high blood pressure, 70,400 with diabetes, 39,600 with heart disease, 30,200 with atrial fibrillation or a common abnormal heart rhythm, 24,400 with COPD which is a lung condition that causes breathing difficulties and 78,900 with asthma[9].
- In terms of mental health, 9,800 people are diagnosed with dementia, 10,400 people are diagnosed with a serious mental illness and 111,500 are diagnosed with depression[9]
- In 2020 across Norfolk and Waveney there were 6,580 cancers diagnosed[10]
- We know there are opportunities for longer term prevention. For example, there are estimated to be
    - more than 120,000 smokers, more than 500,000 people overweight or obese and more than 180,000 who do not exercise[9]
    - more than 89,000 people with high blood pressure that has not yet been diagnosed and managed[11]

---

[2] https://www.nomisweb.co.uk/
[3] https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice (during 2022)
[4] https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/general-practice-data-hub/dentistry (to June 2022)
[5] https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin/2021-22-annual-report
[6] https://digital.nhs.uk/data-and-information/publications/statistical/hospital-accident--emergency-activity/2021-22
[7] https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2021-22
[8] https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice
[9] https://fingertips.phe.org.uk/ (applying Norfolk prevalence to estimates to Norfolk and Waveney population 19+)
[10] https://digital.nhs.uk/data-and-information/publications/statistical/case-mix-adjusted-percentage-of-cancers-diagnosed-at-stages-1-and-2-in-england/2020
[11] https://www.norfolkinsight.org.uk/wp-content/uploads/2022/08/State-of-Norfolk-and-Waveney-health-report-2022_correctedByPAVE.pdf

These facts and figures give us some of the context about the health of our population and the scale of the activity that goes on, week in week out. The longer term prevention opportunities and the number of people who have LTC's highlight where we can focus to make a difference.

3.2 The growing population – our older population

We now want to spend some time looking at some facts and figures about our older population in this section, and why we have an ambition of transforming care in later life. Norfolk and Waveney generally has an older population and this is projected to increase at a greater rate than the England average. This creates a key challenge for our health and care system. From 2020 to 2040 there will be an estimated:

- 36% increase in people aged over 65, mostly in those aged 75+
- 3% increase in people of working age
- 1% decrease in children and young people under the age of 16

The greater increase in those in later life compared to those of working age by 2040 means that there will be fewer people of working age for every person under 16 or of retirement age, which has implications for our workforce.

Over the next five years the population is expected to grow by more than 25,000 people, and about 20,000 will be those aged 65+. We anticipate this to continue, and by 2040 the population is likely to have increased by about 110,000 people, this is about the same as the current population of North Norfolk.

As a result of this we can expect to see an increasing demand for appointments at doctors, dentists and hospitals, emergency admissions, and an increase in the numbers of people with LTC's and increased need for care. For example, if nothing changes and current rates apply to the increasing population then over the next five years:

- the demand for appointments with a doctor is likely to have increased by more than a 1,000 per day
- the number of people with 4 or more LTC's which need ongoing management is likely to have increase by about 1,800 per year
- the number of people going to A&E is likely to have increased by about 900 per month
- the number of people who have to stay in hospital having arrived as an emergency is likely to have increased by about 500 per month

For the 126,700 people with 4 or more LTC's the average cost for hospital care for is more than £4,300 per year[12]. The expected increase in the number of people with 4 or more LTC's is likely to add an additional £7.75 million pounds per year to hospital care costs. There are also additional prescribing costs for medication, and GPs will spend time managing these patients.

This is just the tip of the iceberg and is why it is so important that we prioritise transforming care in later life as one of our ambitions.

[12] Weighted average of costs from Population and Person Insights Dashboard https://tabanalytics.data.england.nhs.uk/#/site/viewpoint/views/Segmentation/SegmentSummary

3.3 We can make a change

What is encouraging to note is that the risks for many LTC's can be reduced through changes in health behaviours and addressing unwarranted variation in clinical care. We have set out a clear ambition in relation to PHM, health inequalities and prevention to start the work on this.

Preventing LTC's improves outcomes for people and reduces costs. While the impacts of health behaviour change might take longer to take effect, we can see impacts over a shorter time frame by improving other aspects of the health and care system like urgent and emergency care, mental health services, services for families and babies, children and young people and people in later life which are all ambitions in our JFP.

However, there are some poor outcomes for some people at different stages along their life course (Figure 1) and we want to tackle those. For example, for children and young people a higher proportion of pregnant females smoke, and young children are more likely to be admitted to hospital as an emergency. When developing our ambitions and objectives we have carefully considered what this outcomes life course is telling us and focussed on where we need to make improvements based on the evidence.

In addition to smoking, being overweight is one of the biggest causes of illness that can be prevented – it can lead to diabetes, problems with bones, joints and muscles ('musculoskeletal') and heart disease (cardiovascular).

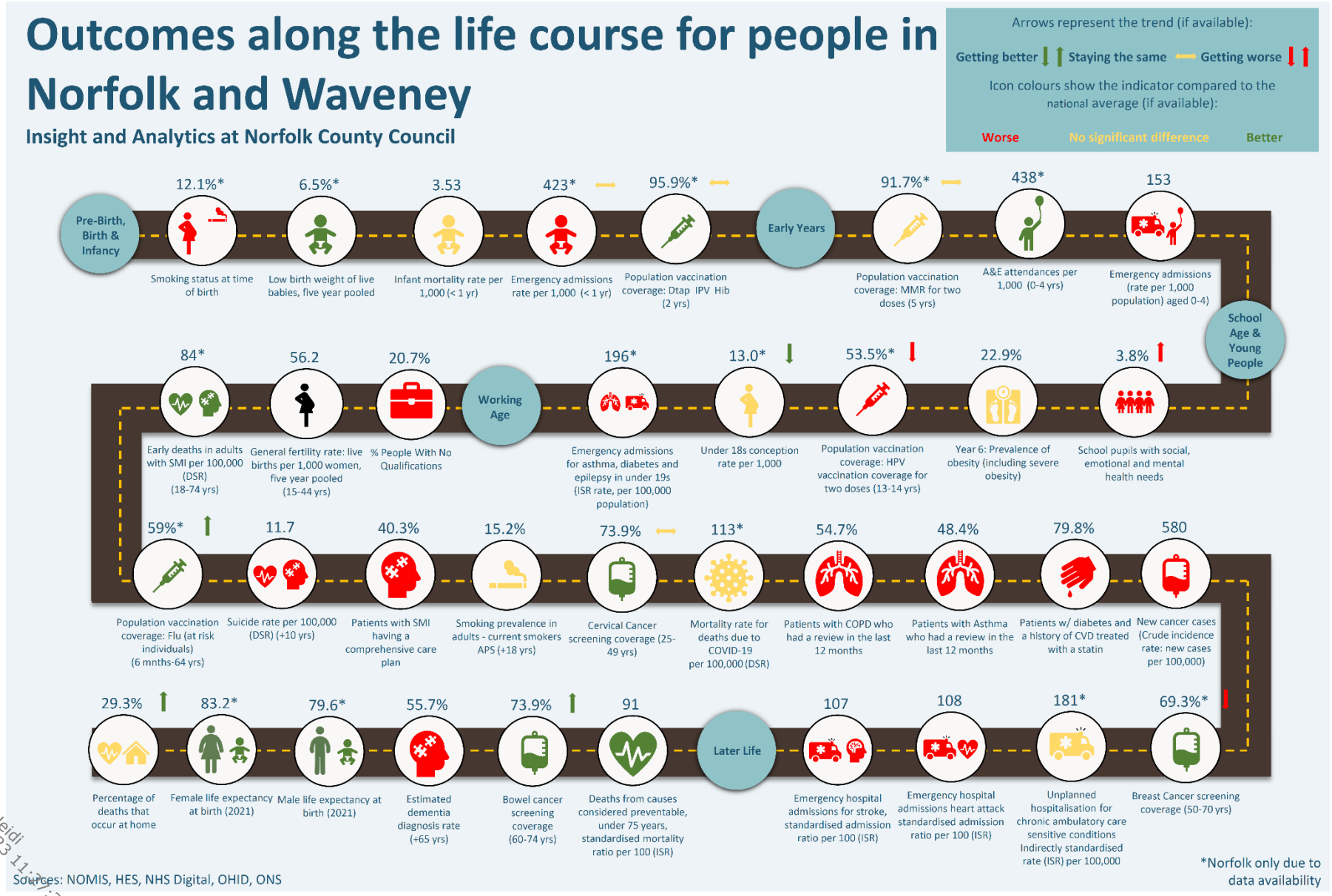


Figure 1 – Outcomes along the life course for people in Norfolk and Waveney

3.4 Health Inequalities

Aside from the conditions that people die from, the amount of disability or illness that people have varies according to where you live – that is a fact. In Norfolk and Waveney many health outcomes for people are as good or better than in England overall as a comparison, and males and females generally live longer lives in Norfolk and Waveney than the England average. However, there are stark inequalities in outcomes for people in the 20% most deprived communities (known as "core 20"), that then accumulate over the life course. These result in poorer health outcomes and ultimately a shorter life expectancy.

The State of Norfolk and Waveney report 2022[13] shows that the 165,000 people of Norfolk and Waveney that live in some of the 20% most deprived communities in England[14] are more likely to:

- have harmful health behaviours, such as smoking and being less active
- have multiple, limiting, long-term conditions
- attend A&E and be admitted to hospital for an emergency
- be in poor health before reaching retirement age
- and to die early

(Core20 and Core20PLUS5 are explained in more detail in the **legal duty to reduce health inequalities**, Part 2 of the JFP)

The core 20 populations in Norfolk and Waveney are shown on the map in Figure 2 and we know that the health outcomes for the populations in our most deprived communities could be improved further.

[13] https://www.norfolkinsight.org.uk/wp-content/uploads/2022/08/State-of-Norfolk-and-Waveney-health-report-2022_correctedByPAVE.pdf
[14] https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice

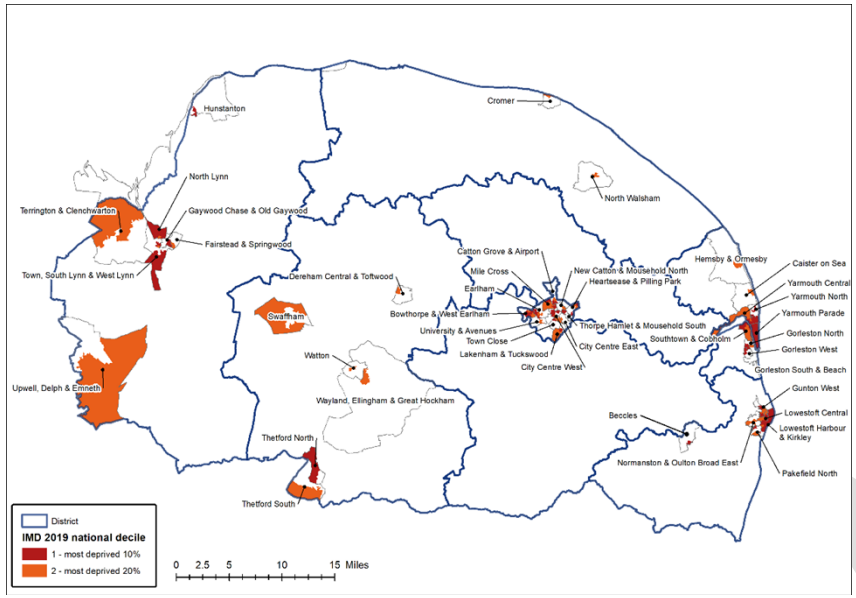


Figure 2 – "Core20" communities across Norfolk and Waveney where some or all of the residents live in the 20% most deprived areas in England according to IMD2019

For example, Figure 3 compares the least deprived communities with the most deprived "core20" communities:

- babies in the most deprived areas are 50% more likely to be of low birth weight and 30% more likely to die before they are one year of age.
- young children are 50% more likely to be admitted as an emergency
- year 6 children are 40% more likely to be obese
- teenage girls are 5 x more likely to have children
- people are 3 x more likely to take their own life
- and people are more than 3 x more likely to die from preventable causes

Other population groups in addition to those that live in the most deprived communities are also more likely to have poor health outcomes and to die early. For example, children and young people with learning difficulties or autism and those that are looked after are more likely to experience mental health issues.

As people move into adulthood those with learning difficulties are 4 times more likely to die early than others with similar characteristics and those with severe mental illness are 3.7 times more likely to die early[15]. Many of these deaths are preventable.

[15] https://www.gov.uk/government/publications/health-matters-reducing-health-inequalities-in-mental-illness/health-matters-reducing-health-inequalities-in-mental-illness

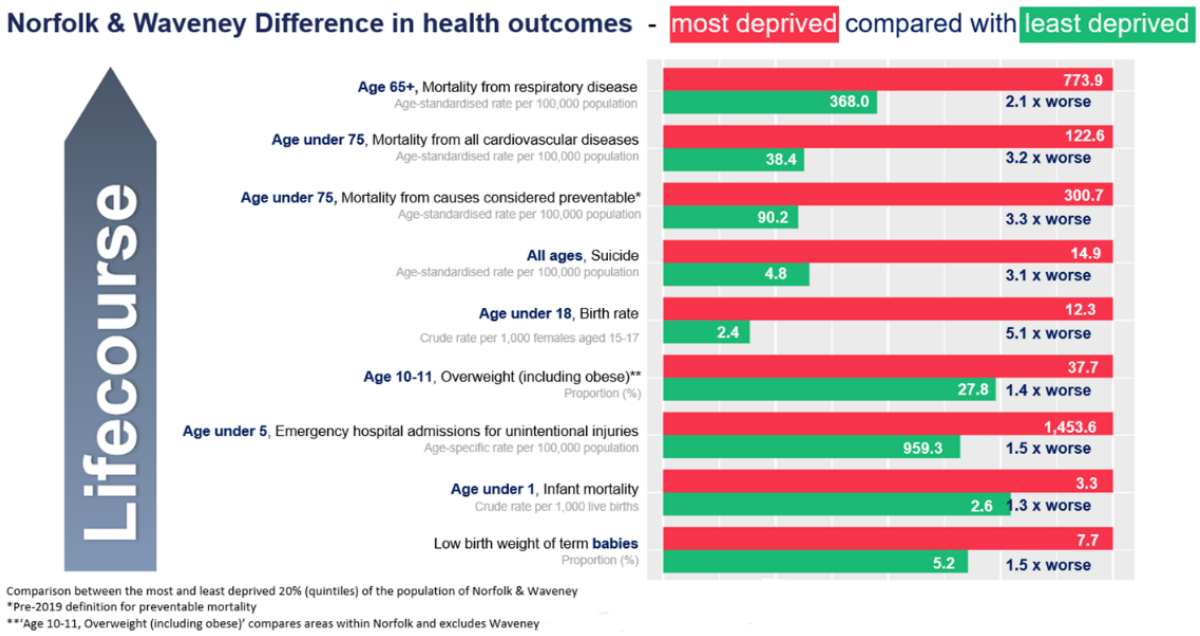


Figure 3 Inequalities in health outcomes between the least deprived and the most deprived core20 communities in Norfolk and Waveney

The accumulation of inequalities over the life course for those in the more deprived core20 communities has an impact on the number of years a person is likely to live.

Across Norfolk and Waveney in 2020-2021 the gap in life expectancy between the most deprived core20 communities and the least deprived communities was 6 years and 9 months for males and 5 years and 4 months for females.

This gap is due to more deaths in the core20 communities from heart attacks, strokes, cancer, respiratory disease and COVID19[16] (Figure 4).

[16] https://analytics.phe.gov.uk/apps/segment-tool/

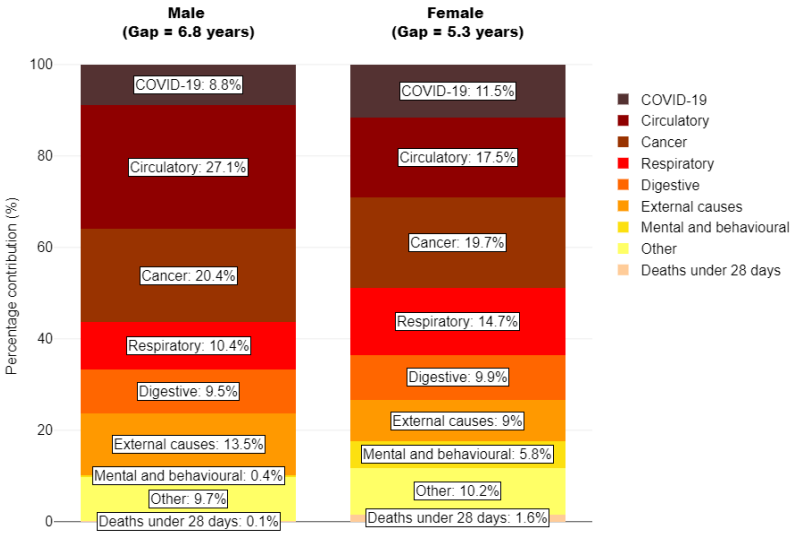


Figure 4 Breakdown of the life expectancy gap between the most and least deprived quintiles of NHS Norfolk and Waveney by cause of death, 2020 to 2021 (https://analytics.phe.gov.uk/apps/segment-tool/)

3.5 Opportunities to improve outcomes

This is all very concerning but some of this gap in life expectancy is preventable by changing health behaviour and addressing unwarranted variation in clinical care. For example, about 20% of the life expectancy gap is due to Cancer. 38% of cancers are preventable, 15% of all cancer is caused by smoking and 6% by obesity[17].

Across Norfolk and Waveney just over half of all cancers are diagnosed early[18] and while overall screening uptake is good (and this helps with earlier diagnosis), people from the core20 most deprived communities are less likely to be screened for cancer. For example, there are 46 GP practices in Norfolk and Waveney where the proportion of people screened for bowel cancer is less than the Norfolk and Waveney average. If all these practices screened at least the Norfolk and Waveney average then an additional 3,500 people would be screened for cancer. For the core20 most deprived GP practices this is an additional 1,300 people, which is more than a 1/3 of the total.

Changing health behaviour will reduce the number of preventable cancers and increasing the numbers of people with cancer diagnosed early, through screening and smoother progress through care pathways, means that chances of survival are better and outcomes improved.

There are also opportunities to improve in outcomes for people with respiratory and circulatory conditions through changing health behaviours and reducing unwarranted variation in clinical care. For example, Norfolk and Waveney has a higher prevalence of COPD than England (2.3% vs. 1.9%)

[17] https://www.cancerresearchuk.org/health-professional/cancer-statistics/risk/preventable-cancers

[18] https://www.cancerdata.nhs.uk/stage_at_diagnosis

but has a lower proportion of COPD patients that receive a 12-month review (55% vs 60%). And there is variation across Norfolk and Waveney from practices with 10% of patients with a 12-month review to practices with over 90% of patients with a review. For circulatory conditions the Cardiovascular Disease (CVD) prevent work shows that if we were to detect and optimally manage 17,000 the hidden cases of high blood pressure then we would save more than 100 heart attacks and more than 150 strokes over the next three years[19]

Due to inequality in health behaviours, the opportunities for improving outcomes are likely to be greater in the core20 most deprived communities. As deprivation increases the proportion of people with risky health behaviour also increases. Over the long term if we are to reduce inequality in life expectancy due to cancer, circulatory and respiratory conditions, then we will have to address health behaviours such as smoking, physical activity, obesity and diet.

Opportunities to improve outcomes are not only limited to physical health conditions but there are also opportunities to improve outcomes for those with severe mental illness. For example, of the people with severe mental illness only 40% have a comprehensive care plan compared to the England average of 50%. Across the Norfolk and Waveney GP practices this ranges from under 5% of patients to 100% of patients. By at least matching the England average across Norfolk and Waveney, 900 extra people would have a comprehensive care plan with potential risk of self-harm reduced.

By improving health behaviours and reducing unwarranted variation in services and care across Norfolk and Waveney and along the life course, it is an opportunity to improve outcomes for those from the most deprived communities AND reduce the demand on hospitals and GP practices.

This evidence makes for compelling reading and our focus on reducing health inequalities and prevention is key to improving the health and well-being of our local population.

The JFP includes a range of ambitions that address both some of the current issues in relation to those in later life and younger people, those experiencing poor mental health and those with existing LTC's. We also want to update our model for Urgent and Emergency Care and reduce the waiting times for planned operations as these are all affecting our population. Critically though the JFP signals an intent to get ahead of the curve, and the opportunity we have to reverse some of the most concerning trends and variations.

There are opportunities through:

- primary prevention, intervening before health effects occur. For example, by changing health behaviours and vaccination
- secondary prevention, intervening to reduce the impact of disease that has already occurred. For example, regular patient reviews and by managing conditions appropriately
- tertiary prevention, intervening through surgery or similar. For example, coronary artery bypass grafting, to prolong life in some people with stable congenital heart defects that have been present from birth

[19] https://www.cvdprevent.nhs.uk/home

3.6 Public engagement on the JFP so far

In addition to the data and evidence base that we have turned into a life course, we have also started our public engagement to understand what matters most to the people of Norfolk and Waveney. At the time of the engagement in December 2022 to January 2023, we had started with the five ambitions listed below. We asked if local people thought they were still correct.

1. Transforming Mental Health services
2. Improving Urgent and Emergency Care
3. Improving Elective Care
4. Developing a resilient and integrated model of Primary Care
5. Improving Productivity and Efficiency

We were told that some things were missing, so we added three more:

6. Population Health Management, Reducing Inequalities and Supporting Prevention
7. Improving services for Babies, Children and Young People and developing our Local Maternity and Neonatal System (LMNS)
8. Transforming care in later life

Our online survey received **700** responses in total.

<placeholder for infographic>

505 people out of **585** who responded (just over 86%) strongly agree or agree that we have chosen the right priorities. **249** people also left free text comments, for example:

- The absence of **social care** as a priority was highlighted by some
- Perception that **GP access** needs improving
- More **NHS dentistry** needed
- Issues highlighted around **older and other vulnerable people being in hospital beds** due to lack of flow through the system, or disconnected services
- Concerns raised about **finances** – how staying within budget will impact services, and how all the priorities are to be afforded
- Emphasis on **community care,** including **end of life and palliative,** as well as primary care
- Someone who disagreed said that **early help and prevention was missing**
- Concerns about **out of county mental health provision**, and lack of **early and preventative mental health** provision, especially for **children and young people** and people with **Autism**
- Issues raised about **recruitment and retention of staff**, including social care
- Some comments that the priorities do not reflect the future aspirations of an ICS and are '**stuck in the past**'

- Access to services for **people with extra needs,** e.g. Learning Disabilities and Autism, deaf/hearing impaired
- Improved **digital connectivity** between services, alongside the recognition that some people are **digitally excluded**

537 people out of 592 who completed surveys (just over 90%) responded to **What matters most to you?**
Many of the points listed above were made again, but other issues raised include:

- Knowing an ambulance will come if I need it
- Getting help with caring responsibilities
- Palliative and end of life care, and bereavement services
- Working with VCFSE and community organisations
- Simple ways of getting help – a single front door
- Joined up services, better collaboration and integration, services under one roof, continuity of care
- More help for people to help themselves
- Support for vulnerable people – homeless, CYP, families and older people
- Getting an appointment, especially with a GP – some like face to face, some online
- Shorter waiting times
- Some comments about better communications, and campaigns about using services and self help
- Health and care services aimed at men, and delivered by male staff
- Increase funding for prevention services, including physical and talking therapies, and public education and awareness raising
- The role Oral Health has to play in promoting and protecting general health and wellbeing
- Developing and supporting our workforce to help retention
- Several comments about the Walk-in Centre in Norwich and the need for a new hospital in King's Lynn

You can read the full report, including examples of the comments people made, on our dedicated webpage: JFP page. (Please note JFP microsite will be active to coincide with launch of the final plan).

This is not the end of the conversation. The projects that will form part of the ambitions and their underpinning objectives will need engagement, involvement and co-production with local people, those who use our services and our workforce. We will build an ongoing programme of participation that includes a range of participation methods. Working with our people and communities will be vital if we are to create services that meet the needs of the different people and groups that live in Norfolk and Waveney. Within part 2 of our JFP you can also read more about our legal duty **to involve the public** where there are some useful web-links to further material.

4.0 Our ambitions for improvement

4.1 2023/2024 immediate priorities

We have two timescales, the immediate priorities that Norfolk and Waveney ICS confirmed to NHS England to meet national NHS planning requirements, and the longer-term improvements captured in our eight ambitions.

We have summarised the immediate priorities below as they are important and form some of the first year elements of our JFP.

Each year the NHS is asked to produce an operational plan detailing the activity levels, performance standards, workforce numbers and financial plans for the next 12 months. Each of these elements are triangulated to ensure consistency, such as an increase in activity is supported by an increase in staffing, which in turn is included in the financial projections. These plans are developed together as a system, working in partnership to achieve the required aims and ambitions as set out in the NHS Priorities and Operational Planning Guidance. The latest 2023/2024 NHS guidance can be found here: Operational Planning Guidance

The operational plan contains many different metrics to enable the NHS to monitor its delivery during the year and there are many links through to the ambitions in the JFP such as:

- Improving the flow of **urgent and emergency care** patients in to and out of our services. We have said we would improve our discharge pathways through increasing the number of virtual ward services for example. This in turn will reduce the length of stay in hospital, bed occupancy, and enable the emergency department to see more patients within 4 hours; allowing ambulances to be released to respond to category 2 calls in the community.
- **Continue to reduce the number of people waiting** for diagnostics and elective care. During the year the plan is to reduce the number of people waiting over 65 weeks for elective care by over 8,000. This and future reductions in waiting times will be achieved by working more closely together, reducing waiting times for diagnostics, faster earlier cancer diagnosis and using technology.
- Increased capacity for people of all ages to **access mental health services earlier**, such as Psychological Therapies and specialist community perinatal services. To manage care closer to home by reducing out of area placements.
- Continue to **address health inequalities and improve prevention services**. For adults this is maternity continuity of care, severe mental health checks, respiratory conditions, early cancer diagnosis and case finding and treating high blood pressure. For children and young people, the focus will be on asthma, diabetes, epilepsy, oral health and mental health.

Through the work undertaken to develop our local plans, we have built upon the system integration and joint working to produce a cohesive and challenging set of targets to deliver on, for the benefit of our population. These are consistent with a number of the ambitions and objectives in the JFP.

4.2 Our eight longer-term ambitions for improvement

The 2023/2024 immediate priorities are not quick fixes and so feed into the longer-term ambitions. Our eight ambitions are evidence based and consistent with what we heard from our public engagement, with a clear focus on planning ahead to make improvements and to get ahead of the curve with prevention. We have also looked at our local population across the course of an entire lifetime, from conception to end of life, to examine outcomes to inform where improvements could be made.

Our eight ambitions are described in more detail in this section, but this is not the only work we are doing. This JFP does not describe 'business as usual must-do's', such as existing and on-going work that is already underway to support the delivery of the NHS Long Term Plan. If we were to do this, our JFP would simply be too large and complex to be useful as a delivery plan.

As system partners we all want to use this plan because it identifies common ambitions, and we can all lean in to support and drive forward improvements together.

This is why we have purposely selected and made a commitment to a number of achievable, measurable and impactful improvements, presented in this section as Objectives, linked to each of the eight ambitions.

These objectives have been developed in response to what our data tells us, and they require a collaborative system-wide approach to successfully deliver them.

Some of the objectives commit to doing more work to develop key strategies, such as for Population Health Management (PHM), Health Inequalities and for people in later life. Others are much more specific projects with defined and measurable outcomes.

We will refresh this JFP at least annually, with the next version ready for April 2024, and ensure our objectives remain current and focused on what we need to deliver.

A summary of the eight ambitions and 21 underpinning objectives is set out in Figure 5.

	Joint Forward Plan eight Ambitions and underpinning objectives
	Ambition Objectives
1	**Transforming Mental Health Services**
1a	Build system resources for early intervention and prevention for people of all ages, including those who experience mental health inequalities. This work will include enhancing and expanding skills and knowledge of mental health across our populations; providing a framework of tools and capacity to support mental wellbeing; and delivering a refreshed suicide prevention strategy.
1b	Mobilise mental health system collaboratives to facilitate partnership working and deliver better health outcomes for our residents. The focus of the adult collaborative in year one is to improve support for older people living with dementia, delirium and depression which also has alignment with the Ambition Transforming Care in Later Life.
1c	Establish a Children and Young People's (0-25 years) Emotional Wellbeing and Mental Health 'integrated front door' so all requests for advice, guidance and help are accepted, and support provided to navigate the system and meet the presenting level of need. This will be developed in line with the Thrive principles, with children and young people at the centre of delivery with resources wrapped around them, enabling them to Flourish.
1d	See the whole person for who they are, beyond their complex behaviour. Develop pathways that support and promote recovery for people living with multiple and complex needs – with a focus on dual diagnosis and complex emotional needs (CEN)
2	**Improving UEC**
2a	Improve emergency ambulance response times
2b	Expand virtual ward services
2c	Delivery of the Improving Lives Together programme to reduce length of stay (LoS) in hospitals
3	**Elective Recovery & Improvement**
3a	Effectively utilise capacity across all Health System Partners
3b	Implement digital technology to enable elective recovery
4	**Primary Care Resilience & Transformation**
4a	Developing our vision to provide a wider range of services closer to home, improving patient outcomes and experience
4b	Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years.
5	**Improving Productivity & Efficiency**
5a	Improve the services we provide by enhancing productivity and value for money, embracing digital innovation and delivering services together where it makes sense to do so.
6	**PHM, Reducing Inequalities & Supporting Prevention**
6a	Development and delivery of two strategies to support prevention: A Population Health Management Strategy, and a Norfolk and Waveney Health Inequalities Strategy to deliver the "Core20plus5" approach
6b	Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people
6c	Early Cancer Diagnosis - Targeted Lung Health check Programme
6d	Cardiovascular disease Prevention
7	**Improving Services for Babies, Children, Young People & Maternity**
7a	Successful implementation of Norfolk's Start for Life (SfL) and Family Hubs (FH) approach
7b	Continued development of our Local Maternity and Neonatal System (LMNS), including the Three Year Maternity Delivery Plan
7c	Reducing health inequalities including an initial focus on asthma, epilepsy and mental health
7d	Develop an improved and appropriate offer across Norfolk and Suffolk for Children's Occupational Therapy, to meet their needs
8	**Transforming Care in later life**
8a	To develop a shared vision and strategy with older people that will help us to transform our services to be easy to access and designed and wrapped around the needs of older people.

Figure 5 – summary of the eight ambitions and 21 underpinning objectives

Ambition 1 Transforming Mental Health Services

Dr Ardyn Ross, Clinical Mental Health Lead, N&W ICB, May 2023

"*Our aim is to ensure that people of all ages can access timely and responsive support for all their mental health needs. Working together with partners across health, care, VCFSE and our experts with lived experience, we will offer person centred care at an earlier stage, and provide services that are compassionate, holistic, and responsive guiding people towards better mental health".*
Dr Ardyn Ross, Clinical Mental Health Lead, N&W ICB, May 2023

We hope the JFP will lead to the personalised, joined-up, holistic, timely and ongoing care and support for the people of Norfolk and Waveney that is needed. This includes addressing mental health inequalities, particularly neurodivergence and Autism.

We hope more effective partnership working will mean people are more connected to wellbeing support as well as the right care for them. We hope a joined-up culture will mean more sharing and support for people who support and care for people too, both unpaid carers and staff.

We look forward to continuing to be involved as equal partners in the implementation of the JFP, ensuring effective influence based on lived experience insight from the people and communities of Norfolk & Waveney.

Expert by Experience Reference Group, May 2023 – to be updated
(Please Note, the statement above is strictly draft and subject to final agreement with Experts by Experience).

Our objectives

a) Build system resources for early intervention and prevention for people of all ages, including those who experience inequalities or challenges to their mental health and well-being due to vulnerabilities or reduced protective factors. This work will include enhancing and expanding skills and knowledge of mental health across our populations; providing a framework of tools and capacity to support mental wellbeing; and delivering a refreshed suicide prevention strategy.

b) Mobilise mental health system collaboratives to facilitate partnership working and deliver better health outcomes for our residents. The focus of the adult collaborative in year one is to improve support for older people living with dementia, delirium and depression, which also has alignment with the Ambition Transforming Care in Later Life.

c) Establish a Children and Young People's (0-25 years) Emotional Wellbeing and Mental Health 'integrated front door' so all requests for advice, guidance and help are accepted, and support provided to navigate the system and meet the presenting level of need. This will be developed in line with the Thrive principles, with children and young people at the centre of delivery with resources wrapped around them, enabling them to Flourish.

d) See the whole person for who they are, beyond their complex and co-occurring needs. Develop pathways that support and promote recovery for people living with multiple and complex needs – with a focus on dual diagnosis and complex emotional needs (CEN).

What would you like to see in our five-year plan for health and care services? What matters most to you?

Children and young people have told us by developing a Mental Health Charter that what matters to them is: -

- Services will care
- Staff will support and be well supported themselves
- Right help, right time, right way
- Treatment will be personalised to meet individual needs
- Communication will be effective
- Young people will have a voice

People with experience of mental health services and others who responded to recent a further mental consultation have also stated *'We must put more focus on prevention and invest in this area, including de-stigmatising mental health – we must see looking after our mental health the same as eating 5 fruit and veg a day'.* They also told us:

- they wanted to be 'empowered to access intervention and holistic wrap-around-care, which supports long-term recovery and on-going they want to 'experience person-centred care, and be treated as an individual, rather than as a diagnosis'. They want choice in how care is delivered and a focus on "what matters to me", instead of "what's the matter with me".
- their diagnosis is only one part of their health journey. Their other physical or mental health conditions, as well as life events, might (or might not) be impacting on my current state. These also need to be considered and addressed.

Why we chose these objectives

Mental health conditions can have **a substantial effect on all areas of life, such** as **school or work performance, relationships with family and friends** and **ability to participate in the community. P**eople with mental health conditions often experience severe human rights violations, discrimination, and stigma

As we can see from the Life Course Infogram in section 3.3, there are increasing numbers of school age pupils with social, emotional and mental health needs, suicide rates are increasing within working age people, and the number of people diagnosed with dementia in later life is up by 55%.

Key vulnerable groups who may be affected by poor MH include children, young people and families, people who experience long term conditions and men experiencing financial and economic constraints and/or relationship breakdown. Improving the offer of proactive and preventive support is a priority outcome for this ambition, where we aim to intervene quickly and broaden the range of specialist support offers to enhance recovery. People with lived experience tell us that the interconnection between mental, social, and physical health is not always recognised, meaning service users, especially those with complex and neurodivergent needs, who do not feel these are met. We will continue to build on our joint working, considering inequalities and additional needs across our population and support personalised approaches to care.

Who we are going to be working with to deliver this	This Mental Health Ambition is aligned with our partners in these areas:
• Norfolk and Suffolk County Councils – Adult and Children Social Care, Public Health • Norfolk & Suffolk Foundation Trust • Cambridge and Peterborough Foundation Trust • Hertfordshire Partnerships Foundation Trust • East Coast Community Healthcare • Norfolk Community Health & Care • Change Grow Live Norfolk Alcohol & Drug Behavioural Change Service • University of East Anglia • Cambridgeshire Community Services • VCFSE • Primary Care • Place Boards and HWP's • NHS England • Norfolk and Norwich hospital • James Paget Hospital • Queen Elizabeth Hospital • Our approach will be guided by the considerations outlined in the N&W I-Statements and will be coproduced with experts by experience, service users and carers, children and young people and families	Building system resources for early intervention and prevention including those who experience MH inequalities links to Better Together for Norfolk, Norfolk County Council's high level strategic priority of *Healthy, fulfilling, independent lives* with a focus on prevention and early help, working collaboratively to deliver outcomes. Early Intervention, Prevention and developing pathways that support and promote recovery for people aligns with the **Promoting Independence strategy** and **Connecting Communities programme** core ambitions of Adult Social Services and **Ready to Act, Ready to Change** Public Health Strategy, based on the recognition that early intervention allows people to live healthier, more fulfilling lives. By continuing to embed the Thrive model and ensure resources work around the child, with the child at the centre, enabling them to Flourish Flourishing in Norfolk: A Children and Young People Partnership Strategy – Norfolk County Council. NCC is also currently developing an **Adult Mental Health strategy** that align to these objectives. **Norfolk County Council Public Health:** • Public Health Audit: Suicide in Norfolk 2022 (norfolkinsight.org.uk) • Norfolk Suicide Audit Summary (norfolkinsight.org.uk) • PowerPoint Presentation (norfolkinsight.org.uk) • PMH_NW_Analysis_Final.pdf (norfolkinsight.org.uk) • Infographic_Mental_Health_and_Wellbeing_FINAL.pptx (live.com) This ambition links to *Our Ambitions for Suffolk*, Suffolk County Council's objectives as set out in its Corporate Strategy 2022-26. As part of its objective for promoting and supporting health and wellbeing, the Council will work with the NHS, district and borough councils, and other partners to prioritise the mental and physical health of all people in Suffolk. Actions will also look to create communities and environments that promote and enable healthier, active lives and

	tackle issues such as isolation, loneliness and obesity. Through its objective of strengthening the local economy, the *Corporate Strategy 2022-26* also recognises the significant impact that economic wellbeing can have on mental and physical health and wellbeing. Our Trust Strategy | Norfolk and Suffolk NHS (nsft.nhs.uk)

Objective 1a Build system resources for early intervention and prevention for people of all ages, including those who experience mental health inequalities. This work will include enhancing and expanding skills and knowledge of mental health across our populations; providing a framework of tools and capacity to support mental wellbeing; and delivering a refreshed suicide prevention strategy.

Mental Health Transformation
Improving Urgent & Emergency Care
Elective Recovery & Improvement
Primary Care Resilience & Transformation
Improving Productivity & Efficiency
PHM reducing inequalities & Supporting Prevention
Improving Services for Babies, Children, Young People & Maternity

What are we going to do?

1. Develop an ICS structure for mental health literacy, which builds a framework of offers
2. Co-produce, implement and promote a system wide resilience framework
3. Co-develop a refreshed N&W Suicide Prevention Strategy & action plan

How are we going to do it?

Building on the targeted grant programme for vulnerable groups and the health promotion campaign 'Take 5' we will develop 2 complementary programmes which will empower communities and individuals to increase their wellbeing:

1. Mental Health Literacy will enhance and expand the skills and knowledge on mental health. To achieve this a community mental health literacy programme will be developed, to inform the

What are the key dates for delivery?

There are three clear new priority activities with the following **milestones**

Year 1 April 2023 – Sep 2023
Develop the recommendations to the system regards introduction of a mental health literacy framework and explore options for resourcing.
Year 1 Oct 2023 – Mar 2024
Publish a co-developed refreshed **suicide prevention strategy**, with agreed monitoring.
Agree on a system approach to delivery of the **mental health literacy framework**.
Year 2 April 2024 – Sep 2024
Begin implementation of the targeted workstreams in the action plan of the refreshed suicide prevention strategy. Ensure monitoring is established.
Year 2 Oct 2024 – Mar 2025
Coproduce and promote a system wide **resilience framework** for and with communities.

Transforming Care in later life	workforce and general population about wellbeing and the mental health continuum and promote activities to keep people well and enable pathways into services if needed. Training and resources will be aimed at: • increasing skills to recognise and address wellbeing concerns • enable individuals to effectively manage their own wellbeing. • Building capacity across the wider system including in the voluntary and community sector to manage wellbeing in the community This will build on two emerging system projects focussed on children and young people – the Talk Centre, and the Health Education England Mental Health learning programme. 2. The Resilience Framework will provide tools and capacity to support mental wellbeing. This will provide a structured framework which provides individuals and communities with the tools to increase and maintain wellbeing will be coproduced, to ensure a consistent standardised approach in the Norfolk and Waveney area. This framework will include a focus on wellbeing initiatives such as a targeted sleep campaign, so that there is a common language and practical solutions to manage mental health and wellbeing. These commitments complement existing prevention initiatives such as digital wellbeing tools, support for schools & families, Community Wellbeing Hubs, and NHS Talking Therapies. We continue to work with experts by experience and learn from others "what good looks like'. 3. the Suicide Prevention Partnership will coproduce a refreshed five-year Suicide Prevention strategy, with anticipated key themes for action around Self Harm, Bereavement, and Primary Care pathways for people with depression – as informed by audits. While this work is underway, we continue to raise awareness,	Launch implementation of the **mental health literacy framework** **Year 3 April 2025 – Mar 2026** Year 3 and 4 – Implement the **resilience framework** and deliver initiatives i.e., impact of sleep and tools to improve sleep quality **Year 4 April 2026 – Mar 2027** **Year 5 April 2027 – Mar 2028** Review the suicide prevention strategy. **How will we know we are achieving our objective?** **Measures** Office for Health Improvement and Disparities, Public Mental Health Dashboard • Self-reporting mental wellbeing – the number of people reporting high anxiety, low happiness and low worthwhile scores Suicide Prevention • Rates of suicide and self-harm

	operate campaigns to reduce stigma, provide accessible training, and invest in community assets tailored to specific at-risk groups. There is commitment to continue monitoring outcomes through Suicide Prevention Audits, and real time surveillance on self-harm and suspected suicides **How are we going to afford to do this?** The initiatives described will be funded from existing provision in the first instance. We will seek to identify what can be achieved through improved partnership working, at no/low cost and scope where additional resource would improve delivery. We have a good track record of developing successful funding proposals when additional national funding has become available. However, going forward the key resources that would need to be prioritised in the system for this work to succeed are a greater investment and emphasis in frontline prevention roles and activities over time, which enable communities rather than navigating to services. Work is currently underway to scope additional resources to deliver the best possible approaches, however, this is likely to include: • Programme management x 2 • Resources development x 2 • Broader system workforce training on mental health literacy, mental health first aid and suicide prevention first aid. • Voluntary and community sector capacity • Continuing to commission delivery of services	

Objective 1b Mobilise mental health system collaboratives to facilitate partnership working and deliver better health outcomes for our residents. The focus of the adult collaborative in year one is to improve support for older people living with dementia, delirium and depression which also has alignment with the Ambition Transforming Care in Later Life.		
Mental Health Transformation Improving Urgent &	**What are we going to do?**	**What are the key dates for delivery?** **Year 1 April 2023 – Sep 2023**

Emergency Care Elective Recovery & Improvement Primary Care Resilience & Transformation Improving Productivity & Efficiency PHM reducing inequalities & Supporting Prevention Improving Services for Babies, Children, Young People & Maternity Transforming Care in later life	Establish an adult Mental Health (MH) system collaborative and a Children and Young People (CYP) System Collaborative. **Adult Mental Health System Collaborative:** Identify opportunities to work collaboratively, using available data, intelligence, and insights, which focus on improving mental health and wellbeing of adults and older people. Consistently using a system-wide perspective when considering how to deliver more integrated, high-quality cost-effective care. **Children and Young People System Collaborative:** Implementation of the Thrive model. In particular, making structural, operational, and cultural changes required to deliver community based multi-disciplinary team working across organisations, to ensure collective support to meet the emotional wellbeing, mental and physical health needs of the Child or Young Person and their family. **How are we going to do it?** Embedding a new approach that: ○ focuses on early intervention and prevention – moving the resource and support further upstream over time and reducing the reliance on specialist and acute support ○ focuses on 'place' and the development of support within local communities – with less reliance on specialist settings, clinics, or institutions ○ moves away from a focus on a clinical model to one which builds understanding and resilience of community-led early support, and which develops the skills and resources of people, families, and communities to help themselves.	○ Adult MH System Collaborative and CYP System Collaborative Core Executive groups and associated delivery groups launched. ○ Rolling programme of engagement/co-production established (to inform the specific work of the collaboratives as they seek to redesign clinical pathways). ○ Establish delivery groups drawn from the wider membership to develop and implement the redesign agreed by the core executive; considering available data, information, and insights to understand enablers i.e. workforce, and identify and agree resource. ○ Monthly meetings of the Adult MH System Collaborative and CYP System Collaborative Core Executives will provide oversight and accountability for delivery of expected outcomes. **Year 1 Oct 2023 – Mar 2024** ○ Continued coalition building; gaining commitment of individual organisations to work together to achieve the new ways of working ○ Achieving tangible action; setting an action plan and agreeing local metrics to measure impact ○ Review arrangements **Year 2 April 24 onwards** ○ Building and strengthening on the Year 1 foundation activity; expanding goals as the programme progresses, recognising success and reflecting on lessons learned. ○ Continued checking back with older people living with dementia, delirium and depression and children, young people and families with emotional wellbeing, mental and physical health needs that the transformed services are meeting their needs. **How will we know we are achieving our objective?** Access to support is streamlined, responsive and coordinated for:

	How are we going to afford to do this? Through the development of the Mental Health System Collaboratives, we will work with providers to ensure our collective resource is efficiently and effectively used across the system, embracing opportunities to improve quality, efficiency, and effectiveness. We intend to make use of existing resources in a different way. For example, existing community-based teams would be upskilled to support people and families with early dementia, which will free up capacity within the specialist teams to support people with more complex needs and reducing the existing specialist waiting lists. This process will be repeated for other conditions and for children and young people too.	- Older people living with dementia, delirium and depression - Children or Young Person with emotional wellbeing, mental and physical health needs. The impact will be measured by actively seeking people, families, and professional's feedback before and after any change that is implemented.

Objective 1c Establish a Children and Young People's (0-25 years) Emotional Wellbeing and Mental Health 'integrated front door' so all requests for advice, guidance and help are accepted, and support provided to navigate the system and meet the presenting level of need. This will be developed in line with the Thrive principles, with children and young people at the centre of delivery with resources wrapped around them, enabling them to Flourish.		
Mental Health Transformation Improving Urgent & Emergency Care Elective Recovery & Improvement Primary Care Resilience & Transformation Improving Productivity & Efficiency PHM reducing inequalities & Supporting Prevention	**What are we going to do?** Norfolk and Waveney health and care partners are launching an integrated front door (IFD) to support Children and Young People (CYP) aged 0-25 with an emotional wellbeing or mental health need to access the right support at the right time. By developing a 'needs led' single integrated access point for all emotional wellbeing and mental health enquiries and requests for support, the aim is that Children and Young People across Norfolk and Waveney will have timely support to allow them to flourish. **How are we going to do it?**	**What are the key dates for delivery?** **Year 1 April 2023 – Sep 2023** - Launch Interim Arrangement for mild-moderate emotional wellbeing and mental health requests for support - Coproduce and launch a health and wellbeing website specifically aimed at young people **Year 1 Oct 2023 – Mar 2024** Launch the Integrated Front Door to include all emotional wellbeing and mental health pathways (0-25 years) of support (except crisis, which will continue to be accessed through 111 mental health option) **Year 2 April 2024 – Sep 2024** Launch the Professional Therapeutic Pathway through the IFD

Improving Services for Babies, Children, Young People & Maternity Transforming Care in later life	The ICB and CYP system partners work collaboratively within a strategic alliance, ensuring that services are committed to working together to provide the best possible care and support for CYP and their families. The IFD will build on this approach to working in an integrated and collaborative way through developing a single place to request advice, guidance and/or support based on an understanding of children and young people's needs. This will provide: - **Self-Care** support, through validated digital resources and tools, including guided self-help, with a 'request for support' process that automatically leads to suitable resources - **Advice and Guidance –** Improved access to advice and guidance through a single telephone number, and offering timely, single session interventions where clinically appropriate - **Request for Support –** One trusted pathway for children, families and professionals to ask for emotional wellbeing and mental health support. The IFD clinical team will triage and assess every request for support and allocate to the most appropriate service offer to meet the needs of children and young people. **How are we going to afford to do this?** The IFD programme is fully resourced through identified mental health service development funding (SDF) and is factored into medium term financial plans. Any efficiencies gained through implementation of the IFD will be re-invested into enhancing the range of emotional wellbeing and mental health service offers and capacity available.	- Refine data and reporting processes (including real-time reporting on system waits and coding) to ensure an improved experience for service users and professionals **Year 2 Oct 2024 – Mar 2025** Develop and embed Artificial Intelligence (AI) and machine learning solutions to improve efficiencies across the IFD **Year 3 April 2025 – Mar 2026** Work with system partners to scope additional CYP and family support services that could be accessed via the IFD and plan for implementation **Year 4 April 2026 – Mar 2027** **Year 5 April 2027 – Mar 2028** **How will we know we are achieving our objective?** 1) Increased proportion of CYP and families directly accessing support for their MH through self-referral 2) More CYP and families will access emotional wellbeing and MH support interventions 3) Reduced waiting lists for CYP to access specialist therapeutic interventions due to optimising capacity and patient flow by integrating system offers 4) An increased number of CYP accessing support for their MH need through advice and guidance, single session and low-intensity interventions across the system 5) Reduced referrals into 'getting more help' and 'getting risk support' based interventions 6) Increased numbers of CYP achieving positive wellbeing outcomes due to the intervention received supporting the presenting need

Objective 1d See the whole person for who they are, beyond their complex needs. Develop pathways that support engagement, treatment and promote recovery for people living with multiple and complex needs, with a focus on Dual Diagnosis and Complex Emotional Needs (CEN).

Mental Health Transformation

Improving Urgent & Emergency Care

Elective Recovery & Improvement

Primary Care Resilience & Transformation

Improving Productivity & Efficiency

PHM reducing inequalities & Supporting Prevention

Improving Services for Babies, Children, Young People & Maternity

Transforming Care in later life

What are we going to do?

Complex Emotional Needs:

1. Further implementation of the Personality Disorder/Complex Emotional Needs strategy, including the development of a collaborative system-wide pathway.
2. Increasing access to psychological therapy for people with complex emotional needs, wherever they present in the system.

Dual Diagnosis:

3. Develop a recognised system-wide dual diagnosis pathway – with consideration to other issues, social or physical that are commonly associated with this cohort

How are we going to do it?

We will work together, as providers and stakeholders, engaging those with lived experience, at all stages from design to delivery to improve access and care for people with dual diagnosis (defined as those with Mental Illness and substance misuse issues), and complex emotional needs', inclusive of this with Neuro Developmental Disorders (NDD).

Accessibility and inclusion are enabled and a "no wrong door" approach will be developed across system partners aiming to meet individuals' needs.

Our goal is to make these pathways as inclusive, accessible and as flexible as possible to our

What are the key dates for delivery?

Year 1 (first half) April 2023 – Sep 2023

Complex Emotional Needs:

- Provide system wide pathway workshops to map pathways, develop, and integrate the PD/CEN pathway
- Integrate new mental health roles within Primary Care Networks
- Continuing to develop the evidence-based therapy offer within place based communities and secondary care.
- Widen the availability of the Knowledge and Understanding Framework multi-agency training to wider system partners

Dual Diagnosis:

- Establish multiagency pathway leadership and group
- Establish mechanism for engaging lived experience.
- Increased joint working for mental health and substance misuse teams
- Mapping and gap analysis of existing provision, considering and exploring digital health initiatives (Virtual consultations)
- Carry out training audit

Year 1 (second half) Oct 2023 – Mar 2024

Complex Emotional Needs:

- Establish regular pathway integration meetings
- Provide a tiered offer of therapeutic interventions for PD/CEN within the Primary care network.
- Widen the availability of formulation and supported psycho-education workbook training to wider system partners.
- Integration of senior clinical roles into the MHICI, providing consultation to the whole system
- Planning the provision of therapeutic interventions of PD/CEN within the primary care network and VCFSE partners based on analysis of unmet needs

	population to promote recovery and independence. System provision will be collaborative and should seamlessly cover unmet needs. We will continue to develop the PCN mental health provision, embed the Complex Emotional Needs Strategy and pathway, and join system partners to collaboratively support people with dual diagnosis. **How are we going to afford to do this?** The initiatives described will be funded from existing provision in the first instance. We will seek to identify what can be achieved through improved partnership working, at no/low cost and scope where additional resource would improve delivery. We have a good track record of developing successful funding proposals when additional national funding has become available. Where initiatives are not funded partners will work collaboratively to explore where the impact of existing resources can be maximised. The Mental Health Integrated Community Interface (MHICI) will consist of system partners joining together to provide this function to improve the experience of people with complex needs.	**Dual Diagnosis:** • Establish protocol for local data collection • Draft of Norfolk & Suffolk Foundation Trust and Change Grow Live pathway with formal agreement **Year 2 (first half) April 2024 – Sep 2024** **Complex Emotional Needs:** • Delivery of a tiered offer of therapeutic interventions for PD/CEN within the Primary care network. • Identify therapy providers and upskill existing staff to meet the therapy gaps • Pilot the use of new roles such as the Clinical Associate Psychologists to meet therapy needs in primary care **Dual Diagnosis:** • Implementation within financial constraints and/or develop funding proposals should additional national funding become available **Year 2 (second half) Oct 2024 – Mar 2025** **Complex Emotional Needs:** • Starting to deliver some therapy provision within the primary care networks developed to meet identified system gaps • Complete implementation of CEN Strategy & integrate our pathways across provider collaboratives • Launching our psychological therapies at place level **Dual Diagnosis:** • Consider further pathway work on wider elements of provision **How will we know we are achieving our objective?** Complex Emotional Needs: • 300 additional staff trained per year in KUF, DBT or psychologically informed approaches system-wide

		• Increase in numbers of service users able to access a psychologically informed intervention outside of the NHS talking therapies and secondary care offer Dual Diagnosis • Referrals into services being accepted via the dual diagnosis pathway • A reduction in presentations to Emergency departments for service users with mental health needs and drug or alcohol problems

Ambition 2 Improving Urgent and Emergency Care

<photo>

Dr Lindy-Lee Folscher, ICB clinical lead for UEC (NNUH)

"The aim is to ensure that the population we serve receive the right care, in the right place, at the right time. Everyone should receive the best care that meets their needs whether they access that care through their GP, 111, 999 or by walking into an Emergency Department (ED)"

Our objectives

a) Improve emergency ambulance response times
b) Expand virtual ward services
c) Delivery of the Improving Lives Together programme to reduce length of stay (LoS) in hospitals

What would you like to see in our five-year plan for health and care services? What matters most to you?

Recent JFP consultation feedback: "Involve other services such as the ambulance service when making your 5-year plan as when all the other services fail it's always the ambulance service picking up the pieces". "Next best thing is more rehab beds for step down patients who do not require an acute bed but are simply not well enough to be at home independently. "Really investing in digital health is crucial to ensure joined up, continuity of care". "Easier access to Primary Care services closer to home services in the community to prevent hospital admission or facilitate early discharge home from hospital."

Why we chose these objectives

We want our population to be confident that when an emergency happens the local NHS is there to rapidly respond. This means we must continuously improve our emergency and urgent care services and adapt to our population's changing needs, take advantage of new technologies and develop trusted relationships across all health and care organisations in Norfolk and Waveney.

We know our population wants to receive care at home and avoid stays in hospital where it is safe to do so and the evidence tells us this is best for people too, avoiding deterioration in mobility through bed-based care or hospital acquired infections. Two of our priorities focus on keeping more people at home through enhancing joint working and collaboration between community teams and ambulance services as well as expanding our virtual ward that has technology at the heart of it. Our third priority is making sure that where hospital is the best place for people to be cared for, there are quick, integrated processes to get people home with the support they need to recover.

The COVID pandemic response enabled lots of our teams to integrate and work closer together however, we still have more to do. The Life Course Infographic in section 3.3 illustrates that for our older people who have a heart attack or stroke and our younger children, further work is required to improve admission to hospital where this is clinically necessary.

In 2018 Boston Consulting Group worked with the Norfolk and Waveney system to analyse demand and capacity across the entire health and care system. The report identified mismatches in demand and capacity across the system, which if not addressed would result in a bed

<table>
<tr><td colspan="2">deficit position by 2023. The recommendations highlighted that these challenges could not be overcome by a single provider but only by the entire health and care system working collectively behind a single vision for urgent and emergency care services and going further with integration. Our three priorities for urgent and emergency care take the next step in collaborative working across organisations to respond to patients when a need arises.</td></tr>
<tr><td>Who we are going to be working with to deliver this

The East of England Ambulance Service (EEAST) including volunteer Community First Responders and other supporting organisations
Primary Care
Place Boards and Health & Well-Being Partnerships
Norfolk Community Health & Care
East Coast Community Healthcare CiC
Norfolk & Norwich Hospital
James Paget Hospital
Queen Elizabeth Hospital King's Lynn
Norfolk & Suffolk Mental Health Foundation Trust
Digital partners such as Feebris for Virtual Wards
Care Homes
Norfolk County Council and Suffolk County Council Social Care – both adults and children

The place-based approach will be critical to the successful delivery of this change. Places will identify which teams will be involved in the urgent community response, how they will work together, what pathways should be led by which teams and who will coordinate the response. This will also mean identifying efficiencies and streamlining the triage process, adopting Trusted Assessor models and operationalising rotational ways of working on a day-to-day basis.

All partners play a vital role in our urgent and emergency care response. We will ensure a joined up approach and will be clear about what is best to be delivered once across the system and what is more effectively done at place or neighbourhood level tailored to the needs of local communities.</td>
<td>The UEC Ambition is aligned with our Partners in these areas:

EEAST's strategy recognises the need to evolve the way care is provided and make the best use of clinical skills and resources available to respond to patients with a care need. This may mean EEAST providing care to a patient at home or it could mean working with community teams to coordinate a rapid home visit from a community matron or therapist who can provide equipment, conduct routine observations and assessments and follow up the next day. This is consistent with the hospitals' shared objective of 'care closer to home'.

Receiving the right care, in the right place, at the right time, ambulance response times and reducing Length of Stay links to Better Together for Norfolk, Norfolk County Council's high level strategic priority of Healthy, fulfilling and independent lives and better local services as well as the Promoting Independence Strategy, Connecting Communities Programme, and Home Care Support strategy core ambitions of Adult Social Services and the Flourish Priorities for Children and Young People.

This JFP ambition links to Our Ambitions for Suffolk, Suffolk County Council's objectives as set out in its Corporate Strategy 2022-26. This priority links to the Council's objective of promoting and supporting the health and wellbeing of all people in Suffolk, through which the Council will:
• Work with the NHS, district and borough councils, and other partners to prioritise the physical and mental health of all people in Suffolk.

This ambition aligns to the Queen Elizabeth Hospital's 2023/24 Corporate Strategy where there is a clear priority to 'ensure equity of access and consistently timely care for our patients.' This is</td></tr>
</table>

	underpinned by a commitment to 'further improve the timeliness and quality of care for our emergency, cancer, and elective patients in line with operational planning guidance'. Within the Clinical Strategy we have clinical priorities to 'provide safe alternatives to emergency admissions and to focus admissions on patients who need them most' and to 'optimise length of stay for all patients (elective and emergency)'.

Objective 2a Improve emergency ambulance response times

Mental Health Transformation
Improving Urgent & Emergency Care
Elective Recovery & Improvement
Primary Care Resilience & Transformation
Improving Productivity & Efficiency
PHM reducing inequalities & Supporting Prevention
Improving Services for Babies, Children, Young People & Maternity
Transforming Care in later life

What are we going to do?

When you call 999 for an ambulance your call is categorised into an urgent or an emergency call.

We will work with the ambulance service and community teams to improve how quickly emergency ambulances can respond to our most unwell patients. To do this, we will support community teams to respond to **urgent** care needs thereby allowing the ambulance service to better respond to **emergencies**.

This will result in more 999 calls being safely and appropriately transferred to community services, where the community is best resourced to respond. You will still receive a visit from a member of your local NHS team. This could be from a community nurse or therapist as part of the 2 hour urgent community response team (UCRT), virtual ward or pharmacy. Community teams will work with senior medical specialists who will advise on treatments and can access rapid-access clinics and same day appointments at hospital.

For patients with an urgent same day care need this will mean an increasing number of patients able to safely stay at home, supported by local health and social care teams to remain safe.

How are we going to do it?

What are the key dates for delivery?

Year 1 April 2023 – Sep 2023

- Existing programme of improvement.

Year 1 Oct 2023 – Mar 2024

- Deliver Category 2 30-minute mean response time by the end of March 2024.
- Maintain consistent 70% 2 hour UCR performance throughout 2023/24.
- Identify appropriate urgent calls for transfer to community response.
- Establish the unplanned care hubs and access routes
- Consolidate community urgent care service access points under the unplanned care hub.

Year 2 April 2024 – Sep 2024

Year 2 Oct 2024 – Mar 2025

- Further review and expansion of the type of urgent calls suitable for transfer from 999.
- Review how community capacity can be expanded through continued integration at place level.

Year 3 April 2025 –Year 5 Mar 2028

- Continued integration of urgent and emergency care provision, further collaboration across system partners, including Voluntary, Community, Faith and

	We will work collaboratively with clinicians in the ambulance service, the community, primary care and others to develop the framework and digital capability to identify and transfer patients from emergency services to urgent community services. Our vision for community response teams an integrated team, working across organisations to share skills and make a greater impact by jointly responding and coordinating care and sharing resources. Leaders from partner organisations will determine how this will be modelled and delivered to meet the needs of the local population. This may mean local variation in how services are set up across Norfolk and Waveney but the outcome will be the same – a rapid response from a clinician suitably skilled to assess and treat the patient. Appropriate urgent 999 calls will be digitally transferred to community unscheduled care hubs which will bring together existing community services into a single point of access. For health and care professionals working in urgent and emergency care services this will result in consistent and standardised access points, a single access route for alternatives to emergency care and easier referral mechanisms to transfer patients between services, which will further support workforce satisfaction and retention. **How are we going to afford to do this?** We are working together as a system with all our partners, to make sure our resources are used to support transformation and deliver the care our patients need in the right place at the right time.	Social Enterprise (VCFSE) to increase the support available. **How will we know we are achieving our objective?** • Confirm a Category 2 30-minute mean response time by the end of March 2024 National description of C2: ***C2** - Emergency. These calls will be responded to in an average (mean) time of 18 minutes, and within 40 minutes at least nine out of 10 times (90th percentile)*

Objective 2b Expand virtual ward services		
Mental Health Transformation Improving Urgent &	**What are we going to do?** Virtual Wards allow patients to get the care they need at home safely and conveniently, rather than being in a hospital setting. In a virtual	**What are the key dates for delivery?** **Year 1 April 2023 – Sep 2023** • Current virtual ward provision.

Emergency Care Elective Recovery & Improvement Primary Care Resilience & Transformation Improving Productivity & Efficiency PHM reducing inequalities & Supporting Prevention Improving Services for Babies, Children, Young People & Maternity Transforming Care in later life	ward, patients are cared for in their home. Support can include remote monitoring using digital technology, wearable medical devices such as pulse oximeters and face to face care provided by multi disciplinary teams in the community. Where patients can leave hospital earlier with remote monitoring support we refer to this as Step Down. All three of our hospitals have a Step Down Virtual Ward in place. We will expand these acute based virtual ward services by increasing the specialties that are supported by virtual ward and by developing a new community-based service to offer an alternative to hospital admission for patients who are unwell in the community – a step up service. We will do this by: • Building a new ICS collaborative partnership to promote joint working, innovation and new ways of working, instead of more traditional commissioning and contracting approaches • Ensuring strong clinical leadership is in place to support collaboration. This will move towards an integrated model of care that uses resources across the system rather than in individual organisations. • Developing a common digital solution with one dashboard for clinical teams to access. • Expanding the conditions that a virtual ward can support to include respiratory, frailty and heart failure provision, as well as pioneering new, locally driven models of care. • Develop a system wide step up model which will play a key role in managing urgent care demand and building capability in the community to safely support people at home outside of a hospital setting. • We will work with the whole provider community -Primary, Community and Acute care, 999 and 111 (CAS) all need to be part of developing, supporting and using the additional capability that the virtual ward creates, to deliver better outcomes for patients • Integrate and embed virtual ward in the care system. As well as pioneering new ways of working, there is a huge	**Year 1 Oct 2023 – Mar 2024** • Put in place a single platform across the ICS to ensure consistent ways of working, reporting and viewing capacity are available. • Launch of the community step up virtual wards across Norfolk and Waveney • Establish consistent tracking against targets to inform the Partnership and aid decision making and risk mitigation • Evaluate virtual wards and use the findings to be at the heart of service transformation. An interim report on the early implementation will be available from October 2023 and will be used in collaboration with all partner organisations to co-design outcome measures for step up and step-down wards. The full report will be available from March 2024. **Year 2 April 2024 – Sep 2024** • Use findings from the evaluation to refine and improve the service. • Agree an ICS wide approach to medicine administration and point of care testing, based on two trials currently under consideration. • Continue to expand the specialties Virtual Ward can support. **Year 3 April 2025 – Mar 2026** • Use outcomes from the evaluation report to further develop virtual wards. • Continue integration of virtual wards with urgent and emergency care services • Extend Virtual Ward service to enhance multiple long term condition management to reduce inpatient demand and improve outcomes. **Year 4 April 2026 – Mar 2027**

	opportunity to link all pre-hospital initiatives into one overall integrated urgent care 'pre-hospital' model with enhanced clinical oversight that allows the community teams to do more to safely support patients outside of hospital. **How are we going to do it?** Virtual Ward will work across the whole health and care system. We will identify referral routes in and out of virtual ward for equal service provision across Norfolk and Waveney. We will make sure there are automated, digital referral routes and the ability to transfer patient details electronically so patients only have to tell their story once. Local teams will design the new models of care and supporting processes that will form the Virtual Ward face to face response. These need to be joined up with existing services and offer staff opportunities to work across different organisations to enable better integration and use of skills. **How are we going to afford to do this?** Virtual Ward has an allocation of national funding that is to be used to maintain and expand services. In the longer term it is expected that local areas will need to fund virtual ward services. As virtual ward expands we anticipate there will be corresponding changes in where urgent care activity is managed – increasingly outside of hospital settings.	• Continuous cycle of learning and evaluation to respond to patient feedback and improve the service. **Year 5 April 2027 – Mar 2028** **How will we know we are achieving our objective?** **Trajectories** • By April 2024 we will have 368 virtual ward beds We will know whether virtual wards are having the impact we want them to have if: • We are able to increase the patients who are discharged earlier from hospital to a virtual ward (reduced length of stay in the acute hospitals). • We are able to offer virtual ward as an alternative to admission to hospital (reduction in admissions, number of referrals from Emergency Departments into Virtual Wards). • We receive good patient feedback and use this to further develop services. • We can see an increase in virtual ward utilisation across the whole urgent and emergency care system.

Objective 2c: Delivery of the Improving Lives Together Programme to reduce length of stay (LOS) in hospitals		
Mental Health Transformation Improving Urgent & Emergency Care	**What are we going to do?** We want to improve discharge planning and processes, so that you can take the next step in your recovery and rehabilitation after a period of illness, quickly and safely, in a place where you can be as active and independent as	**What are the key dates for delivery?** **First 6 Months: April 2023 to September 2023**

Elective Recovery & Improvement Primary Care Resilience & Transformation Improving Productivity & Efficiency PHM reducing inequalities & Supporting Prevention Improving Services for Babies, Children, Young People & Maternity Transforming Care in later life	possible and stay connected with the people and activities that matter most to you. The 'home first' principle is important to us when we start your discharge planning. We want to make sure that you can return to your home, if this is the right place for you, and meets your needs. If things have changed while you have been in hospital, and home is no longer the right place for you to live, then we can work together to plan what that will look like. The date and time for your discharge home will be agreed with you in advance, to allow you to make plans with carers, loved ones and/or family members and we will make sure you have a supply of medication and a discharge letter to share with your GP so that they know what help and support you may need once you arrive home. Better discharge planning helps to reduce your length of stay in hospital, and reduces deconditioning and the need for readmission, which also helps us to bring people into hospital more quickly when they need emergency or planned care because we have more space and resources. It's about getting you to the right place, for the right care and support, at the right time. **How are we going to do it?** The Improving Lives Together Programme will bring system partners together to lead and deliver improved discharge planning and reduced hospital length of stay, across Norfolk & Waveney. There are two timelines for the delivery of discharge improvement, which will happen alongside each other. We will focus on **process-based improvement** to be delivered in the first 6 months and a programme of wider **transformational improvement** with a longer term 18-month timescale. The **immediate** priorities over the next 3 months will be: 1. Mobilise a digital solution (Optica) for managing patients through their discharge pathway more efficiently. It is expected that this will quickly reduce the discharge timeline by up to 14 days in most cases. 2. Focus on early discharge planning, embed the SAFER flow care bundle, and increase the number of Pathway 0 discharges and weekend discharges for people who do not need additional care and support to go home.	• Beginning of Optica phased rollout and real-time tracking of patients through discharge, reducing then eliminating manual Transfer of Care form. Early sight of patient by hubs to start planning complex discharge needs. • Embed SAFER flow bundle and 'red to green' management system. • Focus on early discharge planning for P0 patients and increase P0 discharges through criteria lead discharge and weekend discharge activity. Voluntary sector integration and utilisation by Wards and Discharge Teams. • Agree ITOC system principles, aligning goals and purpose with Place-based delivery. Relationship building & seamless communication. Increase Trusted assessor model. • Increase community bed capacity. • Improve multidisciplinary working to support complex discharge planning for service users awaiting discharge from mental health settings. • Review the ICS Discharge Board and system-level governance. Set and monitor metrics, agreeing principles and outcomes at a system level to ensure consistency. • Reduction of deconditioning so that patients can leave on the most appropriate pathway. **October 2023 to March 2024** • Continue to map and amend pathways and services to support discharge across

3. Build an Integrated Transfer of Care (ITOC) Team at each Place, which will bring together hospital, community, voluntary, therapy, transport and pharmacy resources around the patient and deliver more seamless support.
4. Continue to develop collaborative leadership, with a clear and consistent governance structure to support delivery. Include the needs of people who are being discharged from Mental Health settings into the improvement journey.

The ICS Discharge Board has agreed these priorities and will oversee improvement and delivery of metrics. Principles and outcomes agreed at system level will help ensure consistency while delivery will be driven at Place-level with support from NHSE improvement. In the longer term, the system will create a stable and sustainable model of care for discharge support across the board, but particularly for discharge Pathways 1 to 3, which are pathways for patients who require support following a hospital stay.

Data & Digital
Data is a significant issue and risk for all partners due to the digital immaturity of the Norfolk and Waveney system, however, this highlights the importance of a digital solution to help us monitor, track and report on the discharge position and impact of our interventions and improvements. New national guidance will be issued in 2023 and NHSE will report more discharge data publicly; this will be addressed with current workarounds until Optica is fully operational.

How are we going to afford to do this?
Reducing length of stay for patients improves quality outcomes and offers opportunity for savings to be realised or re-invested. Maintaining people's independence will enable funding to be diverted toward reablement and care at home, reducing costs associated with long term complex care packages and residential care. Reduced length of stay will reduce the risk of patients deconditioning and needing a higher level of care and support, in the longer term.

As part of this ambition, we need to develop a sustainable financing model. To do this we will need systemwide partner financial and operational negotiations, to determine how we can resource changes in activity across the system. Develop and establish the ITOC process at each Place.

- Fully onboard Mental Health into the improvement journey with digital and collaborative leadership.
- Robust oversight of discharge plans to ensure that they are meeting patient needs.
- Reduction in the requirement for intermediate beds and complex long term care packages.

April 2024 to March 2025

- Fully embed Optica digital tool.
- Create comprehensive evidence-based Place-level Discharge Demand and Capacity Plans. NHSE Regional and National Teams to determine the allocation of funding for beds over and above the core offer.
- Evaluation of the programme's effectiveness; review the evidence base and celebrate and share successes.
- Review and reset goals and metrics to measure effectiveness and to evidence continuous improvement.

April 2025 to March 2027

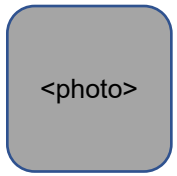
- Deliver a stable and sustainable model of care for discharge. Focus on discharge Pathways 1 to 3, for patients who require additional support following a hospital stay; ensuring there is better patient choice and communication with carers so that decisions can be made together.

April 2027 to March 2028

- Digital maturity fully embedded.
- A model of care that meets demand.

	organisations and develop workforce models that allow organisations to create the right capacity to meet demand, while also ensuring all providers across our system are able to achieve a breakeven position. **How will we know we are making a difference?** • Reduction in length of stay is the key outcome metric of this programme. • We can see a reduction in the average length of stay in acute and community beds and an overall reduction in use of intermediate care beds. • See improved outcomes for patients following discharge, and better experiences for their carers. Deconditioning and readmission rates will fall. • We can see an increase in our daily numbers of patients discharged. • Can stop using surge and escalation beds to manage day to day pressures. • We achieve or exceed the national target to reduced hospital occupancy to 92% or less.	

Ambition 3 Elective Recovery & Improvement



Joanne Segasby
CEO of James Paget and Senior Responsible Officer of Elective Recovery across Norfolk and Waveney

"The aim is to work together to improve access and quality of elective care for the people of Norfolk and Waveney with a focus on addressing inequalities"

Our objectives

a) Effectively utilise capacity across all Health System partners
b) Implement digital technology to enable elective recovery

What would you like to see in our five-year plan for health and care services? What matters to you most?
Recent JFP consultation feedback: "Reduced waiting times for urgent surgery for things that are not necessarily life threatening, but which have a massively detrimental effect on our ability to hold down a job, function at a basic level, and live independently without the need to constantly rely on people for support"

Why we chose these objectives
Our patients and communities identified this as their main concern whilst we carried out engagement on the Norfolk and Waveney ICS Clinical strategy - reducing long waiting times and improving access through elective recovery was very important to them. To improve patient safety, outcomes, experience and improve the welfare of our population it is imperative that across Norfolk and Waveney we reduce long waits for elective (planned) care, cancer backlogs, and reduce our waiting times for those needing diagnostic tests. This is likely to also reduce demand on our Urgent and Emergency Care system. These are also national ambitions. **We recognise that fully recovering elective activity is a longer-term piece of work.**

There are increasing numbers of new cancer cases being diagnosed and we know that early diagnosis is key to saving lives so it is essential that we continue to ensure patients can be offered alternative locations for their care and are seen in the right place, at the right time, by the right person. This will mean that complex health care is seen and treated at an acute hospital whilst less complex but potentially 'life limiting' health concerns may be treated elsewhere. This links to and aligns with the work we are doing around the way people are referred for diagnostic testing and/or treatment in the community or via the local GP.

Who we are going to be working with to deliver this	This elective recovery and improvement Ambition is aligned with our partners in these areas:
Norfolk and Norwich Hospital James Paget Hospital Queen Elizabeth Hospital Norfolk Community Health and Care East Coast Community Healthcare NHS England East of England Cancer Alliance Our local population Our staff Primary Care Leads for Community Diagnostic Centres Independent Sector Our future intention is to increasingly work with: Norfolk and Suffolk County Council Public Health and Social Care teams Voluntary & Community organisations across Norfolk and Waveney	All three hospitals are working together on the development of a joint electronic patient record and development of three diagnostic assessment centres (DAC's), one at each hospital, which will significantly improve access to diagnostic services and reduce waiting times for treatment, especially for a cancer diagnosis. They are also working together to provide community diagnostic hubs in several locations. Two of the three acute hospitals have been successful in securing national Transformation Improvement Funding (TIF) which will see elective hubs built at James Paget hospital and the Norfolk and Norwich hospital. Elective hubs will provide extra theatre capacity. They also benefit from separation from busy A&E departments so that planned care is not interrupted. The Queen Elizabeth hospital in Kings Lynn successfully secured TIF funding to procure a robot which will also help with some procedures. Digital transformation is key for Norfolk and Waveney and is a collective aim. The electronic patient record programme is one of the biggest pieces of digital transformation work we have ever undertaken, moving from paper-based records to electronic ones. By bringing all IT and patient record systems together, we can provide better joined up care wherever patients are treated. Improving performance and providing high quality safe care through service development and transformation is another priority seen throughout the three hospital strategies. An example of this is the combined aim to have a single waiting list across our three acute hospital trusts which helps to achieve and sustain improved waiting times for patients. This is linked to Objective two of this Ambition. The hospitals are working with Primary Care Networks (PCNs) in Norfolk and Waveney. The PCNs are speaking to individuals on waiting lists for planned care and checking they still want to be seen and, if so, would they wish to travel to another place of care if it meant being seen sooner.

	This partnership working will reduce waiting lists and give increased levels of patient choice. This ambition links to *Our Ambitions for Suffolk*, Suffolk County Council's objectives as set out in its Corporate Strategy 2022-26. Through these, the Council will: • Work with the NHS, district and borough councils, and other partners to prioritise the physical and mental health of all people in Suffolk. • Expand the council's integrated health and care technology offer, including greater take-up through NHS organisations in Suffolk, Children and Young People's Services, and the private sector, to help more people to live safe and independent lives. • Play a major role in building one linked health and care dataset for adults across Suffolk; and will also provide new analytics, with health colleagues, to help design and deliver new, targeted health and wellbeing interventions This ambition aligns to the Queen Elizabeth Hospital's 2023/24 Corporate Strategy where there is a clear priority 'to ensure equity of access and consistently timely care for our patients.' This is underpinned by a commitment to 'further improve the timeliness and quality of care for our emergency, cancer, and elective patients in line with operational planning guidance'. Within the Trust's Clinical Strategy, we have a clinical priority to 'optimise length of stay for all patients (elective and emergency)' and to 'transform outpatient services using technology to become a more responsive, patient focused service'.

Objective 3a Effectively utilise capacity across all Health Partners		
Mental Health Transformation Improving Urgent & Emergency Care	**What are we going to do?** We will identify and utilise all available capacity to ensure residents access the right service, at the right time in the most convenient and suitable location. Through working in partnership, we will identify whole system transformational	**What are the key dates for delivery?** *Year 1 April 2023 – Mar 2024* • Mutual Aid rolled out across specific specialties and patient groups.

Elective Recovery & Improvement Primary Care Resilience & Transformation Improving Productivity & Efficiency PHM reducing inequalities & Supporting Prevention Improving Services for Babies, Children, Young People & Maternity Transforming Care in later life	opportunities. This will reduce waiting times, deliver care in more convenient locations and provide a more patient centric service. We will continue to narrow health inequalities in access, outcomes, and experience for our population and ensure this is supported by a strong workforce, digital capabilities and is co-produced with all partners including the residents and patients. We will • Deliver more diagnostic care. • Deliver more elective care. • Increase day case elective procedures. • Reduce cancer backlogs. • Reduce unnecessary outpatient follow up appointments. **How are we going to do it?** **<u>We will deliver more diagnostic care.</u>** Norfolk and Waveney have been asked to develop plans and business cases for multiple Community Diagnostic Centres (CDCs) and are waiting for confirmation of national investment to proceed. • Our plan is to invest in state-of-the-art diagnostic equipment across our geography, new diagnostic centres at acute hospital sites and in the community setting to increase capacity to offer a suite of multiple diagnostic tests in 'one stop' closer to where you live. • Streamlined access for Primary Care colleagues to enable direct access to diagnostic tests and clinical guidance across the health services to meet the needs of the individual. • Tackle health inequalities by creating better access to diagnostic testing in our deprived areas. • We will optimise what we do and share best practice to standardise procedures, processes and pathways to increase productivity, efficiencies and clinical quality. **<u>We will deliver more elective care.</u>**	• PIFU rolled out across specific specialties. • Norfolk and Norwich Orthopaedic Centre opened • James Paget Hospital Elective Surgery Hub opened • There will be additional diagnostic capacity across Norfolk and Waveney (national funding dependent) • The system will work collaboratively to optimise direct access for primary care across health services. • Continue to support Primary Care in the delivery of the Earlier Cancer Diagnosis PCN DES • Continue to support the hospitals to implement the Best Practice Timed Pathways for Cancer • Implementation of a clinical decision support tool for cancer in primary care • Share the learning from improving access to cancer services for people living with learning difficulties project *<u>Year 2 April 2024 - Mar 2025</u>* • Mutual Aid rolled out across all specialties and all patient groups. • Patient Initiated Follow Ups rolled out across all specialties. • Norfolk and Norwich hospital Elective Hub opened • A further increase in diagnostic capacity across Norfolk and Waveney (national funding dependent) • Develop an approach to fixed term posts funded through cancer

- Mutual Aid' (whereby patients are asked if they would be happy to be treated at any of the three acute hospital trusts in Norfolk and Waveney if their treatment can be completed sooner) will be further rolled out.
- Increasingly use data to help understand key areas to improve.
- We will build additional theatre capacity at our acute hospital sites. (i.e. Elective hubs)
- We will more readily share best practice between the acute trusts thereby appropriately increasing standardisation of procedures, pathways and support functions.
- Together these approaches will increase theatre productivity where patients need to be treated in a theatre, but it will also contribute to increased planned care treatments in Hospital Outpatient clinical areas, GP practices and Community care settings.

Increasing rates of 'day case' elective procedures

- We will use national best practice initiatives such as High Volume Low Complexity (HVLC) and Get it Right First Time (GIRFT) to ensure that where appropriate Norfolk and Waveney residents are able to fully benefit from 'Day Case Care' for planned care procedures.
- This will ensure patients have reduced length of stay and risk of complications.
- This will also help release beds and prevent cancellations of planned care procedures which need overnight stay(s) in hospital.

Reducing cancer backlogs

- We will use evidence and audit to co-produce pathways with primary and secondary care, standardising pathways and ensuring appropriate safety netting where possible.
- Continue to embed system-wide nationally defined Best Practice Timed Pathways (BPTP) for cancer, and vague symptoms pathways to improve efficiency, diagnosis, and patient experience
- We will build on our current projects using PHM approaches to identify people who are at a higher risk of cancer, and those with inequitable access to cancer services, so we can apply these methodologies to cancer backlogs in the future. This will form part of the development of our ICS PHM strategy.

transformation funding to improve sustainability
- Develop career pathways for cancer nursing and therapeutic radiography to support recruitment and retention

Year 3 April 2025 – Mar 2026

Expand collaborative working with Public Health, social care and VCFSE partners.

Years 4 and 5 Apr 2026 – Mar 2028

Throughout the phases of this objective, we will review the benefits and explore further opportunities to enhance Elective Recovery & improvement including our digital technology which will inform our strategic direction for years 4 and 5.

Additional Clinical Equipment at Queen Elizabeth Hospital Kings Lynn: Funding utilised on Cancer Diagnostic Equipment (£1.6m), Theatre Equipment of £2.0m & General Clinical Equipment of £3.0m.

How will we know we are achieving our objective?

Waiting time will reduce for patients:

Elective
- Patients will not wait any longer than 65 weeks for their planned care treatment by March 2024 and 52 weeks by March 2025.

	• Provide additional workforce capacity to support clearance of the waiting list • Ongoing work to raise awareness of cancer guidance within primary care to reduce the variation in quality of referrals **<u>Reducing unnecessary outpatient follow up appointments.</u>** • One of key approaches is called PIFU (Patient Initiated Follow Ups) to prevent clinically unnecessary appointments and to ensure that any appointment is booked by the patient at a date, time and location which is convenient to them. • Clinicians will discuss with patients *what* and *when* is expected post intervention and, unless recovery is different from the discussed recovery pathway, the patient will not attend an Outpatient Follow Up appointment. • We will ensure there are opportunities for the patient to request (or initiate) a Follow Up appointment if they are unhappy or worried in anyway and details how to do this will be given to patients. • Patients will notice they have more involvement and/or choice of whether to have Follow Up appointments. This will save patients time and transport costs, whilst at the same time releasing clinician time to other priority areas. **How are we going to afford to do this?** National capital funding (TIF) has been requested through the development of local plans and business cases to support Elective Hubs, Community Diagnostic Centres and Diagnostic Access Centres. We await final funding decisions before we can move forward with these initiatives.	Diagnostics • Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% Cancer • Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days. • Continue to reduce the number of patients waiting over 62 days. • Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028.

Objective 3b Implement digital technology to enable elective recovery		
Mental Health Transformation	**What are we going to do?**	**What are the key dates for delivery?**

Improving Urgent & Emergency Care

Elective Recovery & Improvement

Primary Care Resilience & Transformation

Improving Productivity & Efficiency

PHM reducing inequalities & Supporting Prevention

Improving Services for Babies, Children, Young People & Maternity

Transforming Care in later life

We will implement digital technology and initiatives to support our ambition for elective recovery and improvement.

Digital is a key enabler for improvements in health and care in Norfolk and Waveney and our ICS Digital Strategy sets out clear priorities for improvement. A single waiting list for all three hospitals is stated within our Digital Transformation Strategic Plan and Roadmap as a priority.

- **Peri-operative care** - Digital initiatives will be rolled out in peri-operative care which will allow patients to complete important personal health and lifestyle questionnaires online to streamline the process.
- This will help ensure patients are 'fit and ready' for their planned care/treatment which will reduce cancellations, reduce length of stay and improve recovery.
- We will support patients to "wait well" and identify and prioritise patients at risk of potential harm while waiting.
- We will ensure non-digital options will also be available for those who do not have access to, or cannot use, IT and those who prefer not to.

- **Single Waiting List** - We will have one waiting list across our three hospitals to ensure patients waiting for treatment at any of our hospitals will receive the same levels of access to care (i.e. waiting times for treatment) and we will proactively offer patients an alternative location to receive their treatment if they could be seen more quickly.
- We want to ensure everyone on the waiting list has 'equity of access' This is important as we have pledged to work to actively reduce health inequalities in Norfolk and Waveney.

How are we going to do it?

- Online Peri-operative care is being tested in Trauma and Orthopaedics first as this is a speciality which has large numbers of patients waiting for treatment.
- The next phase of testing with be specialities such as Ear, Nose and Throat and Gynaecology as these also have large waiting lists.
- The intention is roll out across all specialities in two of the three hospitals by March 2024. The final hospital intends to roll out online Peri-operative across its specialities by March 2025.

Year 1 Apr 2023 – Mar 2024

- Online Peri-Operative Care testing complete and rolled out in two of the three hospital trusts.
- Single waiting list testing phase for Trauma and Orthopaedic, Cancer, Ophthalmology, Vascular and Endoscopy complete.
- Single waiting list in operation at all three hospitals by March 2024 for selected specialities

Year 2 Apr 2024 – Mar 2025

- Online Peri-Operative Care implemented in all hospitals.
- All hospitals using the single waiting list across all services.
- All patients at the point of referral to have the choice of the waiting list management to be predicated on the *place* of care or the *timeliness* of their care.

Year 3 Apr 2025 – Mar 2026
Increased levels of data quality assurance routinely seen across all three hospitals waiting lists.

Year 4 and 5 Apr 2026 – Mar 2028

Throughout the phases of this objective, we will review the benefits and explore further opportunities to enhance our

	• This will also help prevent cancellations of planned care procedures which need overnight stay(s) in hospital. • To implement the single waiting list, a new piece of IT Software has been purchased and is currently being implemented in specific areas of care such as Trauma and Orthopaedic and Cancer to test that it is working properly. It is anticipated the testing stage should be completed before the summer of 2023. • Next, we will expand the testing to other areas of care such as Ophthalmology, Vascular and Endoscopy, it is anticipated this will be completed by the autumn of 2023. • Our intention is for all three hospital trusts to be using the single waiting list by March 2024 • This will enable us to actively manage our single patient waiting list to support patients to 'wait well' and identify and manage those at greater risk of harm. • The following years will see increased confidence levels in staff using the new IT software, the process to be really embedded and for all patients to have the choice of the waiting list management to be predicated on the *place* of care or the *timeliness* of the of their care at the point of referral. **How are we going to afford to do this?** We have purchased the software and hardware necessary for both the Peri-Operative Care and single waiting list initiatives. The Peri-Operative Care business case has identified future costs which have been agreed as per the signing off of the business case. With regards to the single waiting list there will be some costs associated with training although the 'Train the Trainer' model should keep costs to a minimum.	digital technology will inform our strategic direction for years 4 and 5. **How will we know we are achieving our objective?** By measuring how many patients have been offered mutual aid once our single waiting list is in place. We will also measure how many patients took the opportunity to choose a different place against those who chose to wait at their preferred treatment location.

Ambition 4 Primary Care Resilience & Transformation

<placeholder>

"The aim is to integrate primary care services to deliver improved access to a wider range of services from a multi-disciplinary team. This will deliver more proactive care, preventing illness and improving outcomes, for local communities closer to home."

Our objectives

1. Developing our vision for providing a wider range of services closer to home, improving patient outcomes and experience.
2. Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years.

What would you like to see in our five-year plan for health and care services? What matters most to you?
Recent JFP consultation feedback: "Primary care needs to be top of the list. People are attending A&E because they cannot see a GP, that needs transforming first. It's been the same for years". "Preventing and managing ill health starts in primary care." "NHS dentistry should be a priority within the primary care focus". "For me personally, primary care and specifically the GP surgery is the key priority. I believe that all the other priorities are heavily dependent on the performance of GP surgeries."

Why we chose these objectives
Primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care is an umbrella term which includes general practice, community pharmacy, dentistry, and optometry (eye health) services.

Nationally, all primary care services are facing greater challenges than ever due to workforce shortages, alongside an increasingly complex workload. Norfolk and Waveney have an ageing workforce within general practice with approximately 30% of staff being over the age of 55. In the last 10 years, the number of dentists has declined in our area compared to the East of England region and the whole of England. This decline has a greater impact in Norfolk and Waveney due to higher levels of need, areas of deprivation and a higher number of residents in later life. Poor oral health is widely considered to be an important aspect of our general health and wellbeing and is largely preventable and can have a significant impact on quality of life, such as eating, speaking, discomfort and cause an increase in days lost from work and school.

Our ambition aligns with The next steps for integrating primary care: Fuller stocktake report which outlines the new vision for integrating primary care services to improve access, experience and outcomes for our patients and communities.
NHS England has recently published the Delivery plan for recovering access to primary care which focuses on the need to streamline access to care and advice, reducing the number of people struggling to contact their practice and so that patients know how their request will be managed, on the day they contact their practice. The plan also outlines the ambition for expanding community pharmacy services to make them the first port of call for minor common conditions, supporting better integration in line with the vision set out in the Fuller stocktake report.

We will

- empower people to understand and manage their health and wellbeing through coordinated care and support networks and, as far as possible, people will be able to manage their health and wellbeing where they live, in their homes and communities.
- make care more personalised; providing individuals with support tailored to their needs, rather than a one-size-fits-all approach which can lead to inequalities in access and health outcomes.

Who we are going to be working with to deliver this	**This primary care Ambition is aligned with our partners in these areas:**
Primary Care Networks (PCNs) General Practices Dentists Community Pharmacists Optometrists Local Medical Committee Local Dental Committee Local Dental Network Local Pharmaceutical Committees Local Optical Committee Our local population Norfolk & Norwich Hospital James Paget Hospital Queen Elizabeth Hospital Norfolk Community Health & Care East Coast Community Healthcare CiC VCFSE sector District Councils County Councils Care Homes Place Boards and HWP's NHS England	PCNs have identified the top three priorities as: • increasing the workforce and building resilience, • improved interface between primary and secondary care and supporting care closer to home, • Better managing complex need and frailty at home. To support this PCNs are • Ensuring the right staff are in the right place to meet health and care needs, • Addressing organisational barriers so we make decisions and implement at pace, • Empowering our people to test opportunities through collaboration and working differently together. Developing integrated neighbourhood teams, services closer to home, improving patient outcomes and experience and stabilising dental services by building a local resilient multi-skilled professional workforce links to **Better Together for Norfolk**, Norfolk County Council's high level strategic priority of ***Healthy, fulfilling, independent lives -levelling up health, living well and better local services.*** Developing integrated neighbourhood teams to provide a wider range of services closer to home, improving patient outcomes and experience aligns with the **Promoting Independence strategy, Connecting Communities Programme,** and **Home Care Support strategy** core ambitions of Adult Social Services and **Ready to Act, Ready to Change** Public Health Strategy, based on improving accessibility to services allows people to live healthier,

	more fulfilling, independent lives. Increasing joint working in communities so more families are able to get the support they need in the places and spaces that they already visit, or in their homes is part of **Flourish** Children and Young Peoples Strategy. This ambition links to *Our Ambitions for Suffolk*, Suffolk County Council's objectives as set out in its Corporate Strategy 2022-26. In particular, this priority links to the Council's objective of promoting and supporting the health and wellbeing of all people in Suffolk, through which the Council will: • Work with the NHS, district and borough councils, and other partners to prioritise the physical and mental health of all people in Suffolk. • Enable residents to lead healthier, active lives and address health inequalities, including working to combat isolation and loneliness and tackling obesity. • Continue, through its services, to prioritise vulnerable older people and adults, as well as young people and children needing extra support.

Objective 4a Developing our vision for providing a wider range of services closer to home, improving patient outcomes and experience.		
Mental Health Transformation Improving Urgent & Emergency Care Elective Recovery & Improvement Primary Care Resilience & Transformation	**What are we going to do?** First, we will develop some overarching principles and our strategic vision for future primary care delivery supporting our ambition to deliver cohesive primary and community care services across Norfolk and Waveney. We will build on this to develop a detailed general practice and dental strategy which we will begin to implement across the second year of this plan.	**What are the key dates for delivery?** **Year 1 April 2023 – Sep 2023** • Develop an outline for key milestones for strategy development including which stakeholders we will engage with and by when. • Review population health data to identify key priorities and need within each Place.

Improving Productivity & Efficiency PHM reducing inequalities & Supporting Prevention Improving Services for Babies, Children, Young People & Maternity Transforming Care in later life	We will develop our local delivery plan for the existing East of England Partnership Strategy for Community Pharmacy, recognising that this strongly supports the Fuller Stocktake vision for integrating primary care. We will also develop our strategy for Optometry services alongside the on-going system Eye Health transformation. Currently, our PCNs work as groups of general practices to deliver care to their population. Our next step is to provide our Community Pharmacy teams with the support, training and mentorship to enable Community Pharmacy PCN Leads to develop the skills they need to integrate local community pharmacies into Primary Care Network planning and activities. Going further, our vision is to create Integrated Neighbourhood Teams that will deliver joined up primary and community care in a model that is closer to patients' homes. The specific delivery model will be designed locally by our Place teams where they will decide which services are needed and how this will improve patient outcomes and experiences. We will deliver services at scale where possible and at PCN level where more targeted local services are required. **How are we going to do it?** We will support our Community Pharmacy PCN Lead roles to engage with the Integrating Community Pharmacy into Primary Care Networks programme. We will agree a local definition of an Integrated Neighbourhood Team and how we will approach new ways of working. We will use population health data to identify the priorities for developing new models to meet local population health and care needs. We will work collaboratively and in partnership with our partners in secondary care, community services, VCFSE and wider groups to support a blended model of care that not only focusses on a patient's health	• Develop local definition of an Integrated Neighbourhood Team. **Year 1 Oct 2023 – Mar 2024** • Overarching Primary care strategy vision and principles developed. • Engagement with our local population and system partners. • General Practice Strategy developed. • Dental strategy developed. **Year 2 April 2024 – Mar 2025** • Implement the first stage of the General Practice and Dental strategy. • Develop the delivery model for Integrated Neighbourhood Teams at Place and PCN level. • Local delivery plan for the East of England Community Pharmacy Partnership strategy developed. • Develop strategy for Primary Optometry services alongside the system ICS Eye Health Transformation programme. **Year 3 to 5 April 2025 – Mar 2028** • Continue to implement the new strategy with frequent monitoring of outcomes. **We will begin to see our approach is working because we will begin to be able to measure** We will have published the first stage of our overarching vision and our strategy for general practice and dentistry by March 2024, informed by strong public engagement and using data to meet the needs of our population.

	needs, but also their socio-economic needs providing more holistic and joined up care, including management of clinical risk. **How are we going to afford to do this?** We will work with our partners to agree how new pathways of care will be resourced and funded from within the current funding allocations across the system.	

Objective 4b Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years		
Mental Health Transformation Improving Urgent & Emergency Care Elective Recovery & Improvement Primary Care Resilience & Transformation Improving Productivity & Efficiency PHM reducing inequalities & Supporting Prevention Improving Services for Babies, Children, Young People & Maternity Transforming Care in later life	**What are we going to do?** Develop a near term plan to identify and prioritise populations in the greatest need of access to NHS dental services using data from the renewed Oral Health Needs Assessment (OHNA) and Public Health data for Norfolk and Waveney. This will ensure we can deliver short term interventions and begin to improve access to NHS dental services by Autumn 2023. Next, we will develop a Norfolk and Waveney strategy to improve the oral health of our population and explain our approach to build resilience across all our NHS dental services including our local workforce plan. This five year strategy will be ready for implementation from April 2024. Working with key stakeholders and system partners to develop solutions for securing access to NHS dental care for the whole population. **How are we going to do this?** We will develop a plan for the near term to address immediate needs: • We will use all available data to understand and prioritise the immediate dental need. This may be a clinical need or a geographical need. • We will seek interest from current dental providers to increase the number appointments they are able to offer on a short term basis.	**What are the key dates for delivery?** **Year 1 April 2023 – Sep 2023** • Updates to the OHNA published in Spring 2023 and updated in Summer 2023. • Develop plan for short term interventions based on updated to the Oral Health Needs Assessment targeting the areas requiring the greatest interventions. **Year 1 Oct 2023 – Mar 2024** • Develop a Dental Strategy to outline our commissioning intentions for the next three to five years, our strategic approach to commissioning and how we plan to build resilience across all our NHS dental services alongside the development of our local workforce plan for Norfolk and Waveney. **Year 2 April 2024 – Mar 2025**

	• We will monitor the impact these actions have to improve access to dentistry and build this information into our next part of the objective – to develop a dental strategy for Norfolk and Waveney. Next, we will develop a five year dental strategy for Norfolk and Waveney: • Establish a 'Dental Taskforce' to hear to the challenges faced by the profession and work collaboratively to find solutions to improve access to dental care. • To listen to our patients and hear their lived experiences, and to ensure our local population has access to oral health prevention advice, working with local authorities and the voluntary sector in Norfolk and Suffolk. • Use our population health data, OHNA we will ensure our strategy is evidence based, balanced to meet the needs of residents, and reduces health inequalities. • Identify steps to retain, grow and develop our local dental workforce to meet our patients' needs. We will build multi-skilled dental teams, including roles such as Dentists, Dental Nurses, Dental Hygienists and Dental Therapists. • We will implement this strategy by April 2024. **How are we going to afford to do this?** We will utilise our existing dental funding allocation to commission services with flexibility to meet the needs from the Oral Health Needs Assessment published in Spring 2023.	• Implement the first stage of the dental strategy. **Year 3 to 5 April 2025 – Mar 2028** • Continue to implement the new strategy with frequent monitoring of outcomes. **How will we know we are achieving our objective?** <KPIs to be confirmed in final plan>

Ambition 5 Improving Productivity & Efficiency

Andrew Palmer, Director of Performance, Transformation and Strategy, Norfolk & Waveney ICB

"Our ambition is to change how we work with partners across the Norfolk and Waveney ICS to look at ways we can work together more effectively and become more efficient, whilst driving forward service improvements to meet the needs of our local population. It is not simply about saving money but also about delivering better services and outcomes for our patients and local communities."

Our objectives

a) Improve the services we provide by enhancing productivity and value for money, embracing digital innovation and delivering services together where it makes sense to do so.

What would you like to see in our five-year plan for health and care services? What matters to you most?

The focus of this ambition is to systematically review data about our services and compare how we perform with other systems nationally, seeking out opportunities to work more effectively and efficiently for the benefit of our population. We will work together in partnership to ensure we achieve value for money, ensuring we use our resources as wisely as possible for the benefit of our population.

Why we chose these objectives

Deciding where to look to improve productivity and efficiency has been driven by the data and in discussion with our staff. All partners are looking at their own internal efficiencies as a constant process. We have access to the Model Health System https://www.england.nhs.uk/applications/model-hospital/ which allows NHS organisations to compare themselves with each other and look for variances. Opportunities to improve productivity and outcomes identified though Getting it Right First Time (GIRFT) https://gettingitrightfirsttime.co.uk/ benchmarking are also being reviewed. We look at examples of good practice across the local system, regionally and nationally, and use our Health Intelligence data to determine where to focus next. Across all the NHS partners we are also looking at opportunities to achieve economies of scale through procurement, sharing estates resources and collaborating when purchasing the medicines we prescribe and dispense.

For Procurement the core programme of work is to modernise the function and work collaboratively across the system to gain value for money by using the purchasing power of the combined Norfolk and Waveney NHS. This programme is live, with a workplan that constantly reviews the opportunities to save money by purchasing suitable supplies at a lower cost.

The Estates programme, similarly to the Procurement work, will maximise the opportunities for more effective ways of working and how we use the Norfolk and Waveney estates assets across all system partners. The goal is to ensure the best value for money, including for example, securing capital receipts for the disposal of old and, where appropriate, surplus estate.

The Medicines Management programme is utilising pharmacy expertise to target drug and medicines savings. One significant opportunity arises when licenses change and certain 'branded' drugs can in future be made by other companies, usually at more competitive prices. Clinicians, pharmacists and procurement experts are working together across the system to ensure best value in this area.

Who we are going to be working with to deliver this	**This Productivity and Efficiency Ambition is aligned with our Partners in these areas:**
Norfolk & Norwich Hospital James Paget Hospital Queen Elizabeth Hospital Norfolk Community Health & Care East Coast Community Healthcare CiC Norfolk & Suffolk Foundation Trust Norfolk & Waveney ICB NHS England, Primary Care and other specialist redesign and transformation organisations	*The thread of productivity and efficiency runs through every organisation and every service development, meaning it is an integral part of every strategy across Norfolk and Waveney*. Increasing productivity and efficiency in key areas links to Better Together for Norfolk, Norfolk County Council's high level strategic priority of *Healthy, fulfilling, independent lives -levelling up health, living well and better local services*. Workforce efficiency, procurement and estates aligns with the **Promoting Independence strategy**, **Connecting Communities Programme, Home Care Support strategy** and **Flourish Strategy** ensuring that working in partnership, our services are sustainable and can meet the needs of the local population which are core ambitions of Adults and Childrens Services. This ambition links to *Our Ambitions for Suffolk*, Suffolk County Council's objectives as set out in its Corporate Strategy 2022-26. Improving productivity and efficiency links to the Council's objective of providing value for money for the Suffolk taxpayer, as driving productivity, efficiency and innovation will help sustain high-quality services and drive future improvement. The Council aims to meet this objective by: • Redesigning services and processes to drive productivity and value for money. • Maintaining its strong track record of sound financial management and governance. • Investing in technology and using the internet and innovation to improve communication, access to services, service delivery and efficiency. The Council's New Ways of Working programme aims to increase the ability of its workforce to deliver these objectives, and to rationalise its office estate, including creating opportunities to share spaces with public sector partners and support effective partnership working. Programmes such as People First and Independent Lives will develop new models of care that will ensure services remain sustainable while enabling people to lead lives that are as independent as possible. The Council will also work with partners to develop a Prevention Action Plan and to implement the service and data improvements needed to

	embed CORE20PLUS5, to improve population health outcomes, reduce health inequalities, and prevent future ill-health in Suffolk. This ambition aligns to the Queen Elizabeth Hospital's 2023/24 Corporate Strategy where there is a clear priority to 'deliver transformation through our major programmes of work including the New Hospital, Electronic Patient Record, Acute Clinical Strategy and Provider Collaboration.' This is underpinned by our commitment to 'deliver our financial plan and savings plan for the year, in turn contributing to delivery of the wider system's financial requirements.'

Objective 5a Improve the services we provide by enhancing productivity and value for money, embracing digital innovation and delivering services together where it makes sense to do so.

Mental Health Transformation
Improving Urgent & Emergency Care
Elective Recovery & Improvement
Primary Care Resilience & Transformation
Improving Productivity & Efficiency
PHM reducing inequalities & Supporting Prevention
Improving Services for Babies, Children, Young People & Maternity
Transforming Care in later life

What are we going to do?

Our organisations have established improvement programmes examining a range of areas in which to increase productivity and value for money. We have already brought together some administrative functions to improve value for money. Existing improvement programmes include a focus on Procurement, Estates and Medicines Management opportunities.

Our two areas of focus for year one and two are:

a) Organisations will continue to improve their operational efficiency across a range of areas of spend including procurement, estates, workforce and prescribing.

b) Work together to enhance outcomes, productivity and value for money through our new Improving Lives Together Programme.

How are we going to do it?

We have established our Improving Lives Together programme, an ambitious improvement programme, drawing together partners from across our system to

What are the key dates for delivery?

Year 1

- By May 2023 our Improving Lives Together programme will develop cases for change for improvements in Digital and Workforce services. These proposals will then be considered by partners in our ICS, and individual projects will be set up to deliver the agreed changes beginning, where possible, in the second half of 2023/24.

Year 2

- 2024/25 will see the full roll out and effect of any changes to Digital and Workforce services, and our Improving Lives Together programme will continue to assess further service areas for wider opportunities to improve.

Years 3 - 5

- Our Improving Lives Together programme will continue to support review and improvements in services as part of our continuous service improvement approach.

How will we know we are achieving our objective?

- We will undertake post implementation reviews for changes led through our Improving Lives Together programme to formally

	work together to improve the services that we provide. We will assess opportunities based on evidence and benchmarking of data through sources including the Model Health System. The initial focus of this work is on Digital and Workforce services, and we have already undertaken a detailed assessment of how we currently deliver these services to see how we can make improvements. Options are being developed that will help us to reduce duplication, improve outcomes and make best use of every pound we spend as an ICS. **How are we going to afford to do this?** This programme of work will deliver enhanced productivity and value for money and is not anticipated to increase overall costs in our system. Options will be carefully assessed as part of approving the cases for change for individual service areas.	assess that we have successfully delivered the operational and financial improvements. • We will use national benchmarking data drawn from the Model Health System to measure our improvement relative to national benchmarks and other ICSs.

Ambition 6 Population Health Management (PHM), Reducing Inequalities and Supporting Prevention

Tracy Williams
ICB Clinical Lead for Health Inequalities & Inclusion Health
N&W ICB
Norwich locality Adviser

Suzanne Meredith
Deputy Director of Public Health Norfolk County Council

Associate Director PHM

"The aim is to enable all people to stay healthy by predicting and planning for health and care needs before they happen, and ideally preventing them if we can. By working together with partners across the NHS and other public services in Norfolk and Waveney we can make an even bigger difference to many of the factors that affect our health and improve the health outcomes for our population"

Our objectives

a)Development and delivery of two strategies:

- A **Population Health Management** Strategy, and
- A Norfolk and Waveney **Health Inequalities** Strategy to deliver the "Core20plus5" approach

The delivery of three specific **Prevention** work programmes designed to tackle:

- b) Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people
- c) Early Cancer Diagnosis – Targeted Lung Health Check Programme
- d) Cardiovascular disease (CVD) Prevention

What would you like to see in our five-year plan for health and care services? What matters most to you?

Recent JFP consultation feedback: "There should be more emphasis on prevention rather than cure." "Preventative Screening needs to be prioritised too". "Focusing on early intervention and prevention by broadening opportunities for roles such as social prescribing, community connectors, champions and health workers - providing holistic support to divert demand and in doing so, building capacity in our communities". "Preventative proactive healthcare in the community through Making Every Contact Count. Education in relation to self-care and responsibility for health"

Why we chose these objectives

We have identified initial Population Health Management priorities at a system level to address health inequalities and meet the Core 20 plus 5 priorities, which will have the greatest impact and where we know there are opportunities to improve. These are smoking, especially smoking in Pregnancy, Serious Mental Illness, Chronic conditions – Cancer (including earlier diagnosis), Cardiovascular and Respiratory. We will be aspiring to a reduction in the differences in outcomes we currently experience in terms of accessing services and improvements in the health care processes for the Core20 PLUS populations. We will also be seeking to prioritise prevention activities, particularly relating to smoking, alcohol, diet and physical activity and uptake of cancer screening and immunisations. Prevention is part of our Business as Usual agenda but we have identified three priority areas that we will lead on, and these are reflected in the three specific Prevention Work Programmes that we have chosen, underpinned by the evidence base as set out here.

In 2020, nationally 8.9% of women smoked at time of delivery. In Norfolk and Waveney, the smoking at time delivery rate (SATOD) is significantly higher at 13.6% and remains an outlier for the East of England. Within Norfolk the highest rates of smoking in pregnancy are in West Norfolk and Great Yarmouth.

At present over 70% of Lung cancers are diagnosed at stage 3 or 4 where treatment is often difficult, or patients are palliative. The early cancer diagnosis programme aims to shift this stage at diagnosis to Stage 1 or 2 when it is at an early stage when treatment with a curative intent is more possible.

People with common conditions such as high blood pressure and high cholesterol are more at risk of developing cardiovascular disease, but they can be given treatment to help stop this happening. It is often the case that people remain undiagnosed and untreated because they have no symptoms. By doing this work, we will be helping to identify and offer treatment to people most at risk and ultimately preventing strokes and heart attacks in people living in Norfolk and Waveney over the next ten years.

Who we are going to be working with to deliver this	**The PHM, Reducing Inequalities and Supporting Prevention Ambition is aligned with existing strategies and plans across the ICS in Norfolk and Waveney. In particular it is aligned with our Partners in these areas:**
Primary Care Networks Place Boards Norfolk County Council – public health, adults and children's social care teams Suffolk County Council – public health, adults and children's social care teams HWP's Norfolk & Norwich Hospital James Paget Hospital Queen Elizabeth Hospital Norfolk Community Health & Care Cambridgeshire Community Services Hertfordshire Community Trust East Coast Community Health Norfolk & Suffolk Foundation Trust VCFSE sector ICS Clinical and Care Assembly Cancer Alliance	The strategies and three work programmes with a focus on predicting and planning for health needs as well as prevention, link to **Better Together for Norfolk**, Norfolk County Council's high level strategic priority of ***Healthy, fulfilling, independent lives - Levelling up Health, Living Well and Better Local Services*** - *where everyone can start life well, live well and age well, and where no one is left behind.* Smoking during pregnancy workstream aligns to the **FLOURISH** strategy and promoting healthier lifestyles in pregnant women. Reducing inequalities and supporting prevention aligns with the Adult Social Care **Promoting Independence strategy** vision of supporting people to be independent, resilient, and well. Prevention and predicting and planning for health and care needs before they happen aligns with the **Ready to Act, Ready to Change** Public Health Strategy, based on the recognition that early intervention allows people to live healthier, more fulfilling lives. This ambition links to *Our Ambitions for Suffolk*, Suffolk County Council's objectives as set out in its Corporate Strategy 2022-26. Through these, the Council will:

	• Work with the NHS, district and borough councils, and other partners to prioritise the physical and mental health of all people in Suffolk. • Strengthen the consideration of equalities and inequalities in decision making. • Work with partners to create communities and environments that promote and enable healthier, and more active lives. • Promote economic growth that reduces inequalities. Key actions include: • Working with the NHS and wider partners to develop a Prevention Action Plan and to implement the service and data improvements needed to embed CORE20PLUS5, to improve population health outcomes, reduce health inequalities, and prevent future ill-health in Suffolk. • Strengthening digital services, so physical resources can be focussed on the most vulnerable and those at risk of the greatest inequalities. This ambition aligns to the Queen Elizabeth Hospital's Clinical Strategy where we have a clinical priority to 'improve access and reduce inequalities of access for patients on waiting lists, improve cancer outcomes and addressing the pandemic related backlog.'

Objective 6a Development and delivery of two strategies to support prevention: A Population Health Management (PHM) Strategy, and a Norfolk and Waveney Health Inequalities (HI) Strategy to deliver the "Core20plus5" approach		
Mental Health Transformation Improving Urgent & Emergency Care Elective Recovery & Improvement Primary Care Resilience & Transformation Improving Productivity & Efficiency	**What are we going to do?** We are going to develop two strategies. The strategies will ensure we are clear on our priorities for targeting resources and that we are working on agreed priorities for PHM and HI together. There is good work happening in pockets across the system, which needs to be co-ordinated so we set out a clear plan of what we are going to tackle first, how we will do it and why. **Develop a Population Health Management strategy**, to proactively use joined up data and to put in place targeted support to deliver improvements in health and wellbeing. The strategy will include our plans for how we will be using data, how we will be developing our ICS-wide intelligence function and a single	**What are the key dates for delivery?** **Year 1 April 2023 – Sep 2023** Start the mapping of existing work, gap analysis, and development of strategic priorities that are evidence based **Year 1 Oct 2023 – Mar 2024** Two strategies published by March 2024 **Year 2 April 2024 – Sep 2024** Action plan developed for each strategy with SMART objectives, milestones and trajectories

PHM reducing inequalities & Supporting Prevention

Improving Services for Babies, Children, Young People & Maternity

Transforming Care in later life

analytical platform to carry out relevant analysis to support our local decision making and planning and how we will evaluate our programme.

This proactive approach will be focussed on prevention, reducing inequalities and improving the quality of care. It will also be driven by our knowledge of local communities, and by partners working together to identify new things that can really help to improve health.

Develop a strategy for reducing health inequalities, aiming to deliver "equitable access, excellent experience and optimal outcomes" for all people and communities living in Norfolk and Waveney. This strategy will include how we plan to implement the "Core20plus5" national health inequality improvement framework which identifies population groups and clinical areas which require accelerated improvement.

We will also be seeking to increase uptake of vaccinations and cancer screening where there is low uptake in patient groups and communities. We will be seeking to minimise the health inequalities as a result of the impact of Covid-19. We will also include the wider factors that impact on health and well-being such as housing and the environment we live in.

How are we going to do it?
By using joined up data to proactively identify prevention opportunities and groups of people who would benefit most from targeted health and care interventions.

We will need to have a data hub in place to allow access to joined up data and facilitated interpretation of the data and insight to support local teams to identify their own priorities.

This approach will be driven by the needs of local communities, and interventions designed to support them. This may also involve working across the ICS to plan new services or models of care in an integrated way across the ICS. Therefore, we need to have participation in the development process by the range of partners and stakeholders.

Year 2 Oct 2024 – Mar 2025
Delivery of the action plan, reflection and review, reporting and re-set for Year 3 based on year 2 outcomes.
Year 3 April 2025 – Mar 2026
Strategy refresh/update if required, and continued delivery
Year 4 April 2026 – Mar 2027
Continued focus on extending our PHM approach and reducing HI based on the data, re-set of SMART objectives, milestones and trajectories
Year 5 April 2027 – Mar 2028
Reflection and continued focus on using PHM to drive improvement across the system and inform where we focus our effort, and a continued targeted focus on reducing HI

How will we know we are achieving our objective?
Publication of a system wide Population Health Management strategy, and a Health Inequalities Strategy setting out our ambitions to reduce health inequalities over the next 5 years and the improvement we expect to see.

Develop a programme of evaluation based on the best available data and insight to measure progress.

	How are we going to afford to do this? No additional funding is required to develop the strategies, but further resources may be needed to support ongoing projects, on an invest to save basis – each project to be considered on its own merits and evaluated. Some national funding is allocated to the ICS to support the delivery of the Core 20 plus 5 priorities.	

Objective 6b Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people.

Mental Health Transformation

Improving Urgent & Emergency Care

Elective Recovery & Improvement

Primary Care Resilience & Transformation

Improving Productivity & Efficiency

PHM reducing inequalities & Supporting Prevention

Improving Services for Babies, Children, Young People & Maternity

Transforming Care in later life

What are we going to do?

Stopping smoking is a preventative approach to improving health for all, especially in pregnancy.

We will develop and provide specialist support that gives all pregnant women across Norfolk and Waveney the best help and advice to stop smoking at a time when they are likely to be motivated to quit, in line with the NHS Long Term Plan commitments.

Our vision reflects the nationally recommended model for stop smoking services for pregnant women and this will be provided through the development of a new midwifery led NHS-based service. Each hospital trust will have stop smoking advisers who will offer support based on what research tells us works best.

How are we going to do it?

- The NHS will work together with local authorities, Maternity and Neonatal Voice Partnership and others through our Tobacco Dependency Clinical Programme Board, Tobacco Control Alliances and the Health

What are the key dates for delivery?

Year 1 Apr 23 – Sep 23

- Gather learning from existing services and agree a new plan.
- Equality and equity plan published.
- Deliver a Population Health Management pilot project, addressing smoking during pregnancy working with midwives at Queen Elizabeth Hospital (QEH).
- Pilot a Smoking in Pregnancy incentive scheme with Norfolk Public Health.

Year 1 Oct 23- Mar 24

- Recruit more maternity tobacco advisors and roll out support at QEH and Norfolk and Norwich University Hospital in line with the new plan.

Year 2 Apr 24 – Sep 24

- Roll out longer term plan, in line with the evaluation of year one.

Year 2 Oct 24 – Mar 25

- Roll out smoking in pregnancy incentive scheme in line with learning from any previous pilots and in alignment of further announcements from the Department of Health and Social Care.

Year 3 Apr 25 – Mar 26

- Review support provision for partners of pregnant women to support smokefree homes.

Improvement Transformation Group to plan how we can best make use of our shared resources and how support should be rolled out. • We will focus on health inequalities ensuring that we understand access by population subgroups (such as age, ethnicity and deprivation) to ensure equity of access. • We will work with the VCFSE around wider issues like income, cost of living and mental wellbeing that could be linked to smoking choices. **How are we going to afford to do this?** National NHS funding has been provided to help us roll out NHS tobacco support in Norfolk and Waveney. In 2023/24 a total of £555k will be received, of which it is suggested £203k should be used for maternity. We are expecting this funding to be made available every year, though this is yet to be formally confirmed by NHS England. The Tobacco Dependency Clinical Programme Board will lead on agreeing how tobacco support (including maternity) should be rolled out over the next five years and the estimated cost, based on learning from areas where support has already gone live. If it is identified that the national funding will not be enough, a formal request will be made for additional investment from NHS and local authority partners.	• Review the current service with MNVP. **Year 4 Apr 2026 – Mar 2027** • Review longer-term support available in the community after the baby is born. • Review engagement with local authority and VCFSE to ensure good access to wider community support e.g., social prescribers and peer support groups. • Explore opportunities to enhance joined up working e.g., between tobacco advisers, antenatal team and mental health for women with perinatal mental health conditions. **Year 5 Apr 2027 – Mar 2028** • Use the Maternity and Neonatal Safety Improvement Programme to ensure we continue to improve on smoking reduction in pregnancy. • Explore opportunities for the use of technology to improve the support to pregnant smokers and their wider families. **We will begin to see our approach is working because we will begin to be able to measure a reduction in the percentage of women in Norfolk and Waveney who are smoking at time of delivery.** Data for Norfolk and Waveney from December 2022 shows that 12% of mothers were smoking at time of delivery. We would aim to see this reduce over the next three years, by March 2026, towards the regional and national average of 9% and to reduce further to 6% by the end of year 5, March 2028. Ultimately, the national ambition, which we share for Norfolk and Waveney, is to become 'smoke-free' by 2030 – achieved when adult smoking prevalence falls to 5% or less.

Objective 6c Early Cancer Diagnosis – Targeted Lung Health check programme

Mental Health Transformation
Improving Urgent & Emergency Care
Elective Recovery & Improvement
Primary Care Resilience & Transformation
Improving Productivity & Efficiency
PHM reducing inequalities & Supporting Prevention
Improving Services for Babies, Children, Young People & Maternity
Transforming Care in later life

Targeted Lung Health Checks are a preventative approach to improve the health of those who may be at risk.

What are we going to do?
Deliver a Targeted Lung Health Check (TLHC) Programme designed to assess a patient's risk of Lung Cancer and to identify any signs of cancer at an early stage when it is much more treatable – ultimately saving lives.

We will prioritise patients in our most deprived, Core 20 populations. The programme will also incorporate smoking cessation support to encourage current smokers to quit as there is strong evidence that individuals who live in areas of high deprivation, with higher smoking rates are likely to have particularly poor Lung Cancer outcomes.

The programme is being offered to people between the ages of 55 to 74 who are current or former smokers and at greater risk of lung cancer.

Those eligible will be contacted by the NHS to invite them for a Lung Health Check appointment. At the Lung Heath Check a risk assessment will be undertaken which will identify if the patient is at a higher risk of lung cancer. If the participant is considered to be at high risk of lung cancer, they are then referred for a Low Dose CT scan, as close as possible to home. If the scan results come back with signs of anything of concern, the participant is contacted with further information and referred for further tests and treatment. Most of the time no issue is found, but if a cancer or an issue with

What are the key dates for delivery?

Year 1 to March 2024

- Continue to deliver TLHC to the Great Yarmouth population reaching full run rate by the start of Q1. This will result in approximately 350 LHCs per month and estimated 200 scans in line with trajectory.
- Expansion to the Lowestoft area by end of July 23. This delivery will be increased to full run rate of 350 LHC per month during Q3 in line with trajectory.

Year 2 April 2024 – March 2025

- Mar 2025 Continue to deliver TLHC to the Great Yarmouth and Lowestoft populations. Commence roll out to Central Norfolk and West Norfolk with a target of expanding to cover the whole eligible population of approximately 125,000 individuals by 2028/29. The initial target will be our Core 20 areas of highest deprivation.
- Confirmation of system model July 2024

Year 3 April 2025 – March 2026

- Complete the Lung Health Checks for the initial eligible population in Great Yarmouth and Waveney and commence 24-month follow-up scanning.
- Invite patients who have reached the age threshold to join the programme. Continue roll out to the remaining ever smoker cohort across Norfolk and Waveney focusing initially on areas of higher deprivation.

Year 4 April 2026 – Mar 2027 and Year 5 April 2027 – Mar 2028

- Continue expansion to the remaining 'ever smoked' populations in Norfolk and Waveney, including invitation of patients who age into the programme and 24 month follow up scanning.

a participant's breathing or lungs is found early, treatment could be simpler and more successful.

How are we going to do it?
Places:

- As the programme is rolled out across the Norfolk and Waveney system, the place-based approach will be supporting promotion of the TLHC programme.
- The programme is currently being delivered in Great Yarmouth, with plans to extend to Lowestoft in July 2023. This will mean that we double the number of eligible patients in the target cohort to approximately 27,500 (20% of the NHSE N&W target eligible population). Of these it is expected that 12,000 will be invited to a LHC across the two areas (approximately 9% of the N&W eligible population).
- Finalise modelling/planning for the system model to incorporate the populations in West and Central Norfolk ensuring capacity and affordability in line with the new funding process.
- This programme links to the work of the Diagnostic Assessment Centres, to build diagnostic capacity in Norfolk and Waveney.

How are we going to afford to do this?

- The Targeted Lung Health Checks programme is currently funded by the National Cancer Action Team, pending the decision from the National Cancer Screening Committee to incorporate it into the National cancer screening programme.

How will we know we are achieving our objective?

Trajectory for 23/24:

Success measures	Planned performance against success measures:				
	Baseline Position Against Metric:	Q1	Q2	Q3	Q4
Number of first invitations sent to eligible participants	712	1600	3000	3600	3600
Number of Lung Health Checks completed	95	1000	1800	2100	2100
Uptake (%) of Lung Health Checks	25% (to date but only just started therefore this is not representative)	40%	40%	50%	50%
Number of CT scans completed (baseline and follow-up combined)	28	650	980	980	1200

Objective 6d: Cardiovascular disease (CVD) Prevention – develop a programme of population health management interventions targeting High Blood Pressure and Cholesterol		
Mental Health Transformation Improving Urgent & Emergency Care Elective Recovery & Improvement Primary Care Resilience & Transformation Improving Productivity & Efficiency PHM reducing inequalities & Supporting Prevention Improving Services for Babies, Children, Young People & Maternity	Early detection of cardiovascular disease forms a preventative approach to improving health of those at risk of developing the disease. **What are we going to do?** We will provide Primary Care Networks (PCNs) with real time data on their specific patients: • a diagnosis of CVD • one of six high-risk conditions associated with CVD • and not being reviewed or treated in line with national guidance. In addition, we will be implementing a Population Health Management pilot as part of our system wide "Priority Patient Review initiative", by case finding specific patients who will benefit from low intensity statins or who have untreated hypertension. **How are we going to do it?** Place engagement will be a key component of the CVD Prevention ambitions. Each place has a different demographic, set of challenges, and an array of VCFSE partners. Their engagement will be key in supporting PCNs to achieve our targets.	**What are the key dates for delivery?** **Year 1 April 2023 – Sep 2023** • We will scope a reliable source of robust data which will be needed by our PCNs. **Year 1 Oct 2023 – Mar 2024** • We will commence production of local data reporting to align with the metrics that are already produced nationally via CVD PREVENT and share with PCNs. **Year 2 April 2024 – Sep 2024** • Delivery to commence through monitoring of identified patients with a diagnosis of CVD or at higher risk. **Year 2 Oct 2024 – Mar 2025** • Year one evaluation to be undertaken. **Year 3 April 2025 – Mar 2026** • Metrics in CVD PREVENT domains should see a notable improvement in Norfolk and Waveney. **Year 4 April 2026 – Mar 2027** • Second evaluation **Year 5 April 2027 – Mar 2028** • Further evaluation. **How will we know we are achieving our objective?**

Transforming Care in later life	We will be use “CVD PREVENT”, a national primary care audit tool, to prevent and reduce the negative outcomes of unmanaged CVD, highlighting gaps, inequalities and opportunities for improvement. We will evaluate our finding using the CVD Prevent audit tool and as part of our Population Health management programme evaluation. As CVD PREVENT is updated on a Quarterly basis, our attainment and progress can be monitored very closely. Provider Collaboratives – We will scope how Primary and Community Care services could work together to enhance our ability to prevent CVD. Given that this ambition focuses on the desire to prevent CVD *before* community services input is required, the greater scope will be for Primary care working with other ICS VCFSE partners. **How are we going to afford to do this?** Funding is identified to support the delivery of the Priority Patient Review initiative. There are links with Primary Care funding and Quality Outcomes Framework funding.	In the short term we expect to see more patients with high blood pressure identified and treated and those who would benefit treated on low intensity statins. In the longer term we would expect to see reduction in inequalities in terms of early mortality, reduction in admissions related to CVD related events, as well as supporting people to live a longer and happier, healthy life.

Ambition 7 Improving Services for Babies, Children, Young People and Maternity (BCYPM)

<placeholder>

"Our collective Ambition is that all babies, children and young people (BCYP) will have the best start in life, achieved through person and family centred, high quality support to enable them to 'Flourish'. We will focus on collaborative working with system partners to promote the importance of a strong start in life for children and young people.

We will prioritise the voices, needs and ambitions of children and young people so they can live their happiest, most rewarding lives and meet their potential."

Our objectives

a) Successful implementation of Norfolk's Start for Life and Family Hubs approach
b) Continued development of our LMNS, including the Three Year *Maternity Delivery Plan*
c) Reducing health inequalities including an initial focus on asthma, epilepsy and mental health
d) Develop a combined and improved offer across Norfolk and Suffolk for Children's Occupational Therapy

What would you like to see in our five-year plan for health and care services? What matters most to you?

Parents and children have told us that they want access to better information and support for their physical and mental health needs, waiting times to assessment and treatment are too long, services supporting children, young people and families should work better together and maternity care should be personalised.

Why we chose these objectives

The first 1001 days of a child's life are critical, and the NHS plays a crucial role in improving the health of babies, children and young people: from pregnancy, birth, and the early weeks of life; through supporting essential physical and cognitive development before starting school through to help in navigating the demanding transition to adulthood. We know the health of children and young people is determined by far more than healthcare. A stable and loving family life, healthy environment, education, safe housing, and income all significantly influence young people's health and life chances.

The outcomes we seek to achieve for children will be consistent across Norfolk and Waveney so that regardless of postcode, families can expect to have access to appropriate services. We aim to provide holistic care through design and implementation of care models that are age appropriate, closer to home and bring together physical and mental health services to support development. We can improve outcomes and make a difference through working in partnership with other organisations.

In Norfolk and Waveney:

- Babies in the most deprived areas are 50% more likely to be of low birth weight and 30% more likely to die before they are one year of age.
- Smoking status at time of delivery is 12% leading to low birth weight, premature births, and increased risk of perinatal deaths
- Poorly coordinated care for Diabetes, Epilepsy and Asthma leads to emergency admissions to hospital and poor health and education outcomes
- Poor access to support and information leads to increased risk of attendance at hospital for 0–4-year-olds

• Children in Year 6 are 40% more likely to be obese, leading to increased risk of long-term conditions and a negative impact on wellbeing.	
Who we are going to be working with to deliver this Core Partners: Babies, Children and Young people Parent/Carer Forums Norfolk County Council and Suffolk County Council Public Health Our Place Boards and Health and Well-Being Partnerships Primary Care Networks Community Health Providers Early Years settings, Schools & Colleges Norfolk and Norwich Hospital James Paget Hospital Queen Elizabeth Hospital King's Lynn VCFSE sector & community groups Local Maternity Neonatal System (LMNS) Norfolk & Waveney Maternity & Neonatal Voice Partnership (MNVP) The Children and Young People's Strategic Alliance Board Prevention and Early Help Board Waveney Children and Young People's group	**The CYP Ambition is aligned with our Partners these areas:** The objectives all link to **Better Together for Norfolk**, Norfolk County Council's high level strategic priorities of ***Better opportunities for Children and Young People and Healthy, fulfilling, independent lives -*** that all BCYP will have the best start in life. The Family Hub, single maternity delivery plan, reducing BCYP health inequalities also align with **FLOURISH** Strategy where every child can flourish and **Ready to Act, Ready to Change** Public Health Strategy, to improve health & well-being outcomes and reduce health inequalities for children and young people in Norfolk. The Start for Life and Family Hubs programme, NHS single maternity delivery plan, Suffolk's Children and Young People's wellbeing plan, Suffolk Family 2020 Strategy, and This ambition links to *Our Ambitions for Suffolk:* Suffolk County Council's objectives as set out in its Corporate Strategy 2022-26. Through the strategy, the Council aims to meet its objective to promote and support the health and wellbeing of all people in Suffolk by: Working with partners, including the NHS and district and borough councils, to prioritise the physical and mental health of everyone Suffolk. • Continuing to prioritise vulnerable children and young people, including delivery of further improvements in services for children and young people with SEND. This ambition aligns to the Queen Elizabeth Hospital's Clinical Strategy where we have a clinical priority to 'improve maternity care in line with national recommendations. National recommendations to be delivered include the **Better Births Review**, **Saving Babies Lives Care Bundle V2** and **Ockenden Review** as well as supporting Families and Local First Inclusion Programmes

Objective 7a Successful implementation of Norfolk's Start for Life (SfL) and Family Hubs (FH) approach

- Mental Health Transformation
- Improving Urgent & Emergency Care
- Elective Recovery & Improvement
- Primary Care Resilience & Transformation
- Improving Productivity & Efficiency
- PHM reducing inequalities & Supporting Prevention
- Improving Services for Babies, Children, Young People & Maternity
- Transforming Care in later life

What are we going to do?

Implement a Start for Life (SfL) and Family Hubs (FH) approach model, using whole family approach to provide a single access point to family support services that is integrated across health (physical and mental health), social care, VCFSE organisations and education settings.

Whilst the emphasis will be on support for families in local areas, there will be a designated physical family hub site in each of the seven districts, which includes a site in each of the four largest urban areas of Norwich, King's Lynn, Great Yarmouth/Gorleston, and Thetford, where 37% of Norfolk's overall population reside, and which also contain the most deprived areas in Norfolk.

Virtual services will also be available through the family hubs approach.

How are we going to do it?

Through improved data sharing arrangements and a more joined up approach to capturing 'whole family' needs whatever part of the system families' access.

Through FH sites and the FH network we will see co-located teams working alongside each other to provide support.

Prioritising prevention and early intervention through providing advice and guidance to families at the earliest opportunity when families engage with FHs. This will also include the signposting to self-care resources, and a strengthened peer support offer.

What are the key dates for delivery?

Year 1 April 2023 – Sep 2023
June 2023 Co-produced Norfolk Start for Life and Family Hubs approach agreed & goes live

Year 1 Oct 2023 – Mar 2024
Year 2 April 2024 – Sep 2024
Year 2 Oct 2024 – Mar 2025
Year 3 April 2025 – Mar 2026
Year 4 April 2026 – Mar 2027
Year 5 April 2027 – Mar 2028

How will we know we are achieving our objective?

The programme team is currently working with the DfE/DHSC in developing an evaluation process for the national FH and SfL programme. In addition, at a local level a performance measurement dashboard will be developed to track the identified KPI's across the programme and for each individual work strand.

1. Feedback from families on Start for Life and family hubs offer (inclusive, 90% accessible, co-ordinated approach, greater connection through services, easier to navigate access services,
2. 90% access integrated referral pathways tell story once & 90% of families access the advice, information and guidance they need feedback from parent and carer panel feedback
3. More Practitioners across agencies work in a whole family approach (data single view – data sharing agreements)

	How are we going to afford to do this? There is circa £1,9m of DHSC funding, for perinatal mental health and parent-infant relationship support, to be effectively utilised to deliver the programme's minimum expectations by March 2025. The funding required to develop and implement a SfL and FH approach in Norfolk is secured through an overall grant of approximately £6m paid to the host agency, Norfolk County Council. There is an added requirement for Partners (resource expertise) across the system to collaborate to ensure the most effective support is in place to benefit families.	4. Recruitment of additional 70 peer support volunteers recording families receiving support and recruitment numbers by 2025/26. 5. Aim 250 of families supported via Every Relationship Matters reduce parental conflict on children 6. Families receiving help to manage financial challenges (measured through DWP advisors embedded in family hubs) 7. Families accessing non funded services 8. Parents accessing Start for Life and family hub services have improved understanding of the contribution to child's wellbeing, achievement & school attendance. Measured increase in number of families receiving support & increase in school attendance. 9. Families with SEND receive early support reducing escalation measured through reduction in EHCP & needing access Alternative provision. 10. Improved health & development outcomes for babies & children with focus on most deprived 20% of Norfolk population (measured by aligned public health outcomes.

Objective 7b Continued development of our Local Maternity and Neonatal System (LMNS), including the Three Year *Maternity Delivery Plan*		
Mental Health Transformation Improving Urgent & Emergency Care Elective Recovery & Improvement Primary Care Resilience & Transformation Improving Productivity & Efficiency PHM reducing inequalities &	**What are we going to do?** The LMNS brings together the NHS, local authorities and other local partners with the aim of ensuring women and their families receive seamless care, including when moving between maternity or neonatal services or to other services such as primary care or health visiting. Alongside this, NHS England published a three year delivery plan for maternity and neonatal services in Spring 2023. https://www.england.nhs.uk/long-read/three-year-delivery-plan-for-maternity-and-neonatal-services/ which sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families.	**What are the key dates for delivery?** **Year 1 Apr 2023 – Sep 2023** Culture Workshop held. Publication of LMNS Data Dashboard to automatically report KPIs to LMNS board. Review of LMNS governance and reporting **Year 1 Oct 2023 – Mar 2024** MNVP action plan produced and published. Review of MNVP function supported by national and regional guidance by Jan 24 **Year 2 Apr 2024 – Sep 2024**

Supporting Prevention Improving Services for Babies, Children, Young People & Maternity Transforming Care in later life	Our LMNS equity and equality action plan Norfolk and Waveney Maternity Equity and Equality action plan is a five year plan that will be monitored, reviewed and updated to ensure; - equity for mothers and babies from Black, Asian and Mixed Ethnic groups - those living in the most economically deprived areas - race equality for staff - development of co-produced equity and equality action plans to support the Core20PLUS5 approach. **How are we going to do it?** The LMNS will continue to focus on delivering a model of care that is community based with equity and equality as the underlying theme supporting local access to maternity services and family support. The LMNS will align with the wider work to develop Family Hubs (implementation of Family Hubs is in objective 1 of this ambition) to ensure that safe, healthy pregnancy and childbirth is embedded into the Start for Life approach https://www.gov.uk/government/collections/family-hubs-and-start-for-life-programme We will - improve equity and equality in accessibility of services. - offer a 'one stop shop' for care to all pregnant women and people. - improve maternity safety and outcomes. - improve maternal and staff satisfaction. - reduce footfall through the acute trust. We will develop a workforce improvement plan to reduce our vacancies for maternity staff. The plan will include - implementation of consistent job roles across the system, - systemwide recruitment of midwifery students, - deliver systemwide training and learning events, - support our hospital trusts to have current and robust digital maternity strategies, forming the basis for digital integration in maternity services.	Revised MNVP approved and ready for implementation. LMNS governance and reporting reviewed, refreshed and updated. **Year 2 Oct 2024 – Mar 2025** Pelvic Health Prevention Service is embedded. **Year 3 (Apr 2025) – Year 5 (Mar 2028)** We will continue to embed the learning, upskill the workforce, continue to hear the service user voice and drive continued quality and safety measures as part of our usual business. **How will we know we are achieving our objective?** - We will see the maternity workforce vacancies reduce and retention improve, with clear evidence of future leaders ready to drive forward maternity improvement. - As at May 2023 the vacancy rate is 9% which will be our baseline position to measure improvement against

	We will make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury. LMNS will have oversight of quality assurance and transformational programmes to ensure the quality and safety of maternity services. We will share learning and development, informed by the experiences of people using maternity services. This will include access to postnatal physiotherapy and a focus on reducing in smoking during pregnancy. We will deliver a workshop aimed at improving the culture to share learning and best practice working with learning and development teams. We will ensure our Maternity and Neonatal Voices Partnerships (MNVPs) are representative of the population and the LMNS can evidence continued co-production with service users of service improvement. **How are we going to afford to do this?** 6 March 2023 funding allocation letter received detailing available funding for delivery of the three year delivery plan across the system. There will also be an expectation that existing funding within the system is utilised to continue to deliver the quality, safety and transformation requirements that will be detailed in the three year delivery plan.	

Objective 7c Reducing health inequalities including an initial focus on asthma, epilepsy and mental health		
Mental Health Transformation Improving Urgent & Emergency Care Elective Recovery & Improvement	**What are we going to do?** We will establish clinically led professional networks who will work together to implement the recommendations of two bundles of care; Asthma https://www.england.nhs.uk/wp-content/uploads/2021/09/B0606-National-bundle-of-care-for-children-and-young-people-with-asthma-phase-one-September-2021.pdf and Epilepsy (expected June 2023).	**What are the key dates for delivery?** **Year 1 April 2023 – Sep 2023** Establish system wide clinical networks. ICS leads should map the pathway of care for CYP with asthma through primary, secondary, and tertiary care.

Primary Care Resilience & Transformation Improving Productivity & Efficiency PHM reducing inequalities & Supporting Prevention Improving Services for Babies, Children, Young People & Maternity Transforming Care in later life	Over the next two years, we will increase access to psychological support for those affected by asthma and epilepsy, raise awareness of the conditions across universal services and improve support available to children and families. This links to the Core20PLUS5, which is an NHS England approach to reduce health inequalities for children and young people at both national and local level. There are '5' focus clinical areas requiring accelerated improvement which includes Asthma and Epilepsy. **How are we going to do it?** Clinical networks will be rolled out involving stakeholders across Norfolk and Waveney to support consistency in clinical pathways, raise awareness of gaps in provision and identify areas for improvement to ensure the NHS improves the quality of care for children with long-term conditions such as asthma, epilepsy and diabetes. This will be achieved though sharing best clinical practice, supporting the integration of paediatric skills across services and bespoke quality improvement projects. Our public participation group has developed a CYP Mental Health Charter, which details what is important to CYP and their families in the delivery of services, and there is a newly developed governance structure which enables CYP to hold the us to account. Our next step will be to increase the reach into communities of CYP and families who are seldom heard to ensure that the experience of all our communities are captured and help to shape the future support to ensure the best start in life. We will support children with epilepsy and asthma to access activities within their communities and remain well while doing so through delivery of better care across clinical and non-clinical services, including access to condition specific training.	Development and implementation of plans to deliver the national asthma bundle **Year 1 Oct 2023 – Mar 2024** Work with regional teams to develop and implement plans to deliver improvements in the four areas of focus for epilepsy improvements **Year 2 April 2024 – Sep 2024** Design and implement new model of care with psychological support. Evaluate impact of Asthma deliverables achieved **Year 2 Oct 2024 – Mar 2025** Increase access to training from VCFSE and extend new model of care with psychological support. **Year 3 April 2025 – Mar 2026** To be defined by the local networks **Year 4 April 2026 – Mar 2027** To be defined by the local networks **Year 5 April 2027 – Mar 2028** To be defined by the local networks **How will we know we are achieving our objective?** Decreased admissions for asthma for young people aged 10-18 Decreased admissions for epilepsy for children and young people aged 0-19

	We will support improved independence to self-manage conditions and access to skilled advice and support to keep children out of hospital. **How are we going to afford to do this?** Regional funding of £115k per annum is allocated to Norfolk and Waveney to progress plans. Local systems are able to submit expressions of interest for linked innovation schemes	Link for indicators is here: https://fingertips.phe.org.uk/indicator-list/view/paGkBr8vy0#page/1/gid/1/pat/15/ati/167/are/E38000239/iid/93136/age/288/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

Objective 7d Develop an improved and appropriate offer across Norfolk and Suffolk for Children's Occupational Therapy		
Mental Health Transformation Improving Urgent & Emergency Care Elective Recovery & Improvement Primary Care Resilience & Transformation Improving Productivity & Efficiency PHM reducing inequalities & Supporting Prevention Improving Services for Babies, Children, Young People & Maternity	**What are we going to do?** Norfolk and Waveney are piloting the impact of integration across children's occupational therapy services. Regardless of where you live, the aim is that access to specialist support should be consistent and of a high quality, able to meet the needs of children and young people. This programme will deliver • Increased and expanded skill mix of the clinical workforce. • Increased access to advice, support, and training for universal services • Publication of a joint commissioning strategy involving Norfolk and Suffolk local authorities • Increased levels of investment to expand the workforce in order to meet need. **How are we going to do it?**	**What are the key dates for delivery?** **Year 1 Apr 2023 – Sep 2023** Establish a clinical working group. Co-design the resources for the website and handbooks for schools Co-design training packages for professionals. **Year 1 Oct 2023 – Mar 2024** Accelerate co-production with parents and carers. Publish the parent page. Commence recruitment of additional therapists **Year 2 Apr 2024 – Sep 2024** Finalise Joint Commissioning Strategy Commence joint funding arrangements with the local authorities. **Year 2 Oct 2024 – Mar 2025** Evaluate the impact of deliverables achieved Refresh the joint strategy and expanding the blueprint for joint commissioning priorities.

Transforming Care in later life	We will improve independence to self-manage conditions and provide access to skilled high-quality advice and support to reduce the need to specialist interventions. We will explore the viability of shared care records across the footprint through a single point of contact, meaning you will only have to tell your story once. We will ensure that children with sensory needs can access clinical support through an NHS pathway. We will work with parents and carers to ensure those with lived experience play an integral part in the co-production of the improved service. Within a joint commissioning strategy, individual pathway teams will work to a consistent service specification with good partnership working across the Norfolk and Suffolk local authorities. We will reduce the number of children who require exceptional treatment options by providing access to targeted training for school staff and parents and carers to create inclusive school and home environments. This will free up specialist support for those who most need it. Children with complex needs will be supported sooner through the implementation of a graduated model of support. Access to a digital offer of support and training will enable universal services to provide better support to children and young people. **How are we going to afford to do this?** External funding for this programme is available until March 2025. Work during 2024/25 will include	**Year 3 Apr 2025 – Mar 2026** Implementation of revised plans **Year 4 Apr 2026 – Mar 2027** Use the evaluation & learning to develop the future service. **Year 5 April 2027 – Mar 2028** **How will we know we are achieving our objective?** Improved patient experience evidenced through feedback with families and a reduction in inappropriate referrals to specialist services. **Outcomes** Improved access to digital resources online and accepted referrals for sensory needs Improved access to specialist advice and therapy through increased interventions Improved access to specialist training by clinical professionals Improved access to universal training non-clinical professionals and parents/carers This programme will be evaluated by Ipsos Mori with outcomes expected by 2024/25

	recommendations to Integrated Care system on how new workforce model can be sustained. Joint Commissioning Strategy will include local authority funded provision assuming a reduction on independently funded packages of care. Engagement with services and families has strengthened and integrated commissioning is an established approach. A four-year occupational therapy transformation programme is underway that will provide a valuable blueprint for the future, across both Norfolk and Suffolk.	

Ambition 8 Transforming Care in Later Life

Dr Frankie Swords
Executive Medical Director,
NHS Norfolk and Waveney

Ian Hutchison
Chair/ Senior Responsible Officer for Ageing Well Programme Board
Chief Executive Officer of East Coast Community Healthcare

Zena Aldridge
Specialty Advisor for Older People, Frailty and Dementia,
NHS Norfolk and Waveney

"Our aim is to simplify, improve and integrate health and care for people in later life (including at the end of their life) across Norfolk and Waveney. We want to design our services with and for the people of Norfolk and Waveney, to support them to have the best possible quality of life."

Our objective

a) To develop a shared vision and strategy with older people that will help us to transform our services to be easy to access and designed and wrapped around the needs of older people.

What would you like to see in our five-year plan for health and care services? What matters to you most?
Recent JFP consultation feedback: "Support for social care for older people to reduce acute admissions". "Access to the right care pathway and improved social care for dementia and Alzheimer's." "Tackling dementia care". "Older/frail people kept well at home"

Why we chose these objectives
Our population is older than in most systems, but a lot of our services have not been designed with older people in mind. Current services are often confusing or complicated to access meaning that people don't always get the help they need until far too late. So, we want to design our services with our older residents. We want to make it easy for older people to access support as soon as they need it, whether that support is for social, care or health needs. We want to simplify and join up all of our different services, so they are wrapped around our residents, and delivered as close to home and as early as possible. By making it easy to access support and by removing the barriers between the different types of support available, we will work together to support older people to maintain their independence and preserve their quality of life.

Who we are going to be working with to deliver this

Partners across the ICS including:

People in later life, their families and carers

This Transforming Care in Later Life ambition is aligned with our Partners in these areas:

Improving wrap around services, enhancing access to early intervention and prevention for those in Later Life links to Better

VCFSE sector Community Healthcare providers Adult Mental Health Provider Collaborative The East of England Ambulance Service (EEAST) Integrated Care 24 (IC24) Norfolk County Council Suffolk County Council General Practices Acute Trusts Healthwatch Via existing forums such as the: • Urgent and Emergency Care Programme Board • Place Boards • HWP's	Together for Norfolk, Norfolk County Council's high level strategic priority of ***Healthy, fulfilling, independent lives levelling up health, living well and better local services.*** Enhancing access to early intervention and developing better integrated care for people also aligns with the aims in the **Promoting Independence strategy**, **Connecting Communities Programme,** and **Home Care Support Strategy** core ambitions of Adult Social Services and **Ready to Act, Ready to Change** Public Health Strategic plan, recognising that early intervention and prevention allows people to live healthier, more fulfilling, and independent lives for as long as possible. This ambition links to *Our Ambitions for Suffolk*, Suffolk County Council's objectives as set out in its Corporate Strategy 2022-26. Through the strategy, the Council aims to meet its objective to promote and support the health and wellbeing of all people in Suffolk by: • Working with partners, including the NHS and district and borough councils, to prioritise the physical and mental health of everyone Suffolk. • Enabling residents to lead healthier and more active lives, tackling issues such as isolation, loneliness and obesity, and working to address health inequalities. • Continuing to prioritise vulnerable older people and adults. Within these, older people will benefit from programmes such as People First and Independent Lives, which both focus on the individual and aim to provide the maximum independence for each person's circumstances. They will also benefit from actions taken against the objective of strengthening the local economy, including older people to switch careers or start a business, and the promotion of economic growth, which encourages people to fulfil their potential and prevents them falling into crisis. This ambition aligns to the Queen Elizabeth Hospital's Clinical Strategy where we have a commitment to become a centre of excellence within Frailty and Stroke.

Objective 8a: To develop a shared vision and strategy with older people		
Mental Health Transformation Improving Urgent & Emergency Care Elective Recovery & Improvement Primary Care Resilience & Transformation Improving Productivity & Efficiency PHM reducing inequalities & Supporting Prevention Improving Services for Babies, Children, Young People & Maternity Transforming Care in later life	**What are we going to do?** Develop a shared vision and strategy with older people, that will help us to transform our services to be easy to access and designed and wrapped around the needs of older people. We will then work together to deliver that strategy, to improve people's health, wellbeing, clinical outcomes and experiences of using and being supported by our services in their later lives. **How are we going to do it?** Bring together members of our older population with colleagues from health, local government, the care sector and voluntary and community services to agree what the ideal service would look like for older people. Work backwards from that to identify what needs to be in place to achieve that vision, using population health data and evidence based best practice to identify where and how this should be delivered. Map our current services to identify gaps and overlaps between the current and desired future state. Identify what new services or projects we need, and which current services need to change, expand or stop to best achieve this. Establish an Ageing Well Programme Board to develop and then oversee the delivery of this strategy over the next 3 - 5 years. **How are we going to afford to do this?** Simplifying access and focusing on early and local intervention will reduce long term need and costs e.g.by preventing unnecessary ambulance call outs and hospital admissions. Co-designing services with older people to focus on maintaining independence will divert funding toward reablement and care at home, reducing costs associated with long term complex care packages and residential care.	**What are the key dates for delivery?** **April - Sept 23**: • Identify partners from across the ICS; including people in later life, to engage and co-produce the vision. • Map the 'as is' position of existing services and support. Identify gaps, overlaps and opportunities. • Agree a system wide definition and assessment tool for frailty to be used across all providers • Develop a strategy and 3-year plan to achieve the vision. Test this with a wide range of people in later life, carers, VCFSE and other health and care professionals **Oct 23 – March 24**: • Develop a detailed road map to identify changes to services, commissioning, and communication of the future state. • Continued coalition building; gaining commitment of individual organisations to work together to achieve the new ways of supporting people as they age to live well. • Set up working groups to lead on the workplan, set and monitor metrics to measure impact. **April 24 – March 25**: Maintaining the momentum and effort • Resetting goals and metrics to measure effectiveness of programme, changing the plan to ensure it is delivering as needed

	Co-ordinating services using a system-wide perspective to deliver more integrated, high-quality cost-effective care from multiple sectors so reducing waste and duplication so saving cost for our system. We will actively seek new external monies / funds to support people in later life.	• Recognising success and reflecting on lessons learned. • Continued checking back with people in later life and carers that the transformed services are meeting their needs. **How will we know we are achieving our objective?** Publication of an Ageing Well strategy including road map of work required to deliver this over 3-5 years.

5.0 When we expect to deliver

For each of the Objectives, we have developed a series of key milestones. To show how the overall profile of work looks for our key objectives, we have split Years 1 and 2 into six-monthly timeframes to provide more detail and then we have included our longer-term planning years 3-5. This provides a programme summary, which will be developed in more detail as our JFP evolves and responds to need, and is shown in Figure 6.

Figure 6 – outline programme plan for the JFP objectives

	Joint Forward Plan eight Ambitions and underpinning objectives							
		Timeline for delivery						
	Ambition Objectives	Year 1		Year 2		Year 3	Year 4	Year 5
		1st	2nd	1st	2nd			
1	**Transforming Mental Health Services**							
1a	Build system resources for early intervention and prevention for people of all ages, including those who experience mental health inequalities. This work will include enhancing and expanding skills and knowledge of mental health across our populations; providing a framework of tools and capacity to support mental wellbeing; and delivering a refreshed suicide prevention strategy.							
1b	Mobilise mental health system collaboratives to facilitate partnership working and deliver better health outcomes for our residents. The focus of the adult collaborative in year one is to improve support for older people living with dementia, delirium and depression which also has alignment with the Ambition Transforming Care in Later Life.							
1c	Establish a Children and Young People's (0-25 years) Emotional Wellbeing and Mental Health 'integrated front door' so all requests for advice, guidance and help are accepted, and support provided to navigate the system and meet the presenting level of need. This will be developed in line with the Thrive principles, with children and young people at the centre of delivery with resources wrapped around them, enabling them to Flourish.							
1d	See the whole person for who they are, beyond their complex behaviour. Develop pathways that support and promote recovery for people living with multiple and complex needs – with a focus on dual diagnosis and complex emotional needs (CEN)							
2	**Improving UEC**							
2a	Improve emergency ambulance response times							
2b	Expand virtual ward services							
2c	Delivery of the Improving Lives Together programme to reduce length of stay (LoS) in hospitals							
3	**Elective Recovery & Improvement**							
3a	Effectively utilise capacity across all Health System Partners							
3b	Implement digital technology to enable elective recovery							
4	**Primary Care Resilience & Transformation**							
4a	Developing our vision to provide a wider range of services closer to home, improving patient outcomes and experience							
4b	Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years.							
5	**Improving Productivity & Efficiency**							
5a	Improve the services we provide by enhancing productivity and value for money, embracing digital innovation and delivering services together where it makes sense to do so.							
6	**PHM, Reducing Inequalities & Supporting Prevention**							
6a	Development and delivery of two strategies to support prevention: A Population Health Management Strategy, and a Norfolk and Waveney Health Inequalities Strategy to deliver the "Core20plus5" approach							
6b	Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people							
6c	Early Cancer Diagnosis - Targeted Lung Health check Programme							
6d	Cardiovascular disease Prevention							
7	**Improving Services for Babies, Children, Young People & Maternity**							
7a	Successful implementation of Norfolk's Start for Life (SfL) and Family Hubs (FH) approach							
7b	Continued development of our Local Maternity and Neonatal System (LMNS), including the Three Year Maternity Delivery Plan							
7c	Reducing health inequalities including an initial focus on asthma, epilepsy and mental health							
7d	Develop an improved and appropriate offer across Norfolk and Suffolk for Children's Occupational Therapy, to meet their needs							
8	**Transforming Care in later life**							
8a	To develop a shared vision and strategy with older people that will help us to transform our services to be easy to access and designed and wrapped around the needs of older people.							

6.0 How are we going to work together differently

The seven ways in which we are going to work differently are explained in this section. This 'how' section is crucial to the delivery of the Ambitions and is as critical as the ambitions and objectives themselves because it is working together differently that signals the changes we need to make as an ICS to successfully deliver our plan.

1. **Place based approach** with clearly defined remit, responsibilities and decision making. Be clear about what we do at System level and what would be more effectively determined and delivered more locally in our communities.

2. **Provider Collaboration** – confirming our Acute hospital, Mental Health and integrated Community Collaborative arrangements, so we understand their remit, responsibilities and decision making.

3. **Existing ICS Strategies** – ensure everything we do is aligned with strategic commitments that we have already agreed such as those set out in our transitional Integrated Care Strategy and Joint Health & Well-Being Strategy, Clinical, Digital, Quality, Estates and Net Zero / Green strategies and our People Plan. The existing Strategies and ambitions in our JFP need to work together as one, all pulling in the same direction.

4. **Empowerment** – defining the functions and responsibilities at system level and those more suited for local determination, to unlock the benefits afforded to ICBs and ICSs, creating the conditions for change and moving our system from responding, to innovating.

5. **People and Culture** – continuing to develop inclusive partnerships as we work together as a senior leadership team and to facilitate a climate of improvement for all our teams to work in, as they deliver the ambitions of our JFP.

6. **Engagement and co-production** – listening and facilitating inclusive engagement with our people, patients and their families and carers, so we can deliver responsive and joined up care that is genuinely co-designed and produced with those that use our services.

7. Empowering and working with the Voluntary, Community, Faith and Social Enterprise (**VCFSE)** sector differently and integrating VCFSE provision into our design and delivery models for services.

The 2022 Health and Care Act established the legislative framework to promote better joined-up services. This includes a duty for all health and care organisations to collaborate to rebalance the system away from competition and towards integration.

Working in this way should mean that health and care providers, including voluntary sector organisations and primary care, will organise themselves around the needs of the population rather than planning at an individual organisational level, in delivering more integrated, high-quality, and cost-effective care.

Provider collaboratives and place-based approaches are just two of the ways of working differently together in an ICS to enable the delivery of our core purpose and the transformation ambitions.

6.1 Our place-based approach

We are committed to the principle of subsidiarity. Described simply, if we can do something better locally, then we should do so, using a place-based approach. We want to build relationships around communities themselves, where local people are involved and take an active part in creating the solutions.

There are five Place Boards and eight Health and Well-Being Partnerships (HWP's) across Norfolk and Waveney ICS and they are shown on the map below in Figure 7.

<placeholder for Figure 7 map>

The key role of our Place Boards is to bring together colleagues from health and care to integrate services, with a focus on effective operational delivery and improving people's care.

The key role of the HWPs is to seek to address the wider determinants of health and wellbeing, through collaboration and in line with evidence-based practice. They are using this planning toolkit to support and develop their work: Toolkit. The HWPs are particularly well placed to deliver against both the Norfolk and the Suffolk Joint Health and Wellbeing Strategy's overall themes of integration, connected, thriving and resilient communities, addressing and reducing inequalities, and prioritising prevention.

The Place Boards and HWP's have complementary roles, which are aligned. They also work with the VCFSE and there is a VCFSE Place based lead aligned to each Place Board.

When we talk about a place-based approach we mean this in the broadest sense of a way of working locally, rather than an entity. The Place Boards and HWP's work with each other and across Norfolk and Waveney. We have agreed that we will establish a coordinating group in central Norfolk to support the three Place Boards to work closely together when needed, for example when working on pathways with the Norfolk and Norwich University Hospital, while also ensuring each Place Board can work on its own local priorities too.

The place-based approach has a proven track record of delivering improvements for local people, especially in prevention, intervening upstream to anticipate issues before they become a problem, providing an integrated community response and connecting communities together.

We do however recognise that the place-based approach needs a framework to work within, and the ICS needs be clear about the overall direction of travel. We have therefore agreed some broad principles. Agreeing 'what is best done where?' is key, so the place-based approach continues to make a difference. Figure 8 below is a helpful way to begin to describe what is decided by the ICS and what is decided locally by Place Boards.

Figure 8 – responsibility map

The place-based approach also needs resources and we have agreed a way that resources can be allocated to Place Boards.
It is proposed to have a new system committee to ensure that place plans are not held up by lots of 'red tape'. The Place Boards would plan services and then seek approval to release the funding. The committee would approve the Place Boards' plans as long as it met the agreed principles.

The governance is intentionally light touch but it will ensure that our efforts are co-ordinated. The HWPs have some resources allocated to them through some funding from the Covid Recovery Fund, Better Care Fund and also Active NoW. We are also reviewing the staffing resources that are available to support the place-based approach, with support from clinical and care professionals.

In 2023/2024, our Place Boards will be primarily focused on delivering against two of our ambitions: urgent and emergency care, and primary care resilience and transformation, particularly moving care closer to home. Other ambitions have referenced Place Boards and HWP's as key partners too, but it is acknowledged that more needs to happen to confirm details and resourcing. This approach sets out an intent and a signal that if we can deliver locally in our communities then we should do so.

The HWPs are working on a strategy for each area across a 2-5 year time period. Action plans are in development as part of strategy work for each HWPs, which will identify timelines and milestones for delivery in 2023. Future plans will be determined through place-based Health and Wellbeing strategies for the 2023-25 period and beyond, developed with reference to key strategic priorities from the District they serve and the ICS vision. Current priorities are set out in Figure 9 and all of them can be linked to at least one of the ambitions in the JFP.

Figure 9 – HWP priorities

Partnership	Priorities
Breckland	Overarching Priority - Inequalities • Mental Health (all ages) • Alcohol (targeted – geographies) • CVD (Prevention)
Broadland	• Long Term Conditions: Musculoskeletal (MSK) problems • Lifestyle: Alcohol • Lifestyle and Long-Term Conditions: Diabetes and Cardiovascular disease
Great Yarmouth	• Health & wellbeing – focussing on inequalities: Increasing healthy eating and physical inactivity • Attainment, skills & aspirations: Increasing employment opportunities • Vulnerability & exploitation: Toxic trio: mental health, domestic abuse, substance misuse • Loneliness, isolation & social exclusion: Connecting residents, building community capacity
KLWN	• Mental Health • Weight Management • Alcohol Consumption
Norwich	• Health Inequalities • Mental Health • Domestic Abuse
North Norfolk	• Aging population • Mental health • Inequalities
South Norfolk	• Long Term Conditions: Musculoskeletal (MSK) problems • Older People: Dementia A) Children, Early Years & Young People: Unintentional injuries in children (0-14 years) B) Lifestyle and Long-Term Conditions: Diabetes and Cardiovascular disease

In summary we are clear about the role of the place-based approach in delivering the medium to longer term priorities in both the Joint Health and Wellbeing Strategy's and the eight ambitions in the JFP, but we cannot do everything at once. We are pulling in the same direction and aiming for the same things, whilst ensuring the place-based approach can respond to local needs. After an initial set up phase and a lot of hard work, the focus is on evaluating what has worked well and re-setting for the future.

6.2 Provider collaboration

This is about partnership arrangements between Trusts who are working together and at scale across multiple places or locations, with a shared purpose. We are on a journey to develop the potential of provider collaboration, which is an important part of successful ICS working.

Acute hospital collaboration

The Norfolk and Waveney Acute Hospital Collaborative (N&WAHC) is a Provider Collaborative formed by the Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust, the Norfolk and Norwich University Hospital NHS Foundation Trust and the James Paget University Hospitals NHS Trust. The aim of the N&WAHC is to improve health outcomes for all through:

- Enhancing clinical effectiveness and patient experience and,
- Reducing known inequities in health outcomes and access to services.

These aims are consistent with the JFP through the ambitions focused on prevention and reducing health inequalities.

The N&WAHC has identified a number of pivotal programmes of work it will be focusing on, which will make a real difference to our local population by doing them together:

The first is **implementation of a single acute Electronic Patient Record (EPR)**
This is a joint digital solution that enables clinical and operational processes to run seamlessly and efficiently on one platform across the three acute trusts bringing tangible benefits around reduced clinical risk, efficient use of clinician time, improved decision-making, patient care and experience. It will also provide a platform to transform integrated acute pathways and services. It is a critical component of the ICS Digital Strategy for good reason because it will make a difference on the ground to our population and our staff and is referenced in nearly all the ambitions as a key enabler.

The second is the **development of a joint Acute Clinical Strategy**
The joint clinical strategy will align directly to the clinical objectives set out in the ICS clinical strategy and it will also support the individual acute hospital trusts' clinical strategies by identifying the specific opportunities where clinical collaboration can improve the way we deliver services for our patients. The objective of the strategy is to ensure right sized and stable inpatient capacity that responds to long-term population health and demand. Underpinning this are design principles of onsite acute care only where true clinical value is added and vertical and horizontal integration of services, teams, and pathways. The development of this strategy is referenced in the place-based approach as we focus on care closer to home as an initial priority, and the ambition that is about primary care resilience and transformation where we talk about the development of neighbourhood teams.

The third programme is about **Unblocking delayed discharges; creating stronger, consistent support for frail elderly**
With an existing population demographic weighted towards people living longer into later life, which is projected to grow and age faster than most other places in England, the collaborative will prioritise resource and capacity to appropriately configure and integrate services, teams, and pathways to reduce the burden of unnecessarily long inpatient stays and the deconditioning of patients. This collaborative focus from the N&WAHC will be a critical

enabler to the ambition that is about transforming care in later life and improving urgent and emergency care where we have a focus on length of stay in hospitals.

The fourth programme is about **Improving productivity across the acutes and the wider system**
N&WAHC will be working more closely together, identifying areas to align support and corporate functions with a focus on doing things once and at scale. This focus is consistent with the ambition to improve productivity and efficiency, and without this focus this ambition is unlikely to succeed as the three hospitals collectively account for the majority of the NHS Norfolk and Waveney budget.

The fifth programme is about **Major acute capital projects.** For example, N&WAHC is collectively working on plans for three Diagnostic Access Centres (DAC's), one at each hospital, which will significantly improve access to diagnostic services and reduce waiting times for treatment, especially for a cancer diagnosis. These are referenced within the elective recovery and improvement ambition as key enablers to the creation of more capacity so more patients can be treated and waiting lists reduced.

Mental health partner collaboration

In addition to the acute hospitals, collaboration across mental health (MH) in Norfolk and Waveney is relatively well established and has been a focus for several years. In 2019 both the adult, and children and young people's (CYP) MH strategies placed integration and collaboration at the heart of their service models moving forward.

We are proposing to establish an adult mental health system collaborative and a children and young people's (CYP) system collaborative. This is because the current providers and models of delivery in each life stage are different. The responsibility for transition services (18-25 yrs) will be agreed for one of the collaboratives to lead but will converge over time. Whilst both collaboratives are prioritising mental health services, we want to include physical health outcomes and a focus on the wider determinants of health aligned to the ICS Clinical Strategy objective of seeing me as a whole person.

Initially the adult mental health collaborative will focus on:

a. Building the 'case for change' for dementia provision, inclusive of delirium and depression.
b. Identifying national best practice and best definitions.
c. Given the breadth of the pathway, using a. and b. to advise on which element/s of provision are addressed first.

This links directly to the transforming care in later life ambition, acknowledging that dementia can span all-age – albeit in smaller numbers.

Initially the CYP MH collaborative will focus on the development of a system collaborative to develop a model of prevention and intervention with an initial focus on the redesign of community-based services covering mental health services; the Special Educational Needs and Disabilities (SEND) redesign of the operating model and neurodevelopmental pathways.

Such is the importance of this enabler, that we have included the development of these two MH collaboratives as one of the key objectives within the Transforming MH services ambition.

Community services collaboration

Prior to the formation of NHS Norfolk and Waveney, community services have been historically commissioned by five different Clinical Commissioning Groups, each having their own approach to prioritisation. This led to differences in how services were commissioned across Norfolk and Waveney. We now have an important opportunity to look at the way community services are commissioned and delivered across Norfolk and Waveney, and we can improve how and where care is provided. To do this, we will undertake a review of community services.

This review is an important first step to the transformation of services and provides an opportunity for us to address some of our historic challenges to ensure that people receive timely care and the support they need, in the most appropriate setting, helping them live independent lives for as long as is possible. It also provides an opportunity to deliver on some of the commitments made in the Norfolk and Waveney clinical strategy, in terms of moving health and care pathways into the community and the Fuller Stocktake, recommending integrated community teams supporting general practice.

The review will cover community services provision for people at all stages in their lives, recognising that a high proportion of our population are older. Engagement with organisations, stakeholders, VCFSE sector and wider partners will take place in the summer followed by the production of a report in the autumn to inform the wider transformation of community services across Norfolk and Waveney. At this point, we will engage fully with the people and communities of Norfolk and Waveney, building on their comments and feedback to date and seeking views on initial ideas to improve and strengthen community health and care of the future.

6.3 Enabling Norfolk & Waveney's Strategies

Within each of the eight ambitions we have shown the linkages with the work that is already being done by partners within the system so we can see how we are all working together and how things join up.

We also evidence how the eight ambitions are supported by published ICS strategies. These provide enabling infrastructure to support the transformation. Some of the individual Strategies have explicit and very direct links to the eight ambitions, and we have clearly referenced these as a separate section in Appendix 1 to Part 1 of the JFP. Using and building upon existing local strategies and plans is a key principle of our approach. In addition, a visual depiction of how our ambitions and strategies link is shown in Figure 10.

<placeholder for Figure 10 Strategy Map>

6.4 Empowerment

We will ensure our system is designed to both preserve accountability, at the right level, and free our leaders to innovate and transform care to deliver the best outcomes for our population. Our work will be underpinned by a quality improvement approach and we will ensure the right data are available to support service improvement and transformation across all levels of our system.

We will define the functions and responsibilities that will be most effective delivered together at a system level and confirm those more suited for local determination to meet local needs. Getting this balance right will unlock the benefits afforded to Integrated Care Boards and Integrated Care Systems, creating the conditions for genuine change and will move our system beyond responding to challenges, into innovating and truly transforming care.

6.5 People and culture

This JFP describes the changes we want to make, and change happens by people working together differently. Our ICS aims to improve performance and effectiveness and Organisational Development (OD), can help to support that change.

The aim of our OD Programme is to shape a thriving Norfolk & Waveney ICS. This can only be achieved by focusing on relationships with and between the people and organisations we work with, the culture and processes, and supporting our leaders to navigate their way through the challenges and complexity. Working across organisations is more challenging as leaders and teams must consolidate their organisations goals with the shared vision and purpose for Integrated Norfolk and Waveney system. The foundation of strong relationships, a deep sense of community, a desire to make the system work for the local population of Norfolk and Waveney and, positive developmental work with key stakeholder groups and Boards across the ICS are the bedrock of our maturing ICS.

Specifically, we are working on a collective system culture of compassion and inclusion and are working on the following:

- With our partner organisations to develop compassionate and inclusive leaders and teams across the ICS;
- With all our Boards and key stakeholder groups to develop mature working relationships and structures to support the goals and ambitions of the ICS;
- We have a Leadership Framework embedded across the ICS to support the people that are leading the changes; and
- We will evaluate and review our actions with the aim of planning and co-creating the next phase of the maturity journey. There are a number of key elements we are focusing on to ensure all our ICS partner organisations work closely together in a very complex health and social care setting to deliver the outcomes set out in the JFP.

An integral part of the People and Culture enabler is the way that **clinicians and care professionals** (CCPs) are involved in decision-making across the ICS. This ultimately improves the quality outcomes and experience of our local population, and it is also recognised nationally as best practice.

Our CCP vision is to '*put CCP leadership at the heart of our discussions at every level of our system, so that it becomes integral to our culture and how we work together'*. We have confidence that the CCP voice is now included in every decision-making group across the ICS – no decision

regarding the care we provide or commission is made without formal consideration by a CCP. This includes at the Place Boards, VCFSE Assembly and Provider Collaboratives.

Working closely with our partners we have ensured that we have Social Care and VCFSE representation forming part of the CCP Assembly membership. Our governance structures also reflect this requirement and we have established one other consultative forum: The VCFSE Assembly, with a third, The Patients and Citizens Assembly due to be set up during 2023/2024. Work to align the forward plans of all three Assemblies is currently underway and this will be aligned to the JFP.

It became clear that historically the majority of our CCPs were doctors, the vast majority of whom were GPs. In the changing health and care environment of the ICS, we are committed to ensuring that our CCP leaders better reflect the diversity of our workforce.

We are implementing a **Leadership Framework and 10-point CCP manifesto which is on our website** <placeholder for microsite link> to take action on the 5 core principles for effective clinical and care professional leadership.

The CCP Assembly (CCPA) reviews and advises on all ICB decisions affecting health and care. It acts as a consultative forum and diverse critical friend for the ICB and ICP to sense-check ideas, plans and decisions that may affect delivery, development and future clinical and care provision for our local population.

We will also be establishing a smaller Clinical and Care Professional Council. It will lead the coproduction of the CCP framework and strategy, support the ongoing programme of training and development for CCPs and support the empowerment culture we wish to create that is also referred to in this section.

We will be working differently in the future and the CCP Leadership programme is extremely ambitious. We recognise that this is a big cultural change required which takes time. Our plans reflect the 3 – 5 years we envisage it will take to fully embed these new ways of working. One of the first things we are doing is exploring options for the development of a series of health and care focus sessions to look at language, relationships, and commonality. This involves identifying key areas of mutual focus.

New CCPL roles have been aligned to each of the ambitions as outlined in the Joint Forward Plan, as well as focusing on those areas highlighted in the national Core20PLUS5 agenda. This will be further strengthened by leadership development and wider training planned for this group of CCP leaders, as we continue to establish a Norfolk and Waveney pipeline of suitable trained, supported and empowered CCPs.

We are also developing an ICS Quality Faculty, focusing on coordinating our training and support programmes in quality improvement and evaluation across the system. As we create an inclusive and empowering culture of improvement, they will bring this community of CCPs together, acting as a role model for this new culture.

6.6 Engagement and Co-production

Norfolk and Waveney is committed to listening and facilitating inclusive engagement with our people, patients and their families and carers, so we can deliver responsive and joined up care that is genuinely co-designed and produced with those that use our services. We believe that all feedback has value and should be supported through a spectrum of participation methods (Figure 11):

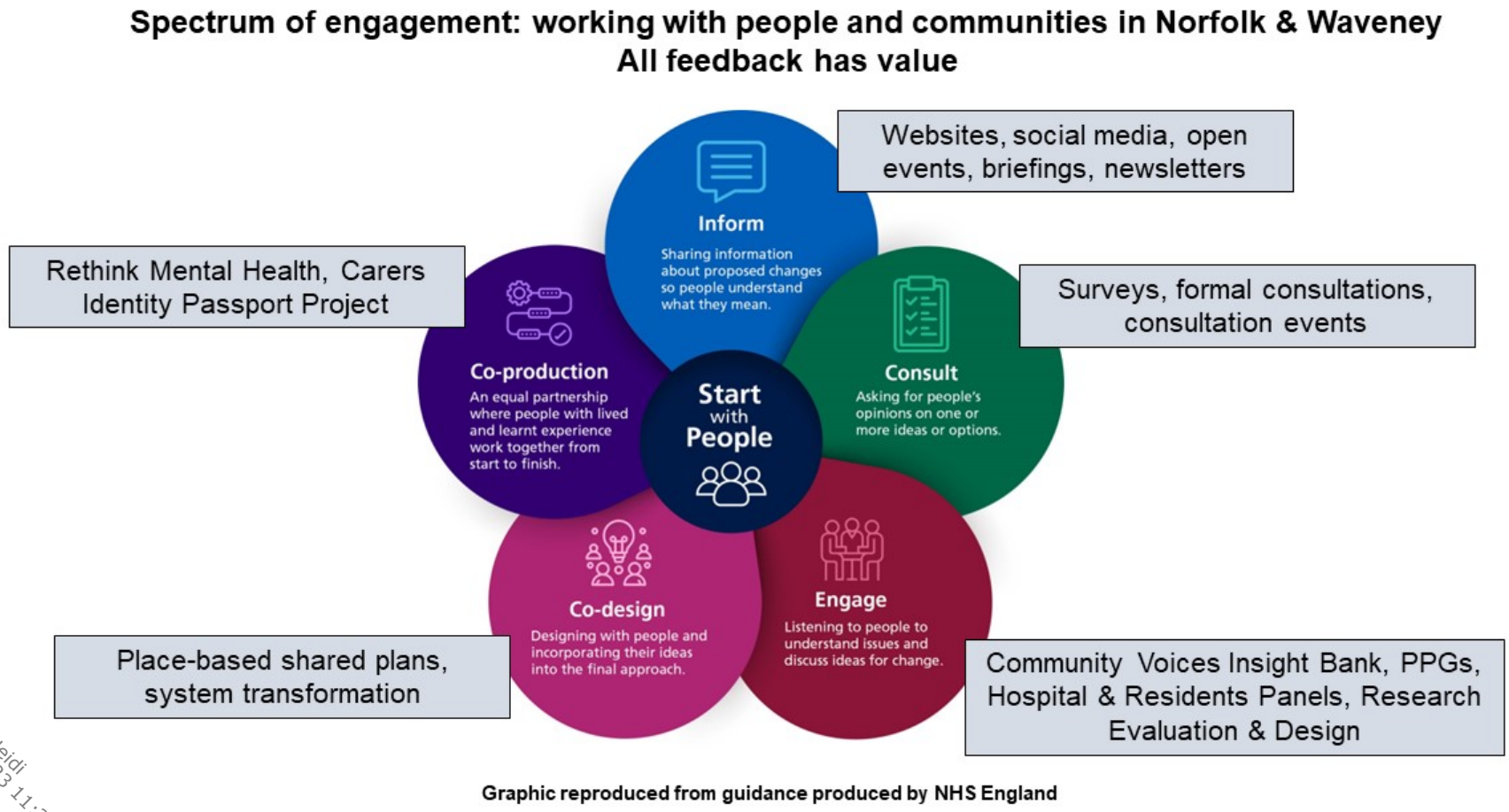


Figure 11 spectrum of engagement

All the partners in our ICS are talking and listening to people and communities every day. Our vision is that people would tell their story of lived experience once and it's heard by everyone in the ICS. We want to develop on-going relationships with communities to learn what matters to them, and work together to address the key issues for our system. This puts us in a very strong place to work with our people and communities around our JFP.

We are working with system partners to align and develop a broad range of participation methods. Some examples of regular partnership working have been developed:

- A Norfolk and Waveney ICS Communications and Engagement (ICS C&E) group was established in September 2021 to work as a system on a variety of local priorities, such as communications campaigns, participation and co-production and to act as a learning network. Membership includes representatives from Norfolk and Suffolk - 8 NHS provider trusts, 2 county councils, 2 Healthwatch's, 8 district councils, Norfolk Police, 2 Chambers of Commerce, Out of Hours/111 provider, Active Norfolk, Norfolk Older People's Strategic Partnership, 4 VCFSE organisations, representatives from housing associations.
- Each Place Board has a C&E lead to support communications and engagement activity for Place Boards and HWP's. Working with people and communities at 'place' level will support all the different voices of our people and communities to be part of local decision-making, as conversations about 'the place where I live' are often much richer.
- Norfolk and Waveney Patient Experience and Engagement Leads meetings have been taking place weekly for several years and give an opportunity for people working in NHS provider trusts to meet and share practice across the system. They have been a vital opportunity to begin to test and develop the idea of the 'wider team' working with people and communities across the ICS to listen to and involve patient experience feedback in quality and wider commissioning.
- Communications and engagement support is being given to the Norfolk and Waveney VCFSE Assembly

The ICS website hosts the people and communities hub for Norfolk and Waveney, which aims to develop and maintain a shared vision in listening to and working with local people across the ICS. It offers a place for all system partners to share live participation opportunities, as well as signposting to information, describing our approach to working with people and communities and feeding back on what we will do as a result of what you have said.

We learnt during the COVID-19 pandemic that we need to get better at listening to what really matters to our people and communities, especially if we are going to address health inequalities, which is one of our eight ambitions. A really effective way to do that is to use trusted communicators, people who are part of the local community – 'people like me'. We can do this by working with VCFSE organisations, as well as colleagues in, for example, housing associations and district and county councils who already have long standing relationships and networks throughout Norfolk and Waveney

Another key area of support centres around the patient voice in primary care. We asked Healthwatch Norfolk to engage with local practices and Patient Participation Groups (PPG's) to find out what support would be most useful. The ICB is now working to deliver the key recommendations from the report. A PPG webpage features case studies including examples that promote different models of patient engagement. There is also other information and links to resources including a toolkit produced by Healthwatch Norfolk following the period of engagement which aims to give Doctor's Practices and PPGs a step-by-step guide. PPGs are another key source of insight and feedback from our people and communities and will be helpful in the delivery of our primary care ambition.

Communications and engagement work at a very local level is key to developing on-going relationships with people and communities and we have aligned our staff resources with this. Opening up new networks for engagement will be vital in supporting the work of the Joint Forward Plan.

One particular area of participation that we will be developing further is around the promotion of true co-production. This refers to a process of shared power to effect change. The term co-production is generally used to mean an end-to-end process where people with lived experience work with those who design services and projects in an equal partnership.

Examples of co-production do exist in Norfolk and Waveney and work is underway within the system to align existing work and develop a shared approach:

- Development of a co-production hub as part of our People and Communities hub to share examples from the system, to promote co-production principles and to signpost to support materials
- Development of a Norfolk and Waveney Mental Health Co-production strategy for lived experience to effectively influence ICS mental health transformation, services and support.
- Being a part of the Norfolk Making It Real (MiR) steering group which promotes co-production particularly for people with lived experience of physical and learning disabilities.
- Supporting various NHS England funded initiatives in Norfolk and Waveney such as a series of co-production projects across the ICS around Quality Improvement
- Co-production as an integral part of designing research projects
- Exploring ideas around the development of some system-wide shared principles around co-production for Norfolk and Waveney
- Developing a Volunteer Expenses and Co-production Payments Policy that includes a threshold for when participation becomes co-production, and details how we can offer effective support for our people and communities through the whole spectrum of participation methods.

6.7 Working with the VCFSE differently

Empowering and working with the Voluntary Community Faith and Social Enterprise (VCFSE) sector differently and integrating provision into our design and delivery models for services is one of our ways of working.

Norfolk and Waveney enjoys a broad and diverse VCFSE sector. There are 3645 registered charities, 220 community interest companies and 124 registered societies with their registered offices in Norfolk & Waveney. Many of these organisations have been born of local communities of interest or geography, responding to specialist need to provide not for profit services and support. Many of these organisations will focus on early intervention and preventative services, born of lived experience, which empower their communities to build resilience and maintain control of their own lives.

Underpinned by a memorandum of understanding our VCFSE Assembly was launched in July 2022 with a headline objective to connect this rich and diverse public benefit across the overarching mission for Norfolk & Waveney's ICS. The Assembly provides the sector with a strong voice across the

decision-making process, having adopted the principles of a Memorandum of Understanding drawn up ahead of its formation. VCFSE representatives sit across our five place boards and eight health and wellbeing partnership boards, providing a vehicle for engagement of local organisations across the eight ambitions and other emerging local priorities.

The VCFSE sector in Norfolk and Waveney is facing a 'perfect storm' of rising running costs and reduced fundraising income as supporters tighten their belts. Set against a backdrop of increasing demand for services more and more sector leaders are currently facing tough decisions as they try to maintain their public benefit mission. With the establishment of our Assembly we do now have an opportunity for ICS partnership and strategic alignment across the early intervention and prevention ambition specifically. Not only could this start to shift demand away from more acute interventions, it will help the people of Norfolk and Waveney to live longer, healthier, and happier lives.

At its heart, the VCFSE Assembly is the vehicle through which our ICS will shape the development of effective strategic and operational partnerships across the diversity of Norfolk & Waveney's VCFSE sector; listening to and seeking to involve any, and every, VCFSE organisation providing health and care support for the benefit of their communities across Norfolk and Waveney. The graphic below (Figure 12) sets out how the listening and involvement work of the Assembly is being augmented; through the support, nurturing and development work of our VCFSE infrastructure organisations and through improved collaboration, co-production and shared governance as an integral part of our ICS.

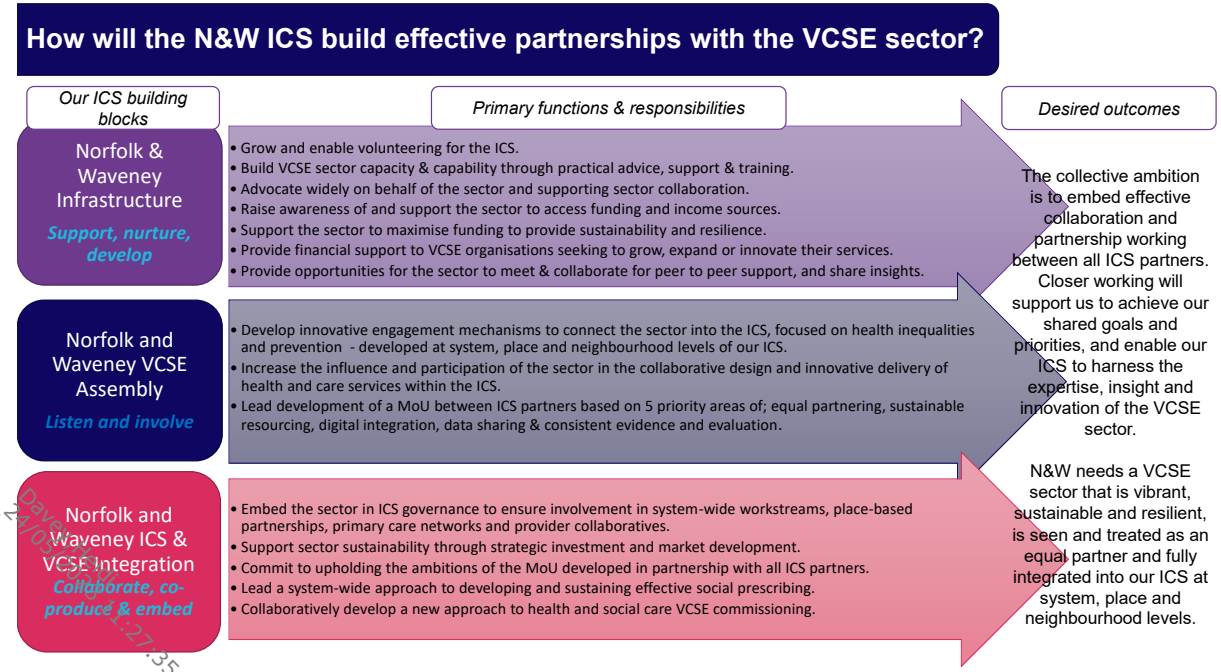


Figure 12 – building effective partnerships with the VCFSE sector

As our place-based approach takes shape the work of the Assembly will focus across the following three priorities over the coming months;

1. **Agree next steps for development of a VCFSE commissioning strategy.** As a system we do already have a number of key commissioning arrangements in place with VCFSE organisations working across our system. The next steps for the development of our commissioning strategy will be to focus on how we can partner across a broader range of organisations, many of whom will work on a smaller scale and at a local level. Our strategy will be informed through relevant stakeholder engagement to help us build shared understanding across three key areas;
   - The impact that preventative and early interventions across our communities can have; what is our shared understanding of value and how can we measure it?
   - The added social value brought through strategic VCFSE sector partnering; financial value, community value, and the value of long term strategic partnering.
   - The importance of building empowering practice into everything that we do, of supporting every individual to understand what behaviour change might mean for the health and wellbeing of themselves and their loved ones.

2. **Support the ICS health inequalities agenda**. Our Place-based Assembly representatives were appointed on the basis of their connectivity to, and insight across, the inequality priorities for each place. These representatives will look to connect relevant VCFSEs into our emerging ambitions and priorities, helping to build the relationships and partnerships that will facilitate the VCFSE sector to engage with places at a strategic and operational level.

3. **Create a 'road map' for VCFSE Assembly development.** The road map will consider all that we have learned through our first fifteen months of operation and make recommendations for the next phase of our VCFSE Assembly in Norfolk and Waveney, considering the following areas in particular but not exclusively;
   - Improving communications and direct engagement opportunities between the Assembly and our VCFSE constituency
   - Reviewing how we best connect relevant VCFSE organisations with the place-based approach and the work happening locally
   - Reviewing Assembly board membership remains relevant to our evolving agenda
   - Ensuring Assembly operations are sustainably resourced and facilitated

7.0 Commitment to achievable, measurable and impactful improvements

The improvements we make will be measured through system Programme Boards, reported in annual plans and key metrics will be included in our Integrated Performance Report (IPR). A summary of key metrics for each objective is shown in Figure 13.

<placeholder for Figure 13 final metric summary>.

Our **commitment** is to listen to the people who use our services to see if we are successfully improving the health and care for the people and communities of Norfolk and Waveney and delivering our joint forward plan ambitions.

Appendix 1 - ICS Strategies that support the Ambitions include:

Ambition 1 Transforming Mental Health Services
The joint HWB and Integrated Care Strategy for N&W priorities of **Driving Integration** by mobilising Mental Health collaboratives in the delivery of people-centred care; **Prioritising Prevention** with a MH collaborative and shared resources, supporting people to be resilient throughout life; **Addressing Inequalities** by providing support for those who are most vulnerable using a collaborative approach to develop pathways **and Enabling Resilient Communities** by supporting people with complex needs to remain independent whenever possible, through promotion of early support and recovery. **Suffolk's transitional Joint Health and Wellbeing Strategy 2022-23, Preparing for the Future** includes priorities for: • Public mental health • Good work and health • The wellbeing of children and young people • Listening and engaging with local voices Actions across these priorities aim to: • Strengthen the protective public factors and lessen the impact of social and contextual factors that adversely impact mental health, such as unemployment, loneliness, social isolation, crime, migration, unsafe environments, and poor housing. • Work to promote healthy workplaces and strengthen the factors that can protect against poor mental health in work setting. • Work with partners, including Integrated Care Systems, to strengthen children's and young people's mental and emotional wellbeing. • Listen to the voices coming from employers, have conversations that support mental health and wellbeing, and hear the priorities of children and young people **Clinical Strategy Objectives:** See me as a whole person including parents, families and carers in these conversations. Agreeing a universal bio-psycho-social model of clinical assessment with clinicians and patients. **Digital Strategy & Roadmap:** Digitised patient records, shared information **Estates:** Norfolk & Waveney estate will play a key role in supporting prevention. Mental Health services have already begun to work in a more integrated way with primary care services, positioning services discretely alongside other community based clinical service provision. We will ensure we have the correct infrastructure model in each locality through the five mental health and wellbeing hubs being developed alongside primary and community health and wellbeing hubs. This will allow for creating a more joined up approach to care and better continuity between urgent care and community services. The hubs will support a reduction in referrals to crisis teams and subsequently

reduce the number of people attending hospital for emergency care. Significant investment in new hospital sites will enable us to care for our population in modern and well equipped environments, securing better health outcomes.

Our Net Zero Green Plan focus areas: Sustainable models of care (community hubs), Digital Transformation, Medicines, Nature Connection and Biodiversity. (**Our Green plan provides a point of focus and coordination across 11 key focus areas. Through this plan we bring clinical and operational service teams together to positively impact the journey toward net zero through innovative projects between our Health providers. In our focus area ‘**Sustainable models of care’ (community hubs) we define and implement ‘health & care pathways’ that enable integration with community based NHS services, seeing the patient as a person and supporting the notion of ‘only telling the story once’; Other parts of our Green plan include Digital Transformation – such as our electronic patient record programme – providing safe access to all clinical practitioners about a person’s health conditions; Optimising medicines to minimise impacts on the environment – such as our inhalers programme changing to inhaler type that exclude harmful propellants; we use our programme for Nature Connection and Biodiversity to coordinate investment in our built environment to provide spaces that promote health and aid wellbeing).

Research: TBC once published

People Plan: Work is underway to make MH services more accessible in the community by integrating new MH roles such as MH Practitioners, MH Pharmacists and MH Recovery. Workers into GP practices. We will continue to build psychological therapy skills in our workforce recognising the importance of giving people the resources they need to recover from poor mental health and build the skills and insights to maintain recovery.

Quality Strategy: Focussed on improving care quality and outcomes, using insights around health inequalities and population health to achieve fair outcomes and ensuring services are safe and sustainable for future generations.

Ambition 2 Improving Urgent and Emergency Care
The joint HWB and Integrated Care Strategy for N&W priorities of **Driving Integration** by working together as a system to ensure people receive the right care, in the right place, at the right time and reducing LoS. **Addressing inequalities** by improving accessibility and reducing ambulance wait times and **Enabling Resilient Communities** by supporting people to return back to their communities by reducing LoS and expanding virtual ward services. It also links to **Suffolk's transitional Joint Health and Wellbeing Strategy 2022-23**, **Preparing for the Future**. This recognises the importance of greater collaboration and system-working as a cross-cutting issue. Its guiding principles also cite the importance of collaborative leadership, of ceding power and resources to make a difference, and of aligning planning and developing shared priorities and outcomes. **Clinical Strategy Objectives**: See me as a whole person to enable patients to only tell their story once and act early to improve health by integrated solutions for effective 111, Urgent Treatment Centres, Same Day Emergency Care, discharge and 999 services. **Digital Strategy & Roadmap**: Digitised patient records, shared information, virtual health and care are all key critical enablers to the UEC ambition **Estates:** Our estate strategy aligns with the UEC ambition by developing and managing estate that allows delivery of the right care in the right place, enables better patient outcomes, and empowers health, social care and third sector staff to provide the best possible care. This is achieved through the strategic objectives of: • Improving Access – ensuring that the right services are delivered in the right place, matching demand and capacity • Improving Quality & Condition – Providing safe, flexible, modern, and fit-for-purpose estate and supporting services for our patients, visitors, and staff • Improving Sustainability – Implementing interventions to decarbonise our estate and reduce carbon emissions arising for our buildings, infrastructure, and services • Improving Efficiency – Providing a right sized estate and supporting services that delivers value for money and long-term financial sustainability • **Our Net Zero Green Plan focus areas:** Sustainable models of care (virtual wards and community hubs), Digital Transformation as referenced in the digital roadmap, Travel and Transport. Our Green plan includes a focus on developing sustainable models of care which aim to embed prevention in the development of all models of care e.g. an expanding virtual ward service enabling patients to recover and be monitored at home. We continue to harness digital technology and systems that support and streamline services, resources, and expand our ability to reduce carbon emissions

Research: **TBC once published**

People Plan: Expansion of the workforce across health and social care to ensure the support of patient flow throughout the ICS.

Quality Strategy: Focus on improving care quality and outcomes, using insights around health inequalities and population health to achieve fair outcomes & ensuring services are safe and sustainable for future generations

Ambition 3 Elective Recovery & Improvement
The joint HWB and Integrated Care Strategy for N&W priorities of **Driving Integration** by working as a single system, collaborating in the delivery of person centred care, making sure services are joined-up, consistent and make sense to those who use them; **Prioritising Prevention** by early diagnosis and reducing waiting times therefore preventing, reducing and delaying need; **Addressing Inequalities** by ensuring our services are easily accessible to all and improving accessibility to our services for those who need more support; and **Enabling Resilient Communities** by supporting 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. The ambition also links to Suffolk's transitional **Joint Health and Wellbeing Strategy 2022-23, Preparing for the Future.** This recognises the importance of greater collaboration and system-working as a cross-cutting issue. Its guiding principles also cite the importance of collaborative leadership, of ceding power and resources to make a difference, and of aligning planning and developing shared priorities and outcomes. **Clinical Strategy Objectives:** Reducing long waiting times by prioritising waiting lists and target those at highest clinical need and developing management and care for those on long waiting lists for example the 'while you wait' information on Improving Lives together ICS website. Developing elective diagnostic hubs which will help with capacity and capability and focus on increasing access to virtual care and services **Digital Transformation Strategic Plan and Roadmap capabilities:** Digitised patient records, Shared Information, Data and Analytics, Citizen and Patient Tools, Virtual Health and Care, Fully Integrated Infrastructure and Connectivity. Digital is a key enabler to this Ambition and a Single Waiting List is specifically noted as a priority within the Shared Information capability in the strategy. **Estates: TBC** **Our Net Zero Green Plan focus areas:** Sustainable models of care (community hubs), Digital Transformation, Medicine, Supply Chain and Procurement, Food and Nutrition **Research: TBC once published** **People Plan:** Ensuring the system has the right capacity to meet demands both in the here and now and in the future. This will include building on the existing substantive workforce to ensure they have the correct capabilities and supporting this through safe temporary staffing measures through the collaborative bank and the reservist programme. Building the workforce to meet future demand will also ensure the system keeps safe and sustainable. **Quality Strategy:** Focussed on improving care quality and outcomes, using insights around health inequalities and population health to achieve fair outcomes and ensuring services are safe and sustainable for future generations.

Ambition 4 Primary Care Resilience & Transformation
The joint HWB and Integrated Care Strategy for N&W priorities of Driving Integration by working in partnership priorities of **Driving Integration** by developing MDT neighbourhood teams shifting focus to community support; **Addressing Inequalities** by ensuring our services are easily accessible to all and improving accessibility to our services for those who need more support at a local level and **Enabling Resilient Communities** by building a local resilient multi-skilled professional workforce and with services closer to home, enabling people to live independent healthy lives in their communities for as long as possible. This ambition also links to **Suffolk's transitional Joint Health and Wellbeing Strategy 2022-23, Preparing for the Future.** This recognises the importance of greater collaboration and system-working as a cross-cutting issue. Its guiding principles also cite the importance of collaborative leadership, of ceding power and resources to make a difference, and of aligning planning and developing shared priorities and outcomes. **Clinical Strategy Objectives:** See me as a whole person, to bring care closer to home wherever possible to do so. **Digital Strategy & Roadmap:** Digitised patient records, shared information, population health management, citizen and patient tools, virtual health and care (e-referrals), fully integrated infrastructure - wi-fi connectivity and cloud telephony in primary care **Estates:** To provide integrated 'out-of-hospital care,' with a focus on prevention, self-care and supporting people to live well at home for longer, our community-based providers, NCHC, NSFT, CCS, EEAST and ECCH, are working with PCNs to develop their integrated service models / PCN Estate strategies, influencing the size and type of wider community estate. Where necessary, community providers will relocate service activity to primary care, or proposed community located care hub and spoke models, whilst retaining core estate to provide more specialist and focussed care. We are investing in health hubs, formed from new and existing community-located assets, and may be comprised of more than one building in a 'Place' level setting. They will offer the opportunity to implement modern technologies and address digital deprivation across the ICS. Health & care estate will be developed to maximise integrated generic spaces in community settings. Bookable clinical and non-clinical rooms will act as a flexible resource for the wider health and social care community. **Our Net Zero Green Plan focus areas:** Sustainable models of care (community hubs), Digital Transformation, Estates & Facilities, Medicine, Supply Chain and Procurement and a bespoke 10-point plan for Primary Care and GP Practices to reduce carbon emissions, including the development of their estates strategies **Research:TBC once published** **People Plan:** Primary Care Workforce Strategy: we will support workforce planning, recruitment, and retention, providing opportunities to all for education, training, and development of the whole primary care workforce.

Quality: Focussed on improving care quality and outcomes, using insights around health inequalities and population health to achieve fair outcomes and ensuring services are safe and sustainable for future generations

Ambition 5 Improving Productivity & Efficiency

The joint HWB and Integrated Care Strategy for N&W priorities of **Driving Integration** by working in partnership on estates, medicines optimisation, workforce efficiency, and procurement; **Addressing Inequalities** by working better together it should improve accessibility to our services for those who need the most support and **Enabling Resilient Communities** by increasing our productivity and efficiency which in turn should enable people to live independent healthy lives in their communities for as long as possible.

Suffolk's **transitional Joint Health and Wellbeing Strategy 2022-23, Preparing for the Future**, recognises the importance of greater collaboration and new ways of working in achieving greater efficiency and making better use of collective resources. It is also a guiding principle of the strategy that evidence and data will be used to set the right priorities based on population needs.

Clinical Strategy Objectives: See me as a whole person and ensuring the essential use of medicines (focussing on over treatment and polypharmacy), Be one high quality, resilient service focusing on integrated service development that strengthens organisations and brings systems and services together, Be reliable and agreeing and adopting a model of value based healthcare plan.

Digital Strategy & Roadmap: A number of enablers within the digital strategy will release staff time and reduce duplication so more time can be spent with patients e.g. such as digitised patient records, shared information, data and analytics, citizen and patient tools and virtual health and care. Digital workforce tools and fully integrated infrastructure and connectivity will have a more direct benefit to this ambition as they are linked to the HR/People and Digital changes that we intend to make through the change programme.

Estates: TBC

Our Net Zero Green Plan focus areas: We have an over-arching vision for Net Zero and within that we state that we will be using what we have got to best effect across all partners - so investing in the right things at the right times and holding each other to account on the use of resources. This Ambition is based on the principle of sharing and collaboration of resources and there is real opportunity to ensure that Net Zero is embedded in this Ambition and aligned to the green plan.

Research: TBC once published

People Plan A number of programmes are being delivered to improve efficiency and productivity across the system. Our 'One-Workforce' programme is looking at how to streamline back office HR and workforce functions across the ICS to reduce duplication, a reduction in agency spend is required to meet national efficiency targets and integrated workforce plans including provider collaborations and working with the VCSFE sectors are to be developed at system level to support the delivery of the NHS Long Term Plan ambitions; Multi professional educational and training investment plans with sufficient clinical placement capacity are required to maintain education and training pipelines.

Quality Strategy: Focussed on improving care quality and outcomes and ensuring services are safe and sustainable for future generations. It is imperative that quality is a theme throughout the change programmes and that financial improvement does not override quality outcomes.

Ambition 6 PHM, Reducing Inequalities and Supporting Prevention

The joint HWB and Integrated Care Strategy for N&W priorities of **Driving Integration** by using and sharing data and evidence to inform planning; **Prioritising Prevention** by delivering the 3 work programmes to prevent people from becoming ill and promoting healthy lifestyles; **Addressing Inequalities** via the work programmes, targeting interventions to those that need it the most; and **Enabling Resilient Communities** by supporting people to live independent healthy lives by early cancer diagnosis and cardiovascular disease prevention.

The Norfolk & Waveney Local Maternity and Neonatal System (LMNS) agreed a plan in September 2021 that sets out in detail what we would like to achieve and put in place locally: https://improvinglivesnw.org.uk/our-work/healthier-communities/maternity-services/local-maternity-and-neonatal-system-lmns/lmns-workstream-prevention/prevention-project-nhs-long-term-plan-smokefree-pregnancy/ .

The JFP ambitions also link to **Suffolk's transitional Joint Health and Wellbeing Strategy 2022-23, Preparing for the Future**. This recognises reducing inequalities as a cross-cutting theme, with actions aiming to reduce inequalities through improving people's access to good jobs, raising incomes, and tackling the effects of poverty on families and children. The strategy also includes as guiding principles:

- Focusing on prevention and early intervention.
- Listening to evidence and data, to set priorities based on population needs, and focusing on what makes people well rather than just repairing damage.
- Aligning planning across partners and developing shared priorities, encouraging Health in All policy approaches, and ensuring decisions are based on improving population health.

Population Health management is an enabler for all ICS strategies – but in particular there are links with:
Clinical Strategy objectives: Act early to improve health by creating a health improvement and transformation partnership and a structured programme to increase vaccination. Plus tackle health inequalities by producing a plan to address CORE20PLUS5 to reduce inequalities through Place based partnerships and to consider resources to minimise the inequalities from the pandemic.

Digital Strategy & Roadmap: There is a dedicated population health management priority which 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

Estates Strategy: there is a focus on population health management through five key programmes of work that form the basis of our enabling work. These include:

- Utilising comprehensive datasets to inform our decision making about investment and development. This includes developing digital tools to improve estate performance.
- Convening a collaborative approach to workforce planning and management, aligning workforce in support of developing clinical services.

- Collectively delivering cost improvement plans and removing unwarranted cost variation, helping reduce financial deficits, focussing our resource for frontline services.
- Embedding policy and protocol to ensure population growth is planned for, and seeking funding through appropriate routes to support mitigation.
- Prioritising investment to best respond to system challenges and priorities, and identifying income opportunities to fund investment need.

Our Net Zero Green Plan focus areas: Sustainable models of care - we will embed prevention in the development of all models of care. (The NHS greatly influences the health and wellbeing of its communities and can make a meaningful impact on the economic, social, and environmental wellbeing of the population.
Our Green plan includes a focus on developing sustainable models of care which aim to embed prevention in the development of all models of care. This is exemplified by:

- Publication of the ICS Clinical Strategy that promotes new sustainable models of care;
- Supporting the Primary Care Network (PCN) development in ways that promote integrated services, closer to home;
- Prioritising investment that further enhances services in our local communities, for example the Primary Care Hub projects and the Community Diagnostic Centres;
- Launched an expanding virtual ward service enabling patients to recover and be monitored at home;
- Continuing to explore clinically equivalent lower-carbon interventions).

Research TBC once published

People Plan Creating a compassionate and inclusive environment will help support inclusion and belonging for all (internally and externally), and creating a great experience for staff through our people working and learning in the ICS can develop and thrive in a compassionate and inclusive environment. Issues of inequality and inequity are identified and addressed for all people working in the system. The workforce and leaders in the ICS will be representative of the diverse population they serve. Maximising our expertise throughout UEA, working as an Anchor Institute across the ICS to achieve sustainable growth across health and care systems focused on workforce and system transformation. The Rural and Coastal programme in collaboration with NHSE will help tackle and address health inequalities through education, training and use of digital technology.

Quality Strategy: Focussed on improving care quality and outcomes and using insights around health inequalities and population health to achieve fair outcomes

Ambition 7 Improving Services for Babies, Children, Young People and Maternity (BCYPM)

The joint HWB and Integrated Care Strategy for N&W priorities of **Driving Integration** by sharing data and evidence and working collaboratively to improve services for BCYP; **Prioritising Prevention** by a systematic approach to preventing ill health from birth through early years; **Addressing Inequalities** by reducing health inequalities; and **Enabling Resilient Communities** by supporting CYP and families to live independent healthy lives in their communities.

This ambition also links with **Suffolk's transitional Joint Health and Wellbeing Strategy 2022-23, Preparing for the Future**, which includes priorities for:

- Public mental health.
- Good work and health.
- The wellbeing of children and young people.
- Listening and engaging with local voices.

Across these priorities, actions aim to ensure that children and young people in Suffolk have the best start in life, enjoy good mental health, are resilient and productive, enjoy positive and happy relationships, and are able to achieve their full potential. The strategy aims to tackle the impacts of child poverty; to ensure equal access to education and other opportunities; and to ensure that children's and young people's interests are recognised in the decisions that affect their lives.

Clinical Strategy Objectives: See me as a whole person by developing an action plan for personalised care that embeds personalisation across the ICS services and agreeing a universal bio-psycho-social model of clinical assessment, working together as one high quality resilient service, acting early to improve health, reliable services and addressing health inequalities

Digital Transformation Strategic Plan and Roadmap: Digitised patient records, shared information and citizen and patient tools will support this objective. For example data sharing arrangements to capture 'whole family' needs, whichever part of the system families access. Empower people to manage their health and wellbeing through the use of patient portals and apps, together with ensuring each hospital has their Digital Maternity Strategies aligned.

Estates: Recent 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. The strategy recognises that more support is needed for communities, focussed on children and young people in the areas of prevention, early help, and health inequalities to promote healthier lifestyles and emotional wellbeing. To deliver the support in communities for children and young persons, partners across the ICS will need to work together focusing on the wider determinants of health to enable the best possible outcomes for residents. This strategy supports the improvements to health services available to patients by:

- Bidding for and developing extra resource to support greater community provision;

- Supporting access to accommodation for all providers using shared processes, opening capacity of our estate and maximising utilisation.
- Directing investment to create suitable environments that support earlier intervention before a person's condition develops to reduce the risk of conditions worsening and becoming entrenched, for example, in eating disorders.
- Direct extra resources to the communities and age groups most in need especially children and young people.

Our Net Zero Green Plan focus areas: Sustainable models of care (family hubs), through digital transformation as referenced in the digital roadmap and through medicines and the opportunity to reduce our carbon emissions related to prescribing and use of medicines and medical products e.g. the greener inhaler campaign for asthma. The NWICS Green Plan drives our journey toward achieving the Net Zero NHS between 2040-2045. In supporting users of health and care services the green plan provides a focus that influences other areas of ICS strategy, and the use of available resources. Examples include:

- Sustainable models of care' (community hubs) we define and implement 'health & care pathways' that enable integration with community based NHS services, seeing the patient as a person and supporting the notion of 'only telling the story once';
- Other parts of our Green plan include Digital Transformation – such as our electronic patient record programme – providing safe access to all clinical practitioners about a person's health conditions;
- Optimising medicines to minimise impacts on the environment – such as our inhalers programme changing to inhaler type that exclude harmful propellants;
- we use our programme for Nature Connection and Biodiversity to coordinate investment in our built environment to provide spaces that promote health and aid wellbeing).

Research – TBC once published

People Plan – Ensuring learnings from areas such as the Ockenden report and East Kent in relation to maternity failings and issues around culture and leadership are adopted across the workforce. Freedom to Speak Up Guardians will ensure everyone working within the ICS feels safe and confident to speak up and the creation of safe spaces to work will create a positive culture for staff.

Quality Strategy: Focussed on improving care quality and outcomes. Using insights around health inequalities and population health to achieve fair outcomes & ensuring services are safe and sustainable for future generations.

Ambition 8 Transforming Care in Later Life

ICS Strategies that will support the Transforming Care in Later Life Ambition include:

The joint HWB and Integrated Care Strategy for N&W priorities **of Driving Integration** by working in partnership to ensure people age well; **Prioritising Prevention** with a focus on enhancing access to early intervention and prevention; **Addressing Inequalities** by improving care for people most at risk of falls using a collaborative system approach and **Enabling Resilient Communities** by enhancing access to early intervention and prevention enabling people to remain independent whenever possible.

Suffolk's transitional Joint Health and Wellbeing Strategy 2022-23, Preparing for the Future, continues to regard a good quality of life for Suffolk's older people as a priority. As such, older people will continue to benefit from actions against the current priorities of:

- Public mental health.
- Good work and health.
- Listening and engaging with local voices.

Working with partners, these actions will, amongst other things, tackle loneliness and isolation, promote active participation in daily life, support greater opportunities for volunteering, and support the development of healthy and sustainable communities where people can live their best lives.

Clinical Strategy objectives of Seeing me as a whole person which is about shared treatment plans, ensuring life circumstances are taken into account, that independence is prioritised and medication will be used where essential to avoid overdiagnosis and over treatment. We want to predict, detect and act early to improve health and prevent avoidable crisis where possible through working together to manage long term health conditions.

Digital Strategy & Roadmap: Developing a digitised patient record and having shared information is key to be able to the clinical strategy objective of Seeing me as a whole person. Population Health Management applies a holistic view to our older population which will help to target interventions and virtual health and care is a key capability that can personalise care and support our population to receive care at home.

Estates Strategy: Norfolk is particularly popular for people looking to retire meaning that many new residents are likely to be older. Our estate strategy includes focus on the effectiveness of available investment resources, by working with partners to enable more housing within public sector assets for the increasing population. We manage existing estate with shared clinical policy alignment, digital investment and management information to drive decision making. The ICS recognises the need to increase both the range and volume of options for older people to access our services and is committed to helping older people live independently for as long as possible. Our approach to managing our estate aims to reduce pressure on health and social care, impacting a reduction in A&E admissions, a reduction in falls, an increase in

wellbeing and mental health, and a reduction in GP appointments. Extra care housing schemes include a variety of features depending on the scale, location, and stated purpose of individual developments. Development of ICS estate continues to consider alignment to this programme, liaising with developers to identify schemes that deliver stronger health outcomes to Norfolk residents.

Green Plan / Net Zero: Our Green plan provides a point of focus and coordination across 11 key focus areas. Through this plan we bring clinical and operational service teams together to positively impact the journey towards net zero through innovative projects between our Health providers. In our focus area 'Sustainable models of care' (community hubs) we define and implement 'health & care pathways' that enable integration with community based NHS services, seeing the patient as a person and to make sure that you only have to tell your story once. Other parts of our Green plan include Digital Transformation – such as our electronic patient record programme – providing safe access to all clinical practitioners about a person's health conditions. This is entirely aligned with the ICS Digital Strategy and Roadmap. Optimising medicines to minimise impacts on the environment – such as our inhalers programme changing to inhaler type that exclude harmful propellants. We use our programme for Nature Connection and Biodiversity to coordinate investment in our built environment to provide spaces that promote health and aid wellbeing.

Research: TBC once published

People Plan: Supports improved wellbeing of staff across the system by involving them in the redesign of services. For N&W the increasing older population will require a different type of workforce to the one it currently has. Changes in skill mix, re-designing of services and increasing the staffing mix will all form part of our immediate and longer term planning.

Quality Strategy: Focussed on improving care quality and outcomes, using insights around health inequalities and population health to achieve fair outcomes and ensuring services are safe and sustainable for future generations

Norfolk and Waveney Joint Forward Plan

Part 2: Legal duties and other content

Contents

Describing the health services for which the ICB proposes to make arrangements

Our Joint Forward Plan sets-out how we will meet the physical and mental health needs of the population and how we will transform services over the next five years.

The plan sets-out eight ambitions, aligned to the priorities in the transitional Integrated Care Strategy for Norfolk and Waveney, which is also our Joint Health and Well-Being Strategy. Our ambitions are:

1. Transforming Mental Health services
2. Improving Urgent and Emergency Care
3. Elective Recovery and Improvement
4. Primary Care Resilience and Transformation
5. Improving Productivity and Efficiency
6. Population Health Management (PHM), Reducing Inequalities and Supporting Prevention
7. Improving services for Babies, Children and Young People and developing our Local Maternity and Neonatal System (BCYPM)
8. Transforming care in later life

The eight ambitions are explained in detail in the Joint Forward Plan (JFP), including clear objectives, trajectories and milestones.

Duty to promote integration

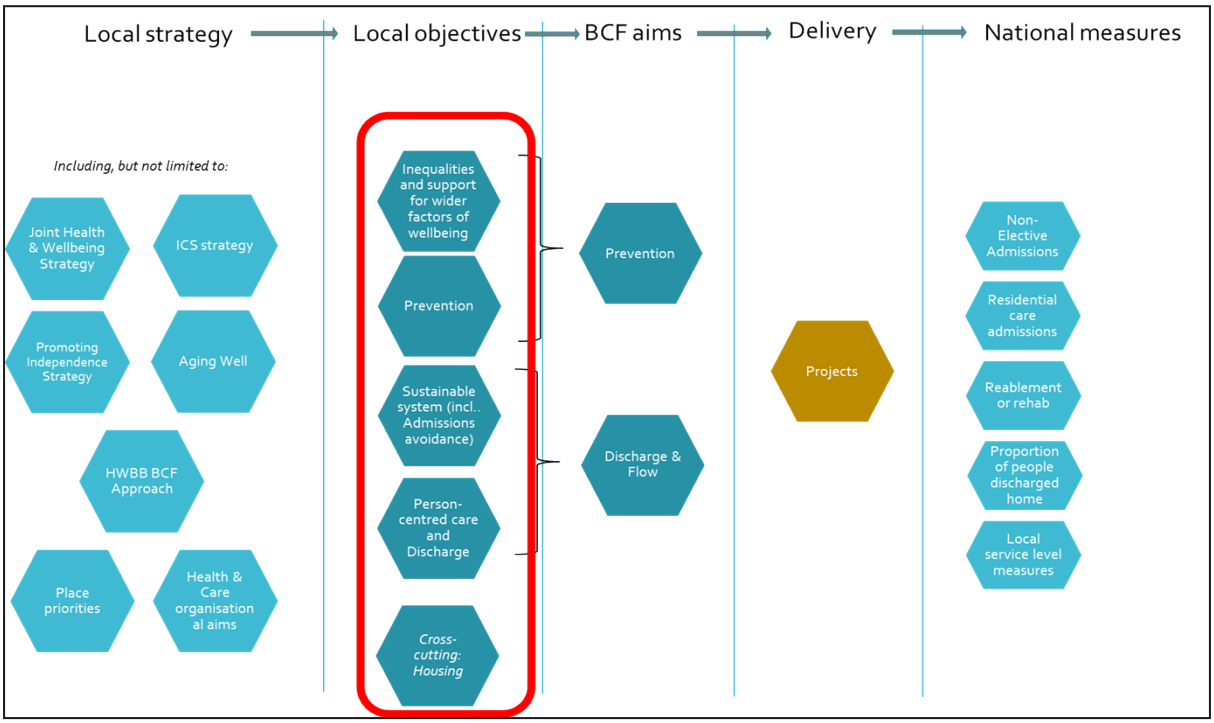
Norfolk and Waveney is committed to integrated working and joint commissioning across the health and social care system. This is reflected in the local approach to the Better Care Fund (BCF) - a nationally mandated programme with the aim of joining up health and care services, so that people can manage their own health and wellbeing and live independently. The BCF is executed through three programmes of work under the BCF 'banner':

- Core BCF - bringing Local Authority and NHS partners together to agree integrated priorities, pool funding and jointly agree spending plans.
- Disabled Facilities Grant (DFG) - Help towards the costs of making changes to a person's home so they continue to live there, led by District, Borough and City Councils in Norfolk.
- iBCF - Available social care funds for meeting adult social care needs, ensuring that the social care provider market is supported, and reducing pressures on the NHS.

Locally the BCF is focused on the following priorities that reflect the wider strategic aims of our system and reinforce the importance of subsidiarity, where we are all working towards the same things:

- Prevention, including admission avoidance
- Sustainable systems
- Person-centred care and discharge

- Inequalities and support for the wider factors of wellbeing
- Housing, DFGs and overarching pieces of work.



The Norfolk BCF now acts as a delivery arm for integrated working across the system and supports Place-based priorities. Norfolk is aiming to increasingly align the BCF Plan with its Places and support important local areas of joint health and care working. Place-based working is also enabling the Norfolk and Waveney system to use the Core BCF guidance to involve and empower NHS Trusts, social care providers, voluntary and community service partners and other system partners in the development of the BCF. Funding through Norfolk's annual BCF uplift has been utilised to support delivery of the priorities at Place, with collaborative proposals developed that best support the delivery of the BCF metrics / aims at a more local level.

The development of the BCF approach, plan and submission brings Local Authority and ICB leaders with wider ICS partners in the Health and Wellbeing Board to make integrated financial and commissioning decisions, engaging with partners across the health and care system in those decisions. System partners in Norfolk have utilised the BCF to fund and develop critical services that support the health and wellbeing of our population, including care from the provider market, key health and care operational teams, and community-based support from the VCSE sector. Many of the BCF services are jointly funded and commissioned, including:

- A Social Impact Bond for Carers – support carers with information, advice, support and Carers Assessments to improve their wellbeing and help them maintain their caring role. This is joint funded by NCC and NHS N&W, with joint membership at the Strategic Board.

- Norfolk Advice Network and Advocacy Partnership – this is a new service jointly funded by NCC and NHS N&W, which aims to provide a single point of contact for information, advice and advocacy in Norfolk.
- Intermediate Care – NCC and NHS N&W are working together to deliver appropriate, integrated intermediate care both preventing hospital admission and supporting discharge.

In addition to service development as part of the BCF our system is also working collaboratively on a number of other integrated programmes between health and social care, including a collaborative review of the Nursing Care Market; an Integrated Care Market Quality Improvement Programme; and the development of an All Age Carers Strategy. The ICS is committed to delivering an effective, integrated oversight of key integrated arrangements, including the BCF and other arrangements for pooling, sharing resources and joint commissioning.

Duty to have regard to wider effect of decisions

The triple aim requires NHS bodies to consider the effects of their decisions on:

- people's health and wellbeing (including inequalities in that health and wellbeing)
- the quality of services
- the sustainable and efficient use of resources.

Here is a summary of how we developed our plan in line with the triple aim and how the triple aim will be accounted for in ongoing decision-making and evaluation processes:

People's health and wellbeing:

- Our two local Joint Strategic Needs Assessments and a case for change have provided the foundation for ensuring that our Integrated Care Strategy and this plan are evidence-based, as set-out in the 'Why are we doing this?' section of this JFP.
- The case for change supports us to prioritise the actions we will take over the next five years to improve people's health and wellbeing, resulting in our eight ambitions and the clear objectives that sit underneath each ambition, that are articulated in this plan.
- We will use a wide range of mechanisms to help us measure our progress with improving the health and wellbeing of local people, to understand the effectiveness of the decisions we've made and to help us decide what we need to do next. These will include future Joint Strategic Needs Assessments, our quality objectives and processes, and the work of the ICB's committees (including the ICB's Patients and Communities Committee which will support us to ensure we understand the views of local people and communities). Importantly, this will include our progress with reducing health inequalities.

The quality of services:

- This plan has been developed in line with our quality objectives and processes, which are detailed in the quality section of this plan.
- Alongside our system's Quality Management Approach, the CQC's assessments of individual providers / services and our Integrated Care System, will help us to collectively understand and drive improvement in the quality of local health and care services.

The sustainable and efficient use of resources:

- This plan has been developed in line with our Medium-Term Financial Plan to ensure that it is costed and affordable, and that it supports our system to achieve our duty to deliver financial balance.
- Our Medium-Term Financial Plan sets-out how we will create more efficient services through integration, innovation, and better use of data to improve productivity, ensuring that we spend every pound effectively. Our work to implement new technology and tools, as outlined in the digital section, will greatly support this work.
- We have a Chief Finance Officer forum which ensures that our planning is coordinated, and our progress is measured together, helping us to really understand where we can drive efficiencies and avoid cost-shunting between organisations.

In addition, all ICB Board and committee reports are required to set-out the implications and risks of decisions on a range of aspects. Reports include the impact on clinical outcomes and the quality of care, delivery of the NHS Constitution, the financial and performance implications and the environmental and equalities impacts.

All proposals to change or develop new services, including those which will deliver this plan, are informed by environmental and equalities impact assessments, engagement, an understanding of the impact on the health and wellbeing of local people (including health inequalities) and our use of resources.

Overall, the duty aims to foster collaboration between local health and care organisations in the interests of the populations they serve. To achieve this, we will need to do more than put in place effective governance arrangements and clear processes; it will also require a cultural change and for people working in health and care services to think and behave differently. As outlined in this plan, we have a significant organisational development programme to accomplish this.

Financial duties

The ICB and its NHS partner organisations have collective local accountability and responsibility for delivering NHS services within the financial resources available.

The 'Revenue finance and contracting guidance for 2023/24' sets out that each ICB and its partner trusts must exercise their functions with a view to ensuring that, in respect of each financial year:

- local capital resource use does not exceed a limit set by NHS England
- local revenue resource use does not exceed a limit set by NHS England.

To achieve this the ICB supports the financial planning process across all NHS organisations within the Norfolk and Waveney system.

The financial resources of the N&W ICB are in two key streams, these are capital and revenue. Capital resources are the funds assigned to improve the infrastructure of the NHS, for example replacing large pieces of medical equipment or building a new hospital and health and social care facilities. Revenue funding is for the ongoing provision of healthcare services on an annual basis, for example paying the salaries of NHS staff and the consumable items such as needles and dressings.

Capital resource planning and approvals

Capital resources are distributed via the Norfolk and Waveney Strategic Capital Board (SCB), which includes representatives of all NHS providers, as well as speciality experts in digital and estates. All parties across the system identify their priorities and the SCB considers these to ensure that the available resource gets assigned to the most important capital requirements. Examples of high priority investment programmes could be those where the Care Quality Commission (CQC) has reported that an area or location is now unfit for modern patient care, or national priorities and ring-fenced money for elective recovery, such as Diagnostic Assessment Centres. Once the SCB has determined the priorities then it makes a recommendation to the Finance Committee and the ICB Board for approval. ICBs and their partner NHS trusts and NHS foundation trusts are also required to share their joint capital resource use plans and any revisions with each relevant Health and Wellbeing Board

Once approved, organisations have the authority to proceed and spend the capital resource on the agreed schemes and this is monitored and reviewed. Any in-year negotiations on under or potential over-spends are led by Chief Finance Officer forum, which comprise the Directors of Finance from each of the NHS partners, together with any subject matter experts through the relevant programme boards.

Revenue resource planning and approvals

The majority of the Norfolk and Waveney revenue resource is already committed to hospitals and services, since running these services is an ongoing commitment. From the annual planning perspective, each NHS organisation is required to produce a financial, activity and workforce plan that delivers the overall objectives set out in the annual planning guidance.

To determine the final annual revenue plan, each organisation considers and prepares its financial position with regard to the allocations and requirements as set out in the annual Revenue Finance and Contracting Guidance documents. This document indicates specific factors such as tariff changes, growth funding, efficiency and convergence requirements which are managed through the annual planning round.

The Chief Finance Officer forum is the initial place where organisational and system wide revenue financial plans are assessed, scrutinised and challenged with peers. The process is collaborative; system wide transformation schemes from the Norfolk and Waveney Productivity Programme Board and other strategic system wide investments are also included to create the complete annual revenue plan. The plan is then considered across a range of groups including with the NHS partners themselves, at the ICS Executive Management Team and with the chief operating officers and workforce leads. Once individual NHS provider boards and the ICB Board are satisfied that the NHS Norfolk and Waveney system revenue plan is complete, it is then submitted to NHS England for final approval.

During the year operational delivery of the plan and achievement of financial objectives are manged via the Chief Finance Officer forum and the ICB Finance Committee, both meet and review progress on a monthly basis. The financial values that have been agreed flow into contracts signed between the ICB and the providers.

The provider contracts are in turn supported with the System Collaboration Financial Management Agreement (SCFMA), which is similar to a Memorandum of Understanding, setting out principles of working together. Where financial plans are not being delivered or are at risk of not being delivered, the first action is to review within the organisation and across the system collectively. We are working to a system control total, so the accountability for the under or overspend is shared and collective decisions have to be made as to how to manage this through risk / investment sharing. Reviewing all current areas of spend would be an immediate priority to see what can be paused or stopped. However, the overriding management approach is to set a robust budget from the outset, with realistic transformation opportunities profiled across the year, with mitigations, escalation and ongoing dialogue so there is transparency and visibility of any emerging divergence from plan.

Ratification for any subsequent decisions or changes to the plan would be via the ICB Finance Committee and the ICB Board, working with NHS England during this time.

Duty to improve quality of services

The Norfolk and Waveney ICS Quality Strategy 2022-25 outlines our quality priorities and makes a commitment to the people of Norfolk and Waveney to deliver quality care, based on what matters most to the people using our services and the friends and family who support them.

Shared Commitment to Quality

We should all expect to receive care and support that is consistently safe, effective, equitable and evidence based. Our experience of this should be positive and personalised, empowering us to make informed decisions about how we access timely care and support. Our Quality Strategy outlines our commitment to deliver care that is:

Our Quality Strategy will support **integration**, **personalisation**, and **outcomes-based commissioning**, as a driver to transform and develop local teams, services and communities that promote wellbeing and prevent adverse health outcomes, equitably, for all people who live in Norfolk and Waveney. As a system, we will ensure that we examine patient experience and outcome metrics and encourage the public to be involved with quality improvement, patient safety, innovation and learning, in a way that is meaningful.

The ICS Quality Strategy is underpinned by continuous development of the ICS model for clinical leadership, quality governance, management and assurance, and research, evaluation and innovation. It is championed and led by the ICB Executive Director of Nursing, as executive lead for Quality and Safety, working closely with the wider Executive Management Team and the system's Director of Nursing Network.

Well-led through a culture of compassionate leadership

There is clear evidence that compassionate leadership results in more engaged and motivated staff with higher levels of wellbeing, which in turn results in higher quality care. According to The King's Fund (What is Compassionate Leadership?) compassionate leaders empathise with their colleagues and seek to understand the challenges they face. They are committed to supporting others to cope with and respond successfully to work challenges and they are focused on enabling those they lead to be effective and thrive in their work.

For leadership to be compassionate, it must also be inclusive; promoting belonging, trust, understanding and mutual support across our system. This needs to be delivered by a compassionate culture that underpins these values and develops people into effective leadership roles. From a quality perspective this means that we will support and empower people to work in a way that is transparent, accountable, and reflective.

Local implementation of the Professional Nurse Advocate (PNA) role will develop skills to facilitate restorative supervision, within nursing and beyond, to improve staff wellbeing and retention, alongside improved patient outcomes, using values of compassionate leadership to understand challenges and demands, and to lead support and deliver quality improvement initiatives in response.

The establishment of a Norfolk and Waveney Allied Healthcare Professional (AHP) Council and Faculty provides a system platform for the development of AHP leadership skills, as well as a scaled-up coordination and delivery arm for Health Education England opportunities for AHP skills, training and leadership development.

The emerging Norfolk & Waveney Clinical and Care Professional (CCP) Leadership Framework puts CCP leadership at the heart of our discussions at every level of our system so that it becomes integral to our culture and how we work together. This is described in the section on People and Culture in the JFP.

The regional East of England Clinical Senate also provides opportunities for collaboration and clinical leadership through cross-system working and strategic alliances, bringing together health and social care leaders, professionals, and patient representatives to provide independent advice and guidance to commissioners and providers on specific transformational work.

Alongside developing leadership skills across our system, we are building system structures that allow us to identify and grow leadership talent across our clinical and non-clinical staff groups and provide a platform for clinical and non-clinical workforce voices, ideas and skills for collaborative quality improvement.

Improving Care Quality and Outcomes

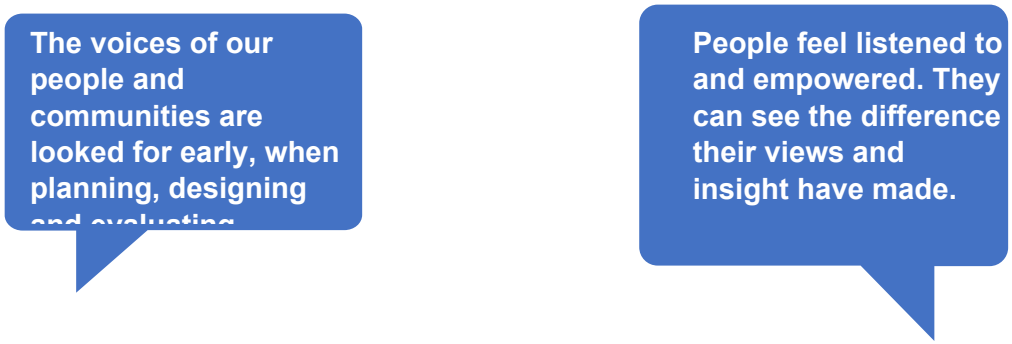
Quality Management Approach

While ownership of quality within services, networks, and organisations needs to start internally, the system will be able to facilitate quality management at scale when required, to improve safety, health and wellbeing for the local population and share learning and good practice. Clear and transparent accountability and decision-making for and by system partners is essential, particularly when serious quality concerns are identified.

Our key partners in quality include people and communities, professionals and staff, provider organisations, commissioners and funders (including NHS England), CQC and other regulators, Healthwatch, research and innovation partners and the voluntary, community, and social enterprise (VCSE) sector.

The **ICS Quality Management Approach Hub** facilitates a systemwide approach to quality management. Through its Quality Faculty, it brings system partners together to share insight and good practice in quality improvement (QI). Staff from across the ICS can access shared QI training and resources via the Hub to support cross-organisational and system-wide QI. A similar system approach will be taken to sharing quality control best practice. The Hub has led on the development and roll-out of a prioritisation matrix to support the system with quality planning and is supporting co-production of QI programmes across the ICS.

Being people-centred is a key part of our quality journey and culture of improvement, acknowledging the value of people's lived experiences as a powerful driver for change. If our co-production work is effective, our people, communities and ICS partners will be able to see that:



Healthwatch Norfolk and Suffolk are key partners in designing, facilitating and reporting on coproduction, offering expert independent advice and developing coproduction skills and confidence. Co-production is referenced in section 6.6 [check] within the JFP.

Quality And Addressing Health Inequalities

There is a strong relationship between service quality, including a service users experience of and equity of access to health and care with the underlying health needs of our population. Quality supports key elements of our populations' health and longer term health outcomes by enabling the delivery of safe, timely, accessible and evidence-based care and support. Further a joined-up approach to quality allows the system to:

- Look at what influences quality and length of life across the whole life course.
- Understand people's health behaviours and improve patient experiences of care.
- Support a healthy standard of living for all, whilst also understanding the 'social gradient' and working to reduce disparities in health outcomes.
- Understand the impact of health conditions on the demand and need for healthcare and the role of high-quality treatment and support as a prevention for further illness.

One of our eight ambitions is PHM, Reducing Inequalities and Supporting Prevention and we have set ourselves an objective to develop and Norfolk & Waveney Health Inequalities Strategy by March 2024, which will include our approach to CORE20PLUS5 Health Inequality Improvement framework for both Adults and Children and Young People.

Quality will be central to our approach to responding to the Core20PLUS5 healthcare inequalities Improvement Framework and our systems workstreams through quality improvement, service user engagement and workforce skills development. We have some specific objectives in our JFP that respond to these such as an initial focus on asthma, epilepsy and mental health in children. The quality approach will be key to the delivery of this objective within the BCYPM ambition as just one example.

Safe System

Defining and Measuring Quality and Patient Safety
Norfolk and Waveney ICB are in the process of developing a System Quality Dashboard, with a suite of metrics already identified. These metrics align to the NHSE System Oversight Framework, ICB statutory duties and CQC Quality Statements:

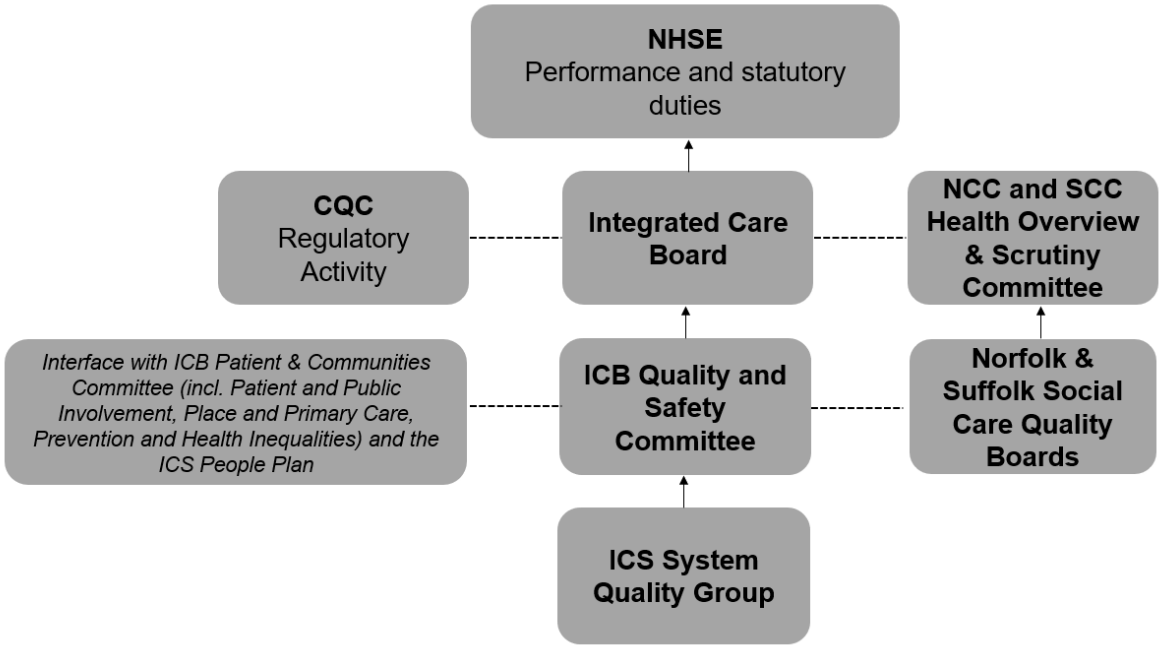
- Embedding a learning culture
- Supporting people to live healthier lives
- Safeguarding
- Safe and effective staffing
- Equity in access
- Equity in experience and outcomes

The System Quality Dashboard remains in the development phase. The dashboard will be used to support quality assurance and quality improvement priorities through a number of key forums including the System Quality Group and ICB Quality and Safety Committee.

The dashboard will also be shared with other key groups such as the Primary Care Commissioning Committee, recognising the importance of the breadth of quality across everything the ICB does. The dashboard will continue to evolve and will reflect the priorities identified through the transition to the Patient Safety Incident Response Framework which is anticipated to take place in September 2023.

Patient Safety Incident Response Framework
The new national framework represents a significant shift in the way the NHS responds to patient safety incidents and local implementation is a major step towards establishing a joined-up approach to safety management across our system, in line with the NHS Patient Safety Strategy.

Quality Governance and Escalation
Governance and escalation arrangements for quality oversight are developing across our system, linked to regional quality oversight arrangements:



In addition to and alongside the ICS System Quality Group, the following portfolios also report into the ICB Quality and Safety Committee:

- Safeguarding Partnerships
- Local Maternity and Neonatal System
- ICS Learning from Deaths Group
- ICS Infection Prevention & Control Partnership
- Health Protection Assurance Board
- ICB Research and Evaluation Team
- ICS Quality Management Approach Hub
- ICS transformation Programme Boards, including UEC, Mental Health, Children and Young People and Learning Disabilities & Autism

The **ICS System Quality Group** enables routine and systematic triangulation of intelligence and insight across the system, to identify ICS quality concerns and risks. It provides a forum to develop actions to enable improvement, mitigate risk and measure impact and facilitates the testing of new ideas, sharing learning and celebrating best practice.

The **ICB Quality and Safety Committee** has accountability for scrutiny and assurance of quality governance and the internal controls that support the ICB to effectively deliver its statutory duties and strategic objectives to provide sustainable, high-quality care. Representation from all the providers enables a partner overview of quality and safety risks, to ensure they are addressed and that improvement plans are having the desired effect. The committee also has delegated authority to approve ICB arrangements and policies to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes. This includes arrangements for discharging statutory duty associated with its commissioning functions to act with a view to securing continuous improvements to the quality of services.

Sustainable System

As a system we recognise the impact of social and environmental challenges, including carbon footprint, within healthcare. Quality will be central to delivery of our Net Zero Green Plan through quality improvement, service user engagement and workforce skills development. There is more about our Net Zero Green plan later in this section.

Duty to reduce inequalities

We are already taking action to reduce health inequalities across Norfolk and Waveney, but we want and need to do more. This is reflected in our 'Population Health Management, Reducing Inequalities and Supporting Prevention' ambition.

As part of this, we will be developing a new strategy for reducing health inequalities, which will be ready by April 2024. This will set out how we plan to reduce health inequalities across Norfolk and Waveney. It will include our approach to the NHS Health Inequality Improvement framework "Core20Plus5" and also addressing wider issues that affect health, including housing, employment, and the environment in which we live.

The actions that will deliver the Health Inequalities strategy will be included in future versions of our Joint Forward Plan, informing all elements of what we do and how we work. More information about this is included in section 4.0. [check]

The following information sets out how we will meet our legal duty.

Using data to identify the needs of communities experiencing inequalities

We use local data to identify the needs of communities experiencing inequalities in access, experience and outcomes. Part 1 of our JFP has more information relating to inequalities.

In addition to the people living in the 20% most deprived communities in Norfolk and Waveney (The "Core20" in the Core20Plus5 NHS approach to reducing health inequalities), we have identified the following "Plus" groups of people who also experience poorer health outcomes and for whom we will focus our programmes of work:

- People living with a learning disability and autistic people.
- People from Minority Ethnic groups, such as Eastern European Communities.
- Inclusion Health groups (including people experiencing homelessness, drug and alcohol dependence, Asylum seekers and vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups).
- Coastal and rural communities where there are areas of deprivation hidden amongst relative affluence.
- Young carers and looked after children/care leavers.

This is alongside the “5” clinical areas of focus for adults (maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension case-finding and optimal management and lipid optimal management) and the “5” clinical areas of focus for children and young people in the Core20Plus5 approach (asthma, diabetes, epilepsy, oral health and mental health). NHS England » Core20PLUS5 – An approach to reducing health inequalities for children and young people

A number of these are reflected within specific objectives in this plan, which complement the established work that is already ongoing within the system, for example in relation to diabetes, respiratory disease and medicines management, together with the Protect NoW approach that is described in the Population Health management section.

Working with and listening to people experiencing inequalities

It is vital that alongside using data, local people and communities inform our decision-making and the development of services. Section 6.6 [check] of our Joint Forward Plan sets-out our approach to working with local people and communities, including our “Community Voices” programme and how we will work with and listen to people who experience health inequalities.

The five strategic priorities for healthcare inequalities

There are five national priorities for reducing healthcare inequalities. Here is a summary of the work we are doing against these:

Priority 1: Restore NHS services inclusively

- Continuing to review inequalities data as part of elective recovery programme and ambition
- Developing an Equalities Impact Assessment and action plan for the elective recovery programme

Priority 2: Mitigate against digital exclusion

- Implementing our digital transformation strategic plan and roadmap that is referenced within the digital and data content of these legal duties. Alongside our core digital initiatives, we will implement a set of underpinning system-wide enablers that include digital and data skills and inclusion

Priority 3: Ensure datasets are complete and timely

- Improving recording of ethnicity data, to allow better analysis of health inequalities and targeting of interventions

Priority 4: Accelerating preventative programmes (including Core20PLUS5 approach)

- **Vaccine inequalities** – a programme to improve the uptake of vaccines, including flu and COVID-19 – including data analysis, using local and national data resources; a roving model has been developed to target and achieve positive outcomes for underserved communities; development of Wellness

Hubs to make every contact count and to offer a wider range of immunisations to local children and young people.

- **Core 20 PLUS 5** – co-ordination and monitoring of progress against all Core 20 Plus 5 programmes, including data analysis and dashboard development.
- **Clinically focussed projects including:** Cancer – addressing inequalities in screening uptake; Cardiovascular disease, NHS Health Checks; Smoking and Physical Activity.

Priority 5: Strengthening leadership and accountability
The Population Health and Health Inequalities Board has been established, this will maintain oversight of our developing Health Inequalities and Population Health Management strategies and work programmes, including:

- Developing our JSNA, to expand our analysis on health outcomes and inequalities and evidence how to address them
- Our inclusion health work, driven by a group of partners that seek to improve health outcomes for inclusion health communities
- Community Voices, which builds capacity in our VCSE sector to have conversations about health and care in communities of interest through trusted communicators, providing a mechanism for insights to be gathered to inform future strategy, planning and decision making and improve access to services.
- Developing our Core20plus5 programme, which includes developing key leaders across the system as Core20 Ambassadors to support the implementation of the Core20plus5 health improvement frameworks.
- Continuing to develop projects relating to the NHS role as an Anchor Institution. The legal duty in relation to social and economic develop also refers to this.

It is important that we recognise the role of the Place Boards and HWP's across Norfolk and Waveney in identifying and addressing health inequalities, including the wider determinants of health. This role will be reflected in our strategies and work programmes, with a focus on providing the infrastructure to enable and empower the place-based approach.

Duty to promote involvement of each patient

Norfolk and Waveney Integrated Care System (ICS) supports the delivery of the Universal Personalised Care Model, building on current developments and existing local good practice, particularly around social prescribing, personal health budgets, shared decision making and personalised care and support plans, addressing health inequalities and promoting preventative health and wellbeing models through personalised care. In turn, supporting people to stay well for longer, utilising and encouraging the use of the expertise, capacity and potential of people, families and communities in delivering better health and wellbeing outcomes and experiences, focussing on population health one individual at a time.

Norfolk and Waveney ICS is fostering a new relationship between people, professionals and the health and care system. This change shifts the power and

decision making to enable people to feel informed and empowered to have a voice by working in partnership, connected to being focussed on a positive patient experience through their local communities having choice on control of health and wellbeing outcomes that are important to them.

Norfolk and Waveney ICS strives to involve patients, their families and carers in all decisions regarding their physical, mental and wellbeing health outcomes and shape individualised personalisation. Our aim is for personalised conversations around someone's health and wellbeing to happen at all ages and in all parts of the health and care system, working together with equal voice and influence to achieve the individual's vision and goals.

The strength of personalised approaches is demonstrated through current good practice in maternity services and with our carers as demonstrated in the case study example below, where shared decision-making discussions are documented on a Personalised Care and Support Plan with all the vital information of '*what matters to you'* conversation being entered.

Our whole population can access social prescribing, a standard model of which has been developed by NHS England in partnership with stakeholders, which shows the elements that need to be in place for effective social prescribing to happen. Norfolk and Waveney continue to mature and develop in an all age, whole population approach. There is still work to do, and why a working group has been set up in 2023, where those who have lived experience are invited to participate in developing a sustainable social prescribing model over the next 3 to 5 years.

Personalisation for carers

When a person goes into hospital, it can be a challenging time for their carer. Many carers want to be involved, informed, and continue to provide care. Carers are real experts and know the person they care for well, including complex conditions, learning or communication difficulties or memory loss. They often know about medication, side-effects and how the patient wishes to be cared for.

In 2022, Norfolk and Waveney acknowledged a gap in communication and provision of carers support. A thorough and wide-ranging process of co-production commenced comprising of carers, system engagement leads and chaired by a carers organisation "Carers Voice". A 'Carers Identity Passport' was launched on Carers Rights day (24th November 2022), including 'Carer Awareness training' which has also been developed with experts by experience involved in design and delivery. A Clinician in relations who was part of the co-production work said, *"Thank you to everyone for sharing their experiences, highlighting things that have not gone so well and letting us listen and learn and improve."*

Norfolk and Waveney are making good progress in personalisation and will continue to grow and expand in promoting personalised care with patients, their families and carers at the centre of all discussions about them. Local health and care intelligence highlights there is still work to do in supporting people to self-manage their conditions and non-clinical concerns no matter where they are in a demographic. As a system we will come together to understand how our population would like to do this

ensuring supported self-management and shared decision-making being first option people choose. This will include giving people the right skills and knowledge to do so, through coaching, peer support and educating through collaborative and partnership approach, with patient's voice being heard in decision making and having more choice and control about their health and wellbeing needs.

Duty to involve the public

The Norfolk and Waveney Integrated Care System is passionate about working with people and communities to ensure we all live longer, happier, and healthier lives. The only way we can do this is by working together.

The overarching vision for working with people and communities in Norfolk and Waveney is that all partner organisations will consistently work together, with the public, to share insight and learning. This will maximise resources and ensure that the voice of local people, especially some of our quieter voices that do not always engage with health and social care services, are heard and shared as widely as possible.

Our approach to Working with People and Communities can be read in full or as an Easy Read summary. It has been tested with our local people and partners and will continue to develop and adapt as a working draft, to reflect local aspirations as needed. It received very positive feedback from NHS England when assessed in 2022 and singles us out as a national exemplar for our work with inclusion health groups. You can read the full feedback from NHS England here.

At system level, partners who are working in Communications and Engagement or communities' functions are coming together regularly to join as a system. The Norfolk and Waveney ICS Communications and Engagement Group meets every six weeks and is proving a useful forum for joint working and sharing of insight. Alongside this, the Norfolk and Waveney Patient Experience and Engagement Leads meetings have been taking place weekly for several years and give an opportunity for people working in NHS provider trusts to meet and share practice across the system. They have been a vital opportunity to begin to test and develop the idea of the 'wider team' working with people and communities across the ICS to listen to and involve patient experience feedback in quality and wider commissioning.

The ICS website has become a vital focal point for communications and engagement activity since the ICS was formed in July 2022. It is well designed, easy to navigate and is becoming a trusted source for information or links to information. This website now hosts the people and communities hub for Norfolk and Waveney, which aims to develop and maintain a shared vision in listening to and working with local people across the ICS. It includes live projects from across the system that give local people the opportunity to participate, and helped promote some high level engagement on our priorities for our Joint Forward Plan. The You Said, We Did/We Will/We Can't section is designed to feed back on the difference participation has made, and will be a useful focal point for engagement and co-production around the Joint Forward Plan as it develops.

The ICB Communications and Engagement Team is divided into two key areas - Partnerships and Programmes – that work closely together to ensure that the ICB maintains focus on the strategic People and Communities work as well as offering professional support and guidance for the day to day and transformational work undertaken by the ICB staff. A toolkit has been developed and is being refined to enable communications and engagement to become part of everyone's core business.

The promotion of health equality is a high priority for Norfolk and Waveney, and so communications and engagement links have been developed over the last couple of years with our Health Inclusion Group. This is a multi-agency group that builds on partnership working during the COVID-19 pandemic and includes many ICS partners outside the NHS. Professionals from statutory and VCSE organisations come together to hear the voice of and understand the needs of vulnerable and health inclusion groups and align services accordingly. This group offers grassroots support to work with health inclusion groups to understand what matters to them as part of the people and communities work in Norfolk and Waveney. They help us access the views of some of our quietest voices, such as refugees and asylum seekers, sex workers and homeless and rough sleepers, i.e. people who do not usually come forward to share their views.

To ensure that the voices of people and communities are at the centre of decision making and governance, at every level of the ICS, we have appointed a Director of Patients and Communities to oversee the all the work with our people and communities. The Director is a participant in ICB Board meetings and is a member of the system's Executive Management Team.

A newly formed Patients and Communities Committee meets every other month in public and reports into the ICB Board. The Committee will include lived experience members. A recruitment pack is being developed in partnership with local people and system partners to ensure it is as accessible and open as possible. Lived experience members will then be recruited to the committee which will regularly review and update the ICB's People and Communities approach. This committee will apply the 'so what' principle to the insight received by the ICB to ensure it leads to change. It will also play a key part in monitoring the on-going participation that will take place surrounding the Joint Forward Plan as it is planned and delivered.

Duty as to patient choice

Norfolk and Waveney ICS is committed to ensuring that the patient has the right to choice of GP and provider, is provided with the necessary information to ensure that they are choosing the most appropriate organisation for their specific needs and requirements, and that they are able to take an active part in the decision making process about their care.

Our demographics mean it is very important that we provide realistic options for enabling patient choice, for example for people living in areas of deprivation and in rural areas with limited public transport. We must take this into account when commissioning new services. This means that the location of new services such as

Community Diagnostic Centres and community dermatology clinics for example need to be easy for patients to access with extended opening hours, and that a wider range of services can be delivered closer to home, or, by maximising use of new technology, in the patient's home. The use of Equality Impact Statements when designing new services or reviewing existing ones helps to focus attention on the needs of different patient groups and how best to deliver services that are inclusive and accessible to all.

The ICS is transforming the knowledge repository used by professionals and patients when making a referral or deciding on the next stage of treatment. The current website is being updated to provide more information in Accessible Information Standard formats and in different languages. Updating this will help to ensure that a wider range of patients, and carers, have access to the information that they need to help them make an informed choice about their care.

The knowledge repository also contains details of all the services in the ICS, including community services, voluntary services, and independent sector providers. This is used as the central source for all referral forms, clinical pathway information, and patient information leaflets etc. The updated search facility will make it quicker, and easier for GPs, and patients, to identify the best service for their needs and have the right information available to help patients make an informed choice about their care and treatment.

Some services are not able to offer choice of provider at source, for example, high street optometrists. To ensure that the patient still has informed choice, the ICS commissions a cataract triage service for optometrist referrals. Patients are provided with information such as waiting times, location, opening times, transport options and if there are any clinical restrictions which might limit choice of provider. Patients are contacted by telephone and offered choice of provider and interpreter services used where appropriate. The call handers are also able to identify if patients can use services virtually, and flag to the providers if this is not an option.

The ICS is aware that there are significant numbers of patients who are unable to access digital technology. This means that some patients may not be able to access services such as virtual outpatients or virtual wards. The ICS continues to work with partners to reduce the impact of digital exclusion by ensuring that patients still have a choice to access services on a face-to-face basis and promoting use of "Connect" pilots with the Norfolk Library Service to support digital access.

Elective recovery is one of our eight ambitions and reducing the variation on waiting times across the ICS is part of that objective, through a single waiting list. Many patients may be unaware that they have the right to choose an alternative hospital if the waiting time for treatment is longer than 18-weeks. The ICS has taken a proactive approach by contacting long wait patients to identify if treatment is still required and if the patient would like the opportunity to be seen elsewhere. Specialist call handlers have been commissioned to provide additional support to those patients who require additional assistance with completing the questionnaires and ensuring that all residents of Norfolk and Waveney have a choice of where to be treated.

Duty to obtain appropriate advice

The ICB and its partner NHS trusts and foundation trusts have strong relationships with and significant involvement from clinical and care professionals, including public health colleagues, which enable the organisations to obtain appropriate advice to effectively discharge their responsibilities. This involvement is evident in our Joint Forward Plan, which is based on evidence provided by public health and shaped by the knowledge and experience of a wide range of clinical and care professionals.

Membership of the ICB Board includes the director of nursing, medical director and a member nominated by primary care (currently a GP). The ICB Board also benefits from the input of the director of public health for Norfolk, who is participant in Board meetings. Although this isn't a requirement of the role, the current partner member for NHS trusts is also a registered mental health nurse.

In addition to the ICB Board, clinical and care professionals are involved in the ICB's committees, the boards of our trusts and foundation trusts, our Integrated Care Partnership, health and wellbeing boards, place-based arrangements, the system's Executive Management Team, and in projects and programmes of work.

We have a comprehensive Clinical and Care Professional Leadership Programme to further develop our approach. This is explained in more detail in the System Transformation and Culture section of the JFP. As part of this, the ICB has recently conducted a review of its clinical advisors to ensure the organisation has the right expert advice to effectively discharge its functions effectively.

All of our work with professionals is complemented by research, co-production, engagement, consultation and co-production with local people – this includes the involvement of experts by experience.

Introduction to duties to promote research and innovation

The ICS research and innovation strategy was finalised and published in May 2023. [check for latest update] It sets-out how we will strengthen research and innovation activity across our system – see below for more detail. There are many opportunities locally to embed research and innovation in all that we do. We have great assets, including the University of East Anglia with a large Faculty of Medicine and Health Sciences and a health and care workforce of over 55,000 people.

Duty to promote innovation

Innovation is central to addressing the challenges facing our health and care system. Innovation is a broad term, and to us, means new ways of doing things. This could be a new technology or treatment, a new service or even implementing an existing service in a new setting.

Innovation is a cross-cutting theme within the ICB and across the ICS, and we aspire for it to be integral to everything we do. We wish to ensure that the opportunities for

receiving innovative services are equitable across the ICB boundary and will consider mechanisms to support the adoption and spread of innovations.

Our collaboratively developed strategy will ensure we have actions in place to work together, in conjunction with the Eastern Academic Health Science Network (AHSN), to identify innovation opportunities, promote innovation adoption and spread and ensure equitable access for our population. We will carefully consider innovations to be implemented to reduce the risk that they exacerbate existing health outcomes.

One of our mechanisms to ensure our commitment for innovation will be delivered is through a new and jointly funded role (with Eastern AHSN). The Head of Innovation role will facilitate the introduction of proven innovations in medicine, technology, and care pathways. The Head of Innovation will be fully embedded within the ICS and hence will have the local relationships to understand the most relevant challenges to be addressed. They will also work closely alongside Eastern AHSN to gain access to Eastern's curated pipeline of solutions, which also contains local and national learnings on how to introduce and implement these solutions in a local context. Eastern AHSN will also support the ICS to leverage industry support and investment.

Duty to promote research

Norfolk and Waveney ICS is committed to embedding a culture of research and evidence use for the benefit of our communities and workforce. Health and care research is fundamental to our health and wellbeing. It provides the evidence base which underpins how services are designed and delivered and helps us to tackle unequal health and care outcomes.

The ICB has a dedicated research and evaluation team which supports research and evidence use within the ICB and across the ICS. Board level representation is via the ICB Medical Director, ensuring research has visibility across the Executive Team.

Core R&D functions are provided by the research and evaluation team for primary and community care and non-NHS settings, including care homes, working in partnership with the Clinical Research Network for the East of England (CRN EoE). The team also works collaboratively alongside R&D offices within the three acute trusts, the ambulance service and the mental health trust. These collaborative working arrangements will continue.

Five of our NHS trusts and the ICB are full members of UEA Health and Social Care Partners, which also includes Norfolk County Council. The partnership facilitates collaborative, practice-led research, linking frontline staff with academic researchers, seed-funding early collaborations and maximising the impact of research across our system.

NWICS Research and Innovation Strategy 2023-2028

The strategy is being developed via a series of collaborative workshops with patients and the public, our partner trusts, primary care, the National Institute for Health and Care Research (NIHR) infrastructure partners, VCSE partners and higher education institutions. It will set out how we will ensure that research and innovation is focused

on our communities, that we have a confident and capable workforce, that research and innovation is collaborative and coordinated and that evidence is incorporated in the commissioning and delivery of services and infrastructure.

We will engage with NIHR supported research networks and infrastructure located in Norfolk and Waveney and the East of England, such as the Clinical Research Network, Research Design Service, Applied Research Collaboration and the Norfolk Clinical Research Facility, so as to leverage expertise and resources and facilitate access to research for our workforce and communities.

We will develop a rolling programme of public participation involvement and engagement activities to disseminate information about research, working towards ensuring our research is reflective of the communities we serve.

Duty to promote education and training, and other information about our workforce plans

#WeCareTogether, the Norfolk and Waveney People Plan

#WeCareTogether, the Norfolk and Waveney People Plan for 2020-2025, sets-out our ambition for the Norfolk and Waveney system to be best place to work. We are currently refreshing the plan looking forward to 2028. It is important that we take account of our experience of the pandemic, and that our People Plan accurately reflects our new reality and updated national guidance for the NHS, social care and volunteer workforce.

#WeCareTogether refresh

We know that the vacancies, staff absence and turnover rates for people working in health and care have remained the same or worsened for some areas since 2020. Our refresh of #WeCareTogether will take a structured and collaborative system approach to build capacity, capability, competencies, career structures and the infrastructure towards creating a ‘One Workforce’ approach across our ICS. Our provider partners are also refreshing their local plans, and through our People Board infrastructure and networks, we will utilise the principle of subsidiarity to streamline transformation at the right place and at the right time.

A priority focus in 2023/24 will be to continue to build on the existing work underway and incorporate these activities into the broader strategic priorities for the ICS. We will ensure our plan is evidence-based and closely aligned to finance and activity planning as set out in our operational planning submission.

Our planning is informed by the work the system has done with a range of organisations. Insights and recommendations from Viridian and the Boston Consulting Group will support a focus on efficiencies, particularly for reducing how much we spend on bank and agency staff. The work we have undertaken through the Improving Lives Together programme on our corporate HR services will similarly aim to improve quality and the experience for our workforce, whilst also making sure

we use the system's resources efficiently. This is one of our eight ambitions, Improving Productivity and Efficiency.

The 10 ICS People Function Outcomes

The 10 ICS People Function Outcomes are set-out in 'Building strong integrated care systems everywhere: guidance on the ICS people function'. In all areas of transformation, we will take a long-term view using evidence-based modelling to re-design routes into careers. This will help to create a workforce who are trained not just clinically, but who also have a greater understanding of population health and inequalities, so that staff treat the whole person with both compassion and care.

This work will include updating the way we attract and retain staff, refreshing education programmes (including lifelong learning and quality improvement), changing the shape of existing services and developing new ones, and using technology to take over tasks (not jobs) to release capacity. The activities below will form a key part of the delivery plan to achieving an integrated workforce across health and social care, and will be incorporated into the #WeCareTogether refresh.

Here is a summary of how we are working towards the 10 ICS People Function Outcomes:

Supporting the health and wellbeing of all staff

We know that if people feel safe and supported with their physical and mental wellbeing, they are better able to deliver excellent health and care. Over the last three years, individual employers and as a system, we have supported the physical and mental health of our staff, as well as the social and financial wellbeing needs of our workforce. The national restoration requirements for the NHS and more recently industrial action mean that, alongside our current workforce vacancy levels and system flow challenges, people's wellbeing continues to be impacted. Low morale, attrition from learners, burn out and moral injury are growing challenges which we must recognise and address openly across health and social care.

We know there is an urgent need to do more for our people and our ICS Health and Wellbeing Group will continue to challenge, innovate and promote equitable offers for our whole workforce. We have also worked with partners to update policies, procedures and access for health and wellbeing support; embraced a culture of flexible working arrangements; initiated financial support schemes through Vivup; and offered trauma based coaching programmes for front line leaders. System support has included the establishment of a Mental Health Hub and COVID-19 service for our health, social care and VCSE workforce.

Growing the workforce for the future and enabling adequate workforce supply

Our integrated workforce planning approach is multi-faceted and relies on each of the 10 People Function Outcomes converging. Working with health and social care partners to 'check and challenge' plans, we will identify system level opportunities and challenges, streamline our approaches to recruitment and retention, develop an at scale attraction plan for core roles such as nurses, allied health professionals and learners, to ensure education pathways are fully subscribed and talent retained in our system. Our role as an anchor institution will focus on widening participation,

recruiting for values and experience, and supporting people to develop core skills and competencies ‘on the job’.

Supporting inclusion and belonging for all, and creating a great experience for staff

The Norfolk and Waveney culture for inclusion continues to develop, but we recognise there is much more to do over the coming years so that our people may thrive and develop in compassionate and inclusive environments. The last Workforce Race Equality Standards (WRES) report for the ICS has highlighted significant challenges for our staff from ethnic minority backgrounds, centring around harassment, bullying or abuse from patients, relatives, the public and other staff. It also highlights higher than average levels of discrimination for these staff from a manager/team leader or other colleagues in last 12 months. The WRES does also highlight areas of best performance being career progression in non-clinical roles (lower to middle to upper levels).

Anti-racism

Over the last 12 months we have worked as system to deliver the NHS East of England Anti--Racism plan. We have developed a de-biasing of recruitment toolkit which is now being implemented through a train the trainer model to providers; developed and matured staff networks across protected characteristics; and increased our approach to education and knowledge through the launch of our Equality, Diversity and Inclusion Resource Hub, which is open to both the workforce and the public. We launched our ‘Stop the abuse’ anti-bullying campaign in May this year. EDI Resource Hub - Norfolk and Waveney ICS (improvinglivesnw.org.uk).

Widening our EDI lens

We recognise that in addition to racism, the ICS needs to focus this year in particular on women, age and the impact of inequalities for our coastal populations. Our ambition is to bring together the pillars of health inequalities, population health management and workforce so that we can consider this cultural transformation wholistically. This will form part our ICB Change Programme, so that we ensure as an organisation, our infrastructure enables us to work with system partners and our local communities to tackle some of our biggest challenges, including racism and inequalities.

Creating a great experience

The NHS staff survey has highlighted three key themes of safety, recognition and compassion. Staff experience is an organisational responsibility but as an ICS we are committed to ensure that our ‘one workforce’ ambition allows us to work with partner organisations to agree some core principles for staff experience. The staff survey reports that we need to focus more on safety, recognition, and compassion, and we will work though our networks to identify opportunities for collaborative ways to improve in these areas.

Valuing and supporting leadership at all levels, and lifelong learning

We will continue to invest in leadership and management development programmes, mentorship opportunities and other initiatives to support the growth and development of our staff right across the ICS, particularly to ensure our leaders are representative

of the workforce and population we serve. The health and wellbeing of our leaders will be a core thread of all programmes to ensure people have the tools and support to remain resilient.

Leading workforce transformation and new ways of working

Our #WeCareTogether refresh will include a spotlight on driving efficiency through our HR teams through automation of processes and by streamlining our teams. This, alongside the ICS Digital strategy, will enable service redesign through new ways of working, making the most of people's skills and time, and the better use of technology.

Educating, training and developing people, and managing talent

We will work closely with educational providers supporting our medical and non-medical learners, to ensure programmes are reflective of local plans. We shall also work and listen to learners to ensure consistency and quality of experience during training and having regular careers conversations to support individuals to wish to remain working in our system after they have completed training.

Driving and supporting broader social and economic development

As the largest "employer brand" in Norfolk and Waveney, our health and social care organisations collectively employ the largest number of staff in Norfolk and Waveney. As such the ICS takes its responsibility as the largest employer seriously to create a vibrant local labour market, promote local social and economic growth, and to work to address the wider determinants of health and inequalities. Investment in Anchor Institutions locally provides us with unique opportunities to accelerate this ambition over the next few years. Working with UEA, we are taking a research-led focus on recruitment, retention and continuous development of our clinical workforce. Working with East Coast College we are actively co-designing as a system a holistic offer to local residents to widen participation into health, social care and voluntary sector roles.

Transforming people services and supporting the people profession

The Future of HR and Organisational Development Framework, alongside the ambition to Improve Productivity and Efficiency, will enable us to develop a multi-year plan for new ways of working to maximising resources, efficiencies and staff experience. This will include how we recruit, train, develop careers and take care of our people through occupational health and other wellbeing offers.

We will continue our commitment to identifying opportunities to integrate workforces. We will take a systematic and collaborative approach to workforce analysis, reviewing service delivery models, identifying areas of overlap, engaging with staff and stakeholders, developing multi-professional teams and implementing workforce integration strategies.
We will build the infrastructure, and develop our systems and processes, to embed the changes to enable our people to work seamlessly across the system.

Leading coordinated workforce planning using analysis and intelligence

Our NHS provider workforce planning submissions this year have been collated and show the NHS ambition for workforce growth in 2023/24 to deliver operational priorities aligned to finance and activity. Plans are ambitious and centre on

significant growth in the number of staff in post in registered nursing and those roles providing support to clinical staff. This is also referenced in the 2023/24 immediate priorities section of the JFP.

We recognise that this in isolation is not enough, and as such, we are working as a system to develop an evidence-based, integrated and inclusive workforce planning approach. This will include the way in which we commission education programmes, the importance of retention and career development of our medical and non-medical learners, and it will underpin our ambition to reduce agency and bank spend.

We have identified several workforce priorities for the next five years, such as 'over recruiting' to key roles at system level to achieve greater month by month net gains, growing the assistant and associate roles, and acting fast to build a pipeline of younger people (18 years plus) coming into health and care roles.

We note that while the system is intrinsically linked, core values are aligned and work is underway to support the 'one workforce' agenda, there are distinct differences across health and social care which need to be acknowledged and navigated, as these can act as a barrier to fully integrated working. For example, the number of small to medium sized enterprises in the social care market makes the transformation at scale seen in the NHS much harder, and so we will work closer working with Norfolk and Suffolk County Councils to centrally attract and provide opportunities to retain our social care workforce.

Supporting system design and development

Our approach to delivering this outcome is set out in section 5.5 of our Joint Forward Plan about people and culture.

Duty as to climate change

Climate change poses an existential threat to the whole planet and Norfolk and Waveney is not immune from its consequences. Taking decisive action to reduce our contribution to climate change will save lives, improve people's health and benefit health services.

The organisations responsible for health and care in Norfolk and Waveney have made significant steps towards more sustainable ways of operating. Our system's Green Plans take this further, establishing the bedrock for achieving Net Zero, and meeting the commitment set out in the Climate Change Act 2008 and the Environment Act 2021.

Our Green Plan for the Norfolk and Waveney Integrated Care System sets out how the NHS will work together and with system partners towards Net Zero, by sharing best practice, collaborating and holding each other to account. This has been referenced in each of the ambitions in our JFP. By working together to deliver our Green Plans, we will deliver against the targets and actions in the 'Delivering a Net Zero NHS' report, as well as the four core purposes of an integrated care system by:

- **Improving outcomes in population health and healthcare:** Adopting activities and interventions which slow the associated health impacts of

climate change will help to improve population health, for example by reducing the number of heatwave-related excess deaths and the number of pollution-related respiratory illnesses.

- **Tackling inequalities in outcomes, experience and access:** Supporting action to address poor air quality, which disproportionally affects vulnerable and deprived communities through higher prevalence of respiratory illnesses, will help to tackle health inequalities. Through their transport strategies, the county councils aim to reduce local air pollution as well as transport-related carbon emissions and to encourage active travel for both carbon and health reasons.
- **Enhancing productivity and value for money:** Improving energy efficiency and using renewable energy sources across the ICS estate footprint will reduce long-term energy bills for the NHS and local councils.
- **Helping the NHS support broader social and economic development:** Ensuring all NHS procurements include a minimum 10% net zero and social value weighting will help to achieve this, as will adhering to future requirements set out in the NHS Net Zero Supplier Roadmap. Council procurements similarly place emphasis on reducing scope 3 carbon emissions and both the NHS and county councils require that bidders for contracts valued at over £5m per annum have a carbon reduction plan in place.

Governance

Our system ensures that appropriate board-level oversight and accountability of priorities are clearly stated by setting out management arrangements in the Green Plan. The ICS Green Plan is co-ordinated through the ICS Estates team and delivered by the ICS Green Plan Delivery Group. The group membership is made up of focus area subject matter experts from across the ICS and ICB, and Green Plan leads from member organisations.

The system's Green Plan meets the requirements for ICSs as set out by the NHS. Significant engagement with public sector colleagues is bringing the system's Net Zero process into alignment with the wider work of the Norfolk Climate Change Partnership and the Suffolk Climate Change Partnership, to create close collaboration on the net zero.

The ICS Net Zero green plan delivery group's role is to maintain the plan through working with member organisations, ensuring Government, NHS and local Net Zero ambitions are met.

Monitoring of progress against the system action plan and objectives is co-ordinated by the ICS Estates team, with regular input from focus area leads, subject matter experts and member organisation leads. Progress reports are provided via frequent updates and data collections and are monitored via the ICS Green Plan Delivery Group. These feed into ICS Programme Board meetings and Executive Management Teams accordingly. Each county council reports progress on its respective climate commitments to its elected members.

Annual reporting (introduced from 2023), identifying movement in carbon emissions, programme progress and our journey towards Net Zero ensures the Executive Management Team of the ICS remain sighted on the plan and action required. The update of the operating plan highlights the planned focus and deliverables for the upcoming 12-month period. Both county councils have published dashboards showing their progress in reducing carbon emissions.

We will utilise all national data collections, and build on local benchmarking and analysis practices, to measure and report our success to stakeholders.

Collaboration

Our system's Net Zero Green Plan provides the ICS with a co-ordinated and strategic approach to the net zero programme and sets out how we embed, respond to, and deliver the NHS net zero ambition. The plan sits alongside, and complements individual organisations' plans and focuses on enabling without duplicating, achievement of Net Zero together. The plan identifies key areas to focus on over the next three years, and initiates action around what we will do, and are already doing, to respond to the environment and climate emergency.

The system works with partners to reduce system-wide emissions, including local authorities and the voluntary, community and social enterprise (VCSE) sector, patients and the public. The Norfolk Climate Change Partnership and the Suffolk Climate Change Partnership support local government in Norfolk and Waveney to deliver Net Zero objectives and their objectives align well with the NHS Net Zero ambitions. This programme of work is integral to our forward plan to reduce impacts on the environment and embed a 'one public estate' approach that positively impacts our journey toward net zero.

The Integrated Care Board has moved into Norfolk County Council's headquarters, helping to share the building's carbon footprint as well as encouraging collaboration. Joint procurement is driving carbon reductions in our supply chain. For example, joint procurement of the integrated community equipment stores for Norfolk and Waveney involving the ICB and both county councils resulted in a new contract with a carbon reduction plan that includes reducing delivery mileage through more-efficient routing; the phased introduction of electric vans; a move into a more-energy-efficient warehouse; and a range of measures to reduce the contractor's Scope 3 emissions.

Workforce and Resources

We cannot deliver our Net Zero ambitions without our workforce. It is therefore vital that the system continues to inform, mobilise and train our staff so that they have the knowledge and skills required to help us on our journey. Net Zero is a priority and, accordingly, is led at Board level by the Director of Finance.

The system is engaged with the regional Greener NHS team and neighbouring ICSs to learn and share ideas and best practice. Through the green plan delivery group work the subject matter experts and sustainability leads collaborate to develop enable ICS Green Plan and Operating plan delivery. Existing pilot programmes for

green initiatives are captured to harness their benefit to enhance positively, impacts on climate change and the environment.

The system has recruited resource to lead the delivery of ICS and organisations' Green Plans. These leads work collaboratively in the development and scaling of pilots and programmes that enable our net zero ambitions.

An ambitious programme of training has been identified to upskill the workforce at all levels, through use of best practice carbon literacy, to grow the knowledge and capacity to address the climate emergency. The ICB and Norfolk County Council have agreed to pursue joint carbon literacy training for senior executives across the system.

As part of our communications and engagement programme, the NHS workforce is supported by pledge platforms and incentives to inspire contribution from all.

Adapting to the impact of climate change

There is a time lag between cause and effect in the climate system, which means that we will continue to be affected by past emissions for years to come. Consequently, adapting to the impacts of climate change is important for business continuity. Strategies to adapt to climate change are therefore part of local planning and decision making, bringing multiple benefits to the physical and mental health of the Norfolk and Waveney population.

Taking action on adaptation will improve the resilience of our services and the communities they serve, lessen the burden of illness and disease, and reduce health inequalities. Adaptation also means developing positive networks and sound communication between organisations and local communities, encouraging self-service and the resilience of local communities. Local action on adaptation will support requirements of the Public Health Outcomes Framework.

Norfolk and Waveney already experiences the effects of considerable coastal erosion, and is subject to many flood areas associated with increases in sea levels. Many of the impacts of climate change, including those for health, will be felt locally. Therefore, the system needs to develop responses which encompass national guidance and yet are specific to our local circumstances. The system's Green Plan sets out the approach to mitigating climate change emissions from our activities and ensuring business continuity in a changing climate and includes a focus on increased readiness for changing times.

Both county councils have broader responsibilities for adaptation. These include steps to promote nature recovery, mitigate flooding and support sustainable development.

Addressing the particular needs of children and young people

leadership has been identified in health and social care to drive forward the agenda and to ensure that the voice of children, young people and families is represented at the most senior level. The Children and Young People's Strategic Alliance Board

provides oversight and assurance and is underpinned by thematic sub-groups leading on priority workstreams.

The voice of children, young people and their families

We have invested in a participation and recovery model to ensure that transformation of services is co-produced and enables children and young people to hold us to account through strong and well-established forums. This enables children and young people to be heard by those who commission and deliver services in both Norfolk and Suffolk. We also have well-established parent carer forums to ensure the voices and needs of parents and carers are included in our planning and delivery of support.

Next steps will be to increase our reach into communities who are seldom heard to ensure that the experience of all our communities are captured and help to shape the future support to ensure the best start in life.

Data and insight

Our system approach, and the ongoing monitoring of its delivery, will be increasingly informed by data and evidence. We are developing a systematic whole-partnership monitoring framework alongside the FLOURISH outcomes, to enable the Strategic Alliance to track progress against each outcome, and as a whole, using data and evidence.

This will enable system understanding and oversight of where babies, children and young people are waiting to access care and support, and to inform our focus areas for recovery including access to mental health support, diagnostic delays, workforce information and an ability to focus system resource to the greatest areas of need.

Reducing health inequalities

The CORE20Plus5 approach (described in the 'Duty to reduce inequalities' section) will support us to ensure that healthcare inequalities improvement is built into our strategies, policies, initiatives and programmes.

In addition to those areas identified within Core20PLUS5, our Flourish strategy identifies four priority areas for system focus:

- Prevention and early help
- Mental health and emotional wellbeing
- Special Educational Needs and Disabilities (SEND)
- Addressing gaps in learning following the pandemic

Family Hubs

Norfolk and Waveney system partners will further develop the Family Hub model and this is an objective within the Improving Services for Babies, Children and Young People ambition.

Safeguarding

All systems have a statutory duty to safeguard. The Designated Safeguarding and Looked After Children teams influence, advise and support us to ensure it accords with the principles of the Children Act 1989 and is aligned to the Norfolk and Suffolk Safeguarding Children Partnership and priorities. The Teams ensure health and care services meet the statutory requirements of Section 11 of the Children Act 2004. The priority is to ensure 'safeguarding is everyone's' business' and remains at the heart of service delivery.

Our safeguarding teams work in collaboration with all partners in Norfolk and Waveney in the early identification of children at risk, including risk of exploitation, and recognition of all types of abuse and non-accidental injury promoting the needs of looked after children, those within the youth justice system and unaccompanied asylum seekers. Integrated working will support colleagues to work and communicate effectively across organisational boundaries, to ensure safety and provide child-centred care.

Safeguarding teams support information sharing and provide training to recognise presentations that are safeguarding relevant primary care through training to help GPs to prioritise safeguarding relevant meetings, and to efficiently complete requested reports and this will be further strengthened by the development of Family Hubs which will be vital in the development of early intervention and prevention.

Going forward our teams will drive greater integration through matrix working and multi-agency collaboration. Digital solutions to enable safeguarding information to be disseminated will be further developed and sharing data will be integral to the partnership approach.

Safeguarding professionals will advocate for babies, children and young people, and champion early intervention and prevention services to avoid long term damage that has implications across society. We aspire to be a trauma informed system, recognising the importance of the early days of a child's life and development, and impact of adverse childhood experience on long term health and economy.

Continuing care for children and young people, including palliative and end of life care

The Council for Disabled Children describes a vision of a society in which "children's needs are met, aspirations supported, their rights respected, and life chances assured" (https://councilfordisabledchildren.org.uk/about-us). This underpins the work of our Children and Young People's Continuing Care Team where the aim is to achieve "gloriously ordinary" lives for the babies, children and young people.

Continuing care packages are required "when a child or young person has needs arising from a disability, accident or illness that cannot be met by existing universal or specialist services alone" (NSF for Children and Young People's (CYP) Continuing Care 2016, p5). Unlike adult continuing healthcare packages, which are entirely NHS funded, these packages can be jointly funded with education and social care and are very complex.

Norfolk and Waveney ICB currently offer two main approaches to the provision of continuing care – either a personal health budget (PHB) or a commissioned package of care, delivered by one of five agencies procured specifically for care of children.

Palliative care is a low volume, but significant part of the care delivered to babies, children and young people with continuing care needs. Our fast-track system in place complies with statutory guidance.

Partners have developed joint commissioning and quality oversight arrangements to ensure that all agencies are working together to meet the holistic needs of babies, children, young people and their families. We collaborate with regard to quality assurance and improvement and work together to develop provision closer to home.

Special Educational Needs and Disabilities (SEND)

The Children and Families Act 2014 is a statutory framework for the integration and personalisation of services for children and young people that require education, health, and care services. To fulfil this statutory duty, we work collaboratively with children and young people with SEND and their families, alongside education and social care services to provide the right support. This must be using the key principle of co-production and be person centred.

This includes identification of children and young people with SEND and to support them to access everyday activities with the right support and adjustments. We share support and resources across agencies for those on NHS waiting lists and skilling-up those working with children and young with key neurodevelopment difficulties, such as autism. We are committed to developing the wider workforce on key areas of SEND and to support workers to understand their duties and responsibilities. Children and young people with SEND are a vulnerable group and work will continue to drive equity of services and resources by raising awareness of the need and duty on services to make reasonable adjustments.

There will be key contact points across the health system to provide communication and support for children, young people and their families on health pathways. This will ensure families, young people and those working in education and the care system know where to go to get NHS health advice and resources.

We will continue to ensure that there are opportunities for children, young people and their families to contribute to service development and to ensure their lived experience is heard and understood.

There is a programme to review and improve health pathways. Publications on local websites and Just One Norfolk will also be reviewed and improved.

Working with local authorities and wider stakeholders, we will further develop the SEND annual survey, increase the survey response rate and disseminate the learning to further influence commissioning.

Joint quality assurance visits will take place into complex needs schools to further strengthen quality improvement and build confidence within settings to manage heath/medical needs.

Work is underway to strengthen the use of shared data and analysis to inform commissioning of services for children and young people with SEND.
We aim to have a multi-agency SEND training platform that is accessible to all stakeholders, including children, young people and their families.

We will develop a shared understanding and vision across children, young people and adult commissioning to ensure SEND is seen as everyone's business.

Partnership working will be strengthened through the SEND Partnership board, multi-agency working, and we will feed in regional and national systems to develop innovations and initiatives.

System partners will work together to develop high quality information and support for children and young people with SEND, so that they know what can be accessed, what they can do to self-serve and to signpost to the most appropriate service when it is needed.

We will work as a system to become needs led and not medical and diagnostic driven and we will build confidence in the services and resources available by celebrating difference and individuality.

Autistic Spectrum Disorder (ASD) and Learning Disability (LD)

Individuals with Autistic Spectrum Disorder (ASD) and Learning Disability (LD) face significant health inequalities compared with the rest of the population. The NHS Long Term Plan states a commitment for the NHS to do more to ensure that all people with a learning disability, autism, or both can live happier, healthier, longer lives. This means that we must provide timely support to children and young people and their families and ensure health and care services are accessible and make reasonable adjustments.

As part of the system commitment to improving quality and outcomes through the learning from deaths process, we will continue to contribute to the Learning Disabilities Mortality Review Programme (LeDeR), to ensure that health improvements can be targeted to those areas which will have the biggest impact. Working as a system, we will aim to meet emerging need early.

Children and young people's mental health

We aim to prevent mental illness, early identification of need and the promotion of initiatives that increase resilience to ensure children and young people are supported earlier around their wellbeing needs and reduce the burden on specialist mental health services in the future. Priority areas of focus include:

- Increasing access to mental health services through the Talking Therapies Collaborative to deliver an integrated service offer from VCSE sector and

independent partners, where therapeutic care can be accessed from a range of providers.

- Providing early support in schools through Mental Health Support Teams
- By 2030 we aim to have 100% coverage of mental health support teams across all schools in Norfolk and Waveney and we will adopt a whole family approach to meeting mental health needs across Norfolk and Waveney, with a focus on communities and primary care.
- Providing 24/7 assessment and care to children and young people presenting in a crisis through an Integrated Practice Model, bringing together system partners to support children and young people with complex needs that present in crisis.
- To support early intervention and prevention, we will develop an all-age social prescribing offer ensuring that access to positive activities that improve wellbeing is tailored and accessible to all.
- Building on the use of the Just One Norfolk Platform and Kooth, we will develop a digital strategy ensuring all CYP have access to self-help resources and information about resources and support within Norfolk and Waveney.
- Working with the Anna Freud Centre, The Charlie Waller Trust, The National Children's Bureau and NHS England, we will co-produce, deliver and evaluate a whole system mental health training offer for the wider children's workforce.

Through the Strategic Alliance, decisions are made at a system level and challenges within the system are discussed and resolved in collaboration. To support the integration of services we are launching an integrated front door for all emotional wellbeing and mental health services, providing a trusted assessment and onward referral to the most appropriate service. The integrated front door is an objective within the Transforming Mental Health Services ambition in the JFP.

Local Maternity and Neonatal System (LMNS)

The LMNS brings together the NHS, local authorities and other local partners with the aim of ensuring women and their families receive seamless care, including when moving between maternity or neonatal services or to other services such as primary care or health visiting.

Alongside this, NHS England will publish a single delivery plan (SDP) for maternity and neonatal services in Spring 2023 from which the recommendations will be implemented.

We will continue to focus on addressing exclusion and inequalities. The LMNS has undertaken analysis of the needs and characteristics of its communities and has published an action plan to address these (Norfolk and Waveney Maternity Equity and Equality action plan).

The LMNS will continue to put in place the infrastructure needed to enable rollout of Midwifery Continuity of Carer, so it is the default model for all women and so that 75% of women of Black, Asian and Mixed ethnicity and from the most deprived neighbourhoods are placed on pathways.

Addressing the particular needs of victims of abuse

The ICB is committed to working with all partners across Norfolk and Waveney to consider the needs of and provide support to victims of abuse (including victims of domestic abuse and sexual abuse, both children and adults).

We have important arrangements in place in Norfolk and Waveney for partnership working on this agenda:

- The ICB is an active member of our two local Community Safety Partnerships:
    - Norfolk County Community Safety Partnership (NCCSP), which sits under the jurisdiction of the Office of the Police and Crime Commissioner for Norfolk (OPCCN).
    - East Suffolk Community Partnership (ESCSP), which is hosted by the Suffolk County Council.
- The ICB is represented on the Norfolk Domestic Abuse and Sexual Violence Group (DASVG) by the Adult Safeguarding Lead (who represents the health sector).
- The Adult Safeguarding Lead also chairs the Norfolk and Waveney Domestic Abuse and Sexual Violence Health Action Forum sub-group of the DASVG, and the sub-group tackling Honour Based Abuse, Female Genital Mutilation and Forced Marriage.
- The ICB is represented by the Safeguarding Teams at the DASVG's Adult and Children's sub-groups.
- The ICB has strong links with the OPCCN and the Norfolk Integrated Domestic Abuse Service.

Here are some examples of the work we are doing as a system in Norfolk and Waveney, and ways in which the ICB is delivering against its duty to address the particular needs of victims of abuse:

- The ICB undertook a stocktake review of health services and responses to domestic abuse and sexual violence, in the summer of 2022.
- With system partners, the ICB signed-up to and widely promoted the HEAR campaign – Norfolk County Council's commitment to zero tolerance of domestic abuse in the workforce.
- There are appropriate policies in place in large NHS organisations.
- A template policy has been created for primary care and dedicated domestic abuse training sessions have been held for Lead Safeguarding GPs.
- There is full and active engagement with the Domestic Homicide Review process, that also coordinates and supports the engagement of providers of health services.
- The ICB led work to ensure our three acute hospital trusts provide monthly anonymised assault data, as per the NHS Digital 'Information Sharing to Tackle Violence Minimum Dataset ISB1594'.

- The ICB commissions a range of health specific pathways within a portfolio designed to support children and young people who are victim to serious violence. This includes but is not limited to: talking therapies for victims of and witnesses to sexual violence, trauma informed mental health provision and targeted support for children exposed to and at risk of displaying harmful sexual behaviours.
- The ICB also engages with relevant Suffolk workstreams, in tandem with NHS Suffolk and North East Essex ICB Safeguarding Leads.

The Serious Violence Duty

In December 2022, guidance on the Serious Violence Duty was published by the Home Office. The 'lead' authority for meeting the Serious Violence Duty in Norfolk is the Office of Police and Crime Commissioner, while in Suffolk it is the county council. Each lead agency has convened a partnership group that the ICB attends through its Safeguarding Adult and Children and Young People's Teams.

In line with the duty and the guidance, the ICBs is undertaking a strategic needs assessment and producing a plan to tackle 'serious violence' with partners such as local authorities and the police. The definition of 'serious violence' includes domestic abuse and sexual offences.

This work is being further supported by Crest Advisory, who have been commissioned by the Home Office. There will be two phases of support: Phase 1 is a readiness assessment designed to understand the preparedness of local areas to comply with the Serious Violence Duty, and Phase 2 is tailored support that will be based on the findings of the readiness assessment. The ICB's Adult Safeguarding Lead is engaged in the readiness assessment workshops being held in the first and second quarters of 2023.

The strategic needs assessment and publication of the two local strategies must be completed and published by 31 January 2024.

The ICB is committed to engaging in the regional led scoping and mapping exercises and attending the relevant events being hosted to support the implementation of the duty. This will support us to plan and deliver preventative action and a focus on training, data collection and analysis.

Services commissioned by the ICB that fall within the scope of the NHS Standard Contract must comply with the Domestic Abuse Act 2021 and associated guidance from April 2023.

Implementing any joint local health and wellbeing strategy

The Norfolk and Waveney Integrated Care System covers the whole of Norfolk and part of Suffolk. As upper-tier local authorities, Norfolk and Suffolk each have their own joint health and wellbeing strategy:

- Norfolk's Joint Health and Wellbeing Strategy (which is also the Integrated Care Strategy for Norfolk and Waveney)

- Suffolk's Joint Health and Wellbeing Strategy

There is close alignment between the priorities in the Norfolk strategy and the cross-cutting themes in the Suffolk strategy:

Norfolk priority	**Suffolk cross-cutting themes**
Driving integration	Greater collaboration and system working
Prioritising prevention	Prevention: stabilising need and demand
Addressing inequalities	Reducing inequalities
Enabling resilient communities	Connected, resilient and thriving communities

The JFP is a delivery mechanism for these local Health and Well-Being Strategies and the Norfolk and Waveney Integrated Care Strategy is specifically referred to in Section 1.2 of the JFP.

We are committed to supporting the implementation of both strategies and the Joint Forward Plan sets-out how health services in Norfolk and Waveney will do this. We have involved both health and wellbeing boards in the development of our JFP, asking for their views on the draft document and including their opinions in the document. There is further detail in the JFP about how our eight ambitions align to both Strategies.

We will continue to involve the health and wellbeing boards through the annual refreshing of our JFP (and if we choose to update the plan mid-year). As part of the development of the ICB's Annual Report, the organisation will report to the health and wellbeing boards how they contributed to delivering the priorities in each joint health and wellbeing strategy.

Other content

Digital and data

We are committed to investing in and using technology to improve people's health, wellbeing and care. Our Digital Transformation Strategic Plan and Roadmap sets-out how we will digitise services and connect them to support integration. This will enable new ways of working that can increase efficiency, improve patient experience and outcomes, plus reduce workforce burdens, and help to address health inequalities.

The plan and roadmap are in line with 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.

The digital plan and roadmap are a key enabler to the delivery of the eight ambitions in the JFP. Each ambition is co-dependent with digital and our plans for improvement are consistent so we can ensure all our efforts are joined up and focused in the right areas. You can read more about this within the ambitions as we have mapped the dependencies across to all the relevant ICS strategies to show them in more detail.

This diagram sets-out our vision and strategic priorities for Norfolk and Waveney:

Using digital systems, we will:

- Enable people to access their health and care records securely, quickly and when they want to see information or data.
- Support clinical and strategic decision making through technology, providing health and social care organisations who deliver care access to relevant, accurate and up-to-date information.
- Improve system wide IT services to increase safety and people's health and care experiences, whilst reducing duplication and waste.
- Support and empower people to maintain their health and wellbeing through digital solutions.
- Enable health and care staff and services to provide the best care in all settings, particularly via the use of mobile technology.
- Ensure personal health and care information is kept safe and secure.

- Invest in the infrastructure and technologies needed to help drive improvements to services and provide better care.

Our roadmap details the key milestones for 2022-26:

Estates

Add Hyperlink and review this section: Estates Strategy

Our Estates Strategy sets-out how we will create stronger, greener buildings, enable smarter, better health and care infrastructure, and use system resources fairly and more efficiently. It is based on extensive engagement, and a review of clinical strategies and investment requirements across the ICS.

The vision in our five-year strategy is of providing estate that allows delivery of the right care in the right place, enables better patient outcomes, and empowers health, social care and third sector staff to provide the best possible care.

Our strategic estate objectives are:

- **Improving Access** – Ensuring that the right services are delivered in the right place, matching demand and capacity, delivering multi-disciplinary working in 'Places' and 'PCNs'.
- **Improving Quality and Condition** – Providing safe, flexible, modern, and fit-for-purpose estate and supporting services for our patients, visitors, and staff.
- **Improving Sustainability** – Implementing interventions to decarbonise our estate and reduce carbon emissions arising from our buildings, infrastructure, and services.
- **Improving Efficiency** – Providing a right sized estate and supporting services that deliver value for money and long-term financial sustainability.

During 2023 – 2024, the development of detailed delivery plans will demonstrate the programmes of work and investment to implement our Estates Strategy. The ICB's strategic estates team provides leadership through an integrated programme of planning, improving and adapting the estate to support and enable health and care services to meet the needs of the Norfolk and Waveney population.

Development and use of the Health in Planning Protocol will continue to manage and underpin NHS engagements with the planning process and the development of our communities across Norfolk and Waveney, enabling us to plan sufficient facilities for the delivery of health services.

Systemwide, Person-Centred Estate

We have a significant part to play in supporting and enabling the delivery of a system-wide person-centred estate that serves the needs of all its users, enhancing both patient and staff experience. We will enable the integrated care strategy by:

- Developing a collaborative and joined-up approach across the NHS to estates and facilities service provision, ensuring our assets enable integrated accessible services.
- Ensuring that our estate supports the provision of preventative models of care.
- Working with local planning authorities and public health to ensure their programmes of work and ours are linked and we cooperatively help people live in healthy places, promote healthy lifestyles, prevent ill-health and reduce health inequalities.
- Support delivery of specialist housing programmes that enable people to remain independent and reduce demand on services.
- Enabling relocation of services closer to areas of high need, where clinically appropriate, and supported by investment decisions.
- Reducing the negative impact of wider determinants of health by providing equitable access to care.
- Delivering our Net Zero Green Plan to reduce our carbon footprint and emissions, and tackle the negative impact this has on health and our communities.

Managing the Estate Portfolio

We have established a robust governance process for a systemwide estates team which will enable collaborative working at a system level and make investment decisions for the benefit of the system and our population as a whole. The Estates workstream links operationally to the ICS Executive for its direction through its Senior Responsible Officer.

The Estates Programme Board is an enabling service function within the ICS. Its main role is to bring key system partners together to develop and deliver the strategic estates vision and objectives that support the Norfolk and Waveney Integrated Care System to realise its vision, purpose, goals, and deliver upon its priorities. Our Estates Programme Board is comprised of members leading the estate function across system partners, including links to local authorities and One Public Estate (OPE) partners.

Empowered and Skilled Estates Workforce

In order to provide an effective, safe, and efficient service, now and in the future, we need to have the right estates and facilities resource and expertise available. The ICS Estates workstream will develop an estates and facilities workforce plan and policy that builds on and further promotes system wide workforce planning. It will align with the Norfolk and Waveney People Plan, as well as the national estates and facilities workforce strategies.

Net Zero Estate

Our Net Zero Green Plan is described in the Legal Duty as to climate change. Emissions resulting from NHS building energy, water, and waste account for 11% of our total emissions, and 55% of the emissions we control directly. The Estates 'Net Zero' Carbon Delivery Plan provides a managed approach that will embed and enable the decarbonisation of the estate across the ICS.

Working through the ICS Green Plan delivery group, we will explore and implement interventions to decarbonise our estate and reduce carbon emissions arising from our buildings, infrastructure, and services.

Adapting to Climate Change

Climate change adaptation means responding to both the projected and current impacts of climate change and adverse weather events. Adaptation for our health and care estate is two-fold:

Health and Wellbeing:
- Investing in and managing estate that avoids negatively impacting the physical and mental health and wellbeing of our population.
- Flexibly managing our estate so that our health and care system can respond to different volumes and patterns of demand.

Operational delivery:
- The system infrastructure (such as buildings and transport) and supply chain (for example fuel, food and care supplies) need to be prepared for and resilient to weather events and other crises.

Transformed Models of Care

Transforming through the national New Hospital Programme

The New Hospital Programme delivers Government investment in the replacement of aged NHS hospital estate across the NHS. Within the programme Reinforced Autoclaved Aerated Concrete (RAAC) affected estate has been included for replacement and has included the James Paget Hospital. An extension of the programme includes a bid to bring the Queen Elizabeth Hospital into the replacement programme, and outcome on this is awaited.

Transforming through digital infrastructure and SMART buildings

The use of digital infrastructure and technology is important in delivering our vision and objectives. Digital innovation and enhanced infrastructure, devices, and information systems will help form SMART buildings that advance the experiences of our building users, improve sustainability, and drive financial efficiency.

SMART buildings will monitor, measure, and manage key aspects of a building's fabric and operational use, providing the data and knowledge to drive improvement. Good estates and facilities management can be ensured through the ongoing monitoring of maintenance, operations, and utilisation data generated by SMART building technology.

Digital infrastructure and platforms will include proactive use of digital systems to improve the performance, reliability, quality, and productivity of our estate, and reduce reactive and backlog maintenance costs. This is consistent with our Digital Strategy and Roadmap.

Infrastructure Design and Investment

Improving integration through One Public Estate

One Public Estate (OPE) is an established national programme delivered in partnership by the Office of Government Property and the Local Government Association. We have been an integral part of this programme for a number of years and we will continue this work. The OPE Board provides practical and technical support and funding to councils and other public organisations to deliver ambitious, property-focused programmes in collaboration with central government and other public sector partners.

Procurement / supply chain

Our local NHS providers established the Norfolk and Waveney Procurement Collaborative (NWPC) in 2020. This is bringing provider purchasing teams closer together under a formal agreement to buy in common wherever possible and they have already agreed common standing financial instructions. As our frontline teams work more flexibly across the system, this will help us improve clinical effectiveness through use of standard equipment and products across all our sites. To ensure we maximise these opportunities our clinically led, system wide Clinical Product Evaluation Group will review all proposed purchasing decisions to ensure every opportunity for standardisation has been taken.

This collaboration has already delivered over £4m of procurement savings in 2022/23 and will continue to ensure we get the very best value from our non-pay spend by aggregating our volumes such that suppliers see us as an important strategic customer and all trusts gain the benefit of the best available prices. We have developed category strategies for each of our key spend areas and will deliver a programme of product range consolidation, volume aggregation and commitment to strategic supplier partnerships across the system to support the development of integrated patient pathways.

We will also collaborate regionally with partners across the East of England where this makes sense, notably in the areas of cardiology and diagnostics where we

already work very closely with other trusts, such as Royal Papworth Hospital NHS Foundation Trust and the East of England Collaborative Procurement Hub. We will continue our support for the NHS England strategy of using NHS Supply Chain wherever possible, so that nationally there is the greatest opportunity for the NHS as a whole to leverage its buying power.

Procurement will also make a vital system contribution to key strategic programmes, such as Diagnostic Assessment Centres and the Electronic Patient Record, to ensure we secure value from long term partnership agreements.

We are fully engaged with the new NHS Central Commercial Function and will ensure our procurement services our assessed and showing improvement against the UK Government's Commercial Continuing Improvement Assessment Framework. Currently all our provider procurement teams are rated as 'Good' and we will seek to achieve 'Better' status in 2023/24.

This improvement will be enabled in part through significant development of our procurement information toolkit. NWPC has taken a lead in the NHS's development and deployment of the UK government commercial system known as Atamis. All contract information is now shared across the system's providers with spend analytics to provide in depth analysis on where we can further improve our spend efficiency. We will use this intelligence to prioritise our procurement resources effectively as we align our contracts.

Following our successful partnering with NHS Shared Business Services to provide efficient transactional purchasing services across the system, we will be upgrading our ordering system to offer end users a more 'Amazon' style service. This will help front line teams identify the products they need more quickly and reduce waste across the system. We will also reduce waste through further deployment of modern inventory management systems and NWPC are part of a pilot project with NHS Supply Chain reviewing distribution logistics, which will inform a system strategy on how we should efficiently maintain resilient stock levels, learning important lessons from the COVID-19 pandemic.

Social value and sustainability will be an increasingly important factor in our procurement decision making. 62% of NHS carbon emissions occur in the supply chain, with many of these emissions occurring in the UK. As part of our sustainability commitment, we will work with our supply partners to reduce our packaging and transport carbon impacts. For all contracts over £5m per annum, we will require the supplier to provide a carbon reduction plan.

We will also ensure our procurement tender activity supports UK government social value targets, the Greener NHS Programme to deliver a net zero health service and the drive to eliminate modern day slavery. For each tender we initiate we will evaluate prospective supplier's proposals against requirements in some or all of the following criteria:

- Fighting climate change
- Wellbeing
- Equal opportunity

- Tackling economic inequality
- COVID-19 recovery

This is consistent with our Net Zero Green Plan which is within the legal duty as to climate change.

We will proactively engage with small to medium enterprises in the local area and will publish our forward pipeline of potential procurement activity so that there is greater visibility of opportunities to work in partnership with the NHS in Norfolk and Waveney.

We are fortunate to have skilled and experienced commercial professionals available across the NWPC partners, with a number of 'MCIPS' qualified staff which is the gold standard for procurement. We will continue to invest in the professional development of our commercial team as this is a growing key strategic competence required across the NHS.

The ICB continues to directly host its own procurement function. This manages predominantly procurements for healthcare and non-healthcare services reflecting the commissioning responsibilities of the ICB. The focus of the ICB procurement team is to ensure that the ICB complies with the legal requirements for awarding service contracts that deliver the best services for patients at the best value for the system. We will review our approach to this in the light of prospective new 'provider selection regime' legislation currently making its way through parliament.

As separate legal entities and to reflect the different obligations of commissioning and provider organisations, to date the ICB and provider collaborative procurement functions have operated independently. These teams are however in regular dialogue and work together to identify the most efficient and effective routes to complying with our responsibilities under legislation to the benefit of the whole system. As the system continues to develop, the way in which procurement activities are undertaken and responsibilities for specific programmes of work will continue to be reviewed to ensure that the procurement function is being delivered in the most effective way.

Population Health Management

Population Health Management (PHM) is a way of working, using joined-up local data and information to better understand the health and care needs of our local people and proactively put in place new models of care to deliver improvements in health and wellbeing.

Our newly created ICS Population Health and Inequalities Board is leading the development and implementation of a strategy for Population Health Management, which will be in place by April 2024. This is a specific objective within the PHM, Reducing Inequalities and Supporting Prevention ambition.

The new strategy will set out our ambitions in relation to the delivery of population health management, our priorities and plans for a system level programme and our

approaches for all partners within the system to take forward their own programmes of population health management, focussing on local communities.

By focussing on prevention and health inequalities, and by partners working together to identify new things that can really help to improve health, the strategy will support people to live as healthy a life as possible. It will impact on the way we plan, prioritise and deliver care. It will be one of the key ways we can act together to improve health and wellbeing, making the best use of the resources we have available to us, removing barriers and supporting integrated working across our system.

The strategy will set out our approaches to use joined up data and information to better identify and understand the health and care needs of our population, to identify opportunities for improvements and put in place targeted interventions to support these.

We will be aspiring to a reduction in the differences in outcomes we currently experience in terms of accessing services and improvements in the health care processes for our most deprived populations.

We will also be seeking to prioritise prevention activities, particularly relating to smoking, alcohol, diet and physical activity and uptake of cancer screening and immunisations.

Our approach will also be driven by the needs of local communities and interventions designed to support them. We will be supporting place-led projects to deliver local priorities and to support working with wider partners to develop joint initiatives to address the wider determinants of health, such as housing.

Our strategy will include an ongoing programme of evaluation to measure progress and impact. Progress reports will be received by the newly established ICB Population Health and Inequalities Board, led by our Executive Medical Director, which have a broad membership of ICS representatives, including county council, adult social care and Children's Services, Public Health, NHS providers, and place board and health and wellbeing partnership representatives. In addition, there will be workshops held to develop the strategy and the Clinical Care Assembly will be a key consultative forum. Primary Care Networks, place boards and health and wellbeing partnerships will also be consulted.

We have identified initial Population Health Management priorities at a system level to address health inequalities and meet the Core 20 plus 5 priorities, which will have the greatest impact and where we know there are opportunities to improve. These are:

- Smoking, especially smoking in pregnancy,
- Serious Mental Illness,
- Chronic conditions – cancer (including earlier diagnosis), cardiovascular and respiratory

We already have an approved ICS PHM "roadmap" and our dedicated PHM team have achieved a number of improvements as part of our "Protect NoW" programme of work. This programme is a collaboration between NHS organisations, local

authorities, the voluntary sector and independent partners working across Norfolk and Waveney. It comprises a growing number of projects, each focused on optimising physical and/or mental health and wellbeing. Alongside clinical leadership, our PHM digital supplier provides the bespoke data analysis, technical solutions and digital platforms that underpin the “Protect NoW” projects.
Projects to date have included topics such as:

- **COVID-19 vaccination uptake**- Increasing vaccine uptake and gaining insight into how we can support people to take up the vaccine offer.
- **Falls prevention**- Engaging with people who are vulnerable to having a fall or waiting for a hip or knee operation and assessing if any adaptations or equipment are required, in partnership with the Local Authority Home Adaptations team.
- **Pain management**- Triaging patients on the pain waiting list so that those suffering the most pain are prioritised.
- **Improving Access to Psychological Therapies *(*IAPT) uptake**- Increasing referrals to the wellbeing service and addressing clinical variation.
- **Cervical screening uptake**- Increasing the uptake of Cervical Cancer Screening - reducing inequalities and unwarranted clinical variation.
- **Long Covid clinic design**- Gaining insight from those with lived experience of Long Covid to inform design of service specification for commissioning Long Covid clinics from the community provider.
- **Diabetes prevention**- Increasing referrals into the National Diabetes Prevention Programme to prevent / reverse type 2 diabetes and address clinical variation.
- **Priority Patient Review**- Reducing hospital admissions through primary care risk alerts relating to six biomedical markers. The pilot is seeking to demonstrate that the proactive management of patients with reversible risk across six clinical pathways will result in reduced hospital admissions.
- **ActiveNOW -** focused on supporting health and care professionals to quickly and easily refer patients into suitable physical activities based on their needs.

In order to better understand the health needs of our population and plan and deliver the PHM programme in an integrated way, we need to further develop our infrastructure that underpins it. The development of this infrastructure is closely linked to our ICS digital strategy.

At the moment, data is mostly held within separate organisations and this limits the ability to see the bigger picture. PHM will be optimised when we can join up data sources (including hospital, general practice and social care) to analyse need and plan care at a population level. This includes accessing linked-up data across our system using the ICS’s new data hub. More details about how we are doing this can be found in our Digital Transformation Strategic Plan and Roadmap.

Clear and robust information governance systems and agreements enable us to share and analyse data safely and appropriately. As we develop our PHM programme, we will be ensuring that our cross-system information governance systems and safe access controls are clear and communicated to all partners and break down existing barriers to sharing data.

Access to such data will allow us to undertake sophisticated analysis, modelling future demand, and using techniques known as “population segmentation”, “risk stratification” and “financial risk modelling”- identifying where we can make the most impact and supporting more personalised care. We will be supported to do this by skilled analytical support from our ICS-wide intelligence function. We will also be training our wider workforce to interpret the available information and identify their own, more local, priorities for action.

System Development

To create the change that we want to see and to make the most of the opportunity arising from the transition to an Integrated Care System, it is vital that we look at and understand what needs changing in our governance, processes, leadership and culture. This is why we are going to undertake a governance review in 2023/24, to make sure that we are operating as effectively as possible and are seizing all the new opportunities available to us.

The governance review will build on the plans we already have in place for developing and strengthening how our system works. Information about our plans for the future can be found in the following sections of this plan:

- **Neighbourhood level working:** Working at this very local level is a theme throughout our ambitions and underpinning objectives which are about ensuring provision is very accessible, is what our population needs, and finding out what matters most so it can be delivered as effectively as possible. Examples of this include the Family Hub, starting our journey to develop integrated neighbourhood teams and the maternity pathway to reduce tobacco dependency.
- **Place level working:** Our place-based approach is set out in section 5.1 of our Joint Forward Plan.
- **Closer working between providers of health and care services:** Our plans for working collaboratively are set out in section 5.2 of our Joint Forward Plan.
- **Working with the Voluntary, Community and Social Enterprise (VCSE) sector:** Our plans for developing how we work with the sector, including through our VCSE Assembly, are set out in section 5.8 of our Joint Forward Plan.
- **Improving the quality of care:** Our plans for how our system will build our capability to identify and address quality challenges are set out in the section about our legal duty to improve quality of services included in these appendices to our plan.
- **Our financial performance:** Our plans for how our system will build our capability to identify and address financial challenges are set out in the section about our financial duties included in these appendices to our JFP.

Our Integrated Care Partnership was built on the well-established Norfolk Health and Wellbeing Board, incorporating additional members from Suffolk to cover the Waveney part of our system. We put considerable thought and effort into developing our partnership in advance of its launch, so it is in a good position to deliver its key

functions. How the system relates to the partnership will be considered as part of the governance review. For 2023/24 though, we have adjusted the membership slightly, adding the chairs of our place boards to further strengthen the relationships and links between system and place level.

For Norfolk and Waveney to be a really thriving system, staff need to be supported to work in different ways and this is why we have put in place a comprehensive organisational development programme for our system and for staff at all levels. Specific programmes of work have been developed for the ICB Board, the ICB's senior managers and the system's Executive Management Team, along with training packages and support for the wider workforce, all of which is complemented by the Clinical and Care Professionals' Leadership Programme.

This organisational development work started well before the Health and Care Act (2022) came into force and has played an important role as our system has moved towards greater collaboration over the past few years. The work will continue as our system develops and matures.

Supporting wider social and economic development

We recognise our role as anchor institutions to explore opportunities to collaborate to influence the wider determinants of health within the heart of communities. This ranges from creating opportunities to listen and hear the voice of citizens, sharing data to alleviate respiratory conditions and improve the quality of housing, to accessing and signposting to partners' skills, training and employment pathways in order to grow our system's workforce and create a vibrant local employment market.

Our work to support wider social and economic development will be underpinned by asset-based community development principles, utilising all of our collective assets including workforce, estates and the people themselves to create system change. We will utilise tools such as the Community Voices programme to listen to communities and empower them to be their own agents for change, utilising their insights to influence the services and interventions we develop.

Our eight Health and Wellbeing Partnerships (HWPs) play a significant role in supporting decision making that reflects community need, assets and strengths. They provide a platform to engage a wide range of partners at a local level, that can support the design and transformation of health and care services, whilst ensuring connectivity to other services that can support their wider needs. These HWPs will provide the vital infrastructure, expertise and reach to support development and delivery of the proposed system Health Inequalities and PHM strategies.

Over the coming months we will co-ordinate baselining activity utilising the NHSE measurement framework currently in development, to understand the relationship between employment in the NHS and our local communities, particularly those that experience the greatest inequalities, as well as how we procure and how we currently utilise our estates.

Through this baselining exercise we will determine where we can improve our employment strategies in collaboration with our HWPs, seeking to work alongside the Department of Work and Pensions, local government, educational settings and VCSE organisations to proactively target those furthest away from the labour market and promote access to good, inclusive employment, skills development, and career progression.

Through our HWPs and Place Boards strong equitable relationships exist with local government. Working together we can influence, support and add value to a wide range of programmes that seek to improve access to green spaces, provide access to our collective facilities to support health and wellbeing, support local regeneration and generally provide opportunities for residents to improve their own health and wellbeing. An example of this is the adoption by Norfolk's seven Local Planning Authorities of the 'Norfolk Planning in Health Protocol' (2019).

Through our system Health Inequalities governance arrangements will seek to scale up the projects being delivered through a place-based approach, such as the James Paget University Hospital 'Anchor Pilot' that works with local VCSE organisations and communities in Great Yarmouth. This project is creating accessible green spaces on hospital owned land that can support the health and wellbeing of staff and visitors, which enables local procurement of services whilst supporting local volunteers to access employment skills and training and empowering them to access local job opportunities.

Our Net Zero Green Plan which is described in the legal duty as to climate change, sets out how we seek to reduce our environmental impact across the system. Underpinned by a robust communications and engagement plan, we will coalesce partners around shared ambitions, providing the tools and expertise to effect change.

Improving lives **together**

Norfolk and Waveney Integrated Care System

Integrated Care Board Finance Report

March 2023

(month 12, 2022-23)

Board: 30th May 2023

Contents

1. Executive Highlights

- This report represents the **Draft Pre-Audit** March year-end position of the organisation – this comprises the April to June CCG position (pre-audit), plus the July to March Integrated Care Board (ICB) statutory organisation position.

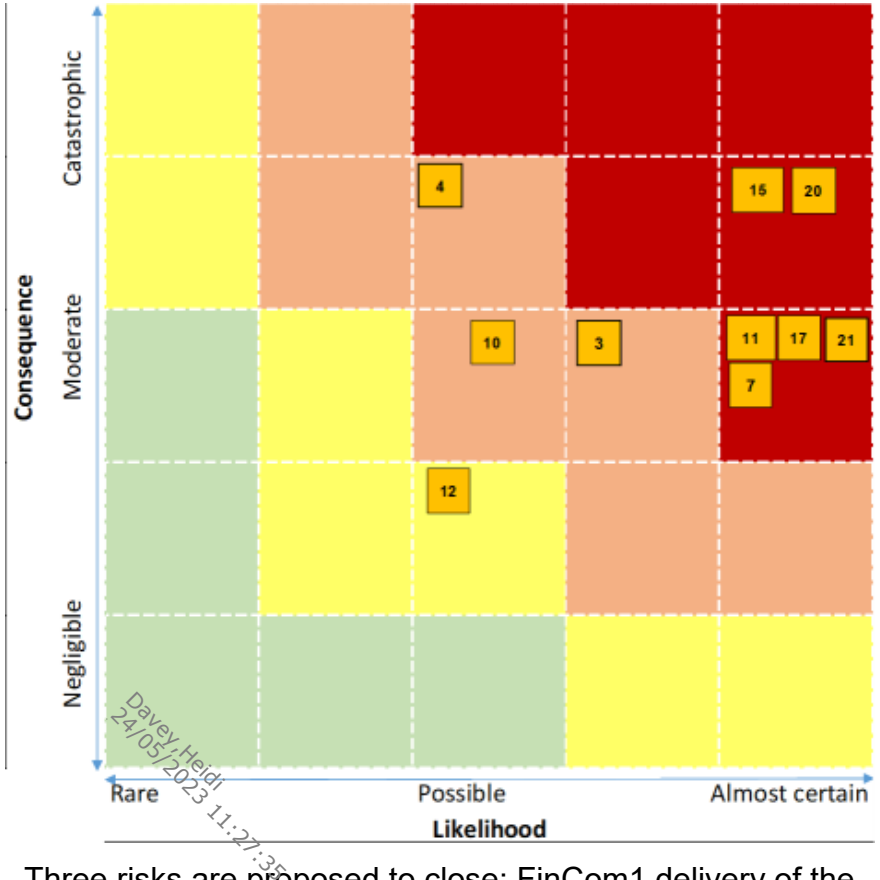
- The consolidated CCG and ICB has reported a **Year-end position of £0.2m Surplus**, which is ahead of plan representing 0.01% of the full year allocations. The year-end position includes offsetting variances, the major items being:
  - £(5.8)m increase in acute independent sector activity;
  - £(1.7)m Elective Recovery Fund underachievement;
  - £(9.7)m Continuing Health Care (CHC) expensive high acuity cases and excess inflation above funded levels;
  - £(5.5)m increases in Community Equipment supporting acute discharges and High cost Long Term Packages;
  - £(5.0)m non-achievement of system back office efficiency target; offset by
  - £27.8m benefit relating to the movements against year-end accruals in CHC, Primary Care, Prescribing, Community and BCF;
  - £9.7m benefit relating to the availability of non-recurrent mitigations including project slippage and non-recurrent incomes;
  - £12.9m of combined smaller favourable benefits including over delivery on efficiencies;
  - £3.1m non-recurrent temporary pay vacancies throughout the organisation.

- The 2022-23 plan included £5.4m of unmitigated risks in line with NHSEI guidance – relating to excess CHC inflation and Elective Recovery Fund (ERF) income, this has all crystalised in the full year.

2. ICB Strategic Financial Risk Register

This risk dashboard categorises the key financial strategic risks by their impact and likelihood to help the strategic focus to be on those that will cause the ICB the greatest issues.

Key: = Worsening Risk = Stable risk = Improving risk



Financial Strategic Risks	Ref.	Details	Committee Month --> Risk appetite	Feb-23	Mar-23	Apr-23
Achievement of Financial plan	1	Achieve the 2022/23 financial plan **(BAF 11)**	8	12	8	Closed
	3	Transition following end of HDP top up allocations	6	12	12	12
	12	Personal Health Budgets (PHB)	4	8	6	6
	15	Underlying deficit position **(BAF 11A)**	12	20	20	20
	16	Capita - Primary Care payments	9	12	12	Closed
	17	Inflationary pressures	9	15	15	15
	19	ISP patient choice	9			
	20	Impact of new prescribing guidance	8	20	20	20
	21	Impact of Direct Commissioing transfer		15	15	15
Demand and capacity	4	Capacity increases in response to COVID continue	8	12	12	12
	5	System approach to service redesign	9			
	7	Continuing Health Care demand growth	6	15	15	15
	9	Acute demand management	8			
	10	Treatment breaks / cancelled operations	6	9	9	9
	11	RTT backlog and Acute demand management	10	15	15	15
	18	Care Home capacity	12			
Efficiency	8	Efficiency, transformation development/delivery	8	20	12	Closed

Extreme	7	6	6
High	6	7	4
Moderate	0	0	0
Low	0	0	0
Total Risks	**13**	**13**	**10**

Three risks are proposed to close; FinCom1 delivery of the 2022-23 financial position, FinCom 16 as Capita payment risks are now at tolerated levels, and FinCom8 delivery of the 2022-23 efficiency programme

The full risk register is shown in Appendix A.

3. ICB Statement of Financial Position (SOFP)

The Statement of Financial Position presents the aggregate closing position of the ICB as at 31st March 2023.

Non Current assets:
IFRS16 was implemented in April 2022 to include the right of use assets for the lease of the premises in King's Lynn, an adjustment for an increase in the term of the lease has been included at March 2023. The premises at Norfolk County Council were introduced in December 2022 as a right of use asset, transactions have been back dated to August 2022 when access was obtained. Corresponding entries are also included in both current and non-current Lease Liabilities.

Current assets:
Total current assets have decreased since March 2022, driven principally by aged debtors and cash. The £8.7m balance is made up of aged debtors of £7.3m (including NHSE £4.3m and NCC £2.2m), net of a provision against this balance of £1.9m and prepayments and accrued income of £3.3m.

Trade debtors are subject to a quarterly review of bad debt for provision or write off, which are presented to the Audit Committee. Further details are presented in Appendix B.

Current liabilities:
Total current liabilities has increased by £30m since March 2022 driven principally by ICB and system invoice accrual timing. The £226m balance is made up of trade creditors of £15m, Prescription Pricing Authority accruals of £26m, payroll costs including GP pensions of £3m, deferred income of £14m and ICB and system invoice accruals of £168m.

Provisions include legal, staffing and estates costs.

Long Term liabilities:
The non-current payables balance is the deferred income relating to research & development 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 28/02/23	Position as at 31/03/23
ASSETS EMPLOYED			
Non-Current assets			
Right-of-use-Assets	0	849	1,152
Accumulated Depreciation	0	(140)	(147)
Total non-current assets	0	709	1,005
Current assets			
Trade and Other Receivables	9,552	8,475	8,676
Cash and Cash Equivalents (less Cash in Hand)	1,481	541	1,649
Cash in Hand	0	0	0
Total current assets	11,033	9,016	10,325
Current liabilities			
Trade and Other Payables	(195,365)	(177,457)	(225,918)
Lease Liabilities	0	(12)	(219)
Provisions for liabilities and charges (including non-current)	(5,194)	(3,543)	(4,732)
Total current liabilities	(200,559)	(181,012)	(230,869)
Long Term liabilities			
Non-Current Payables	(612)	(612)	(686)
Non-Current Lease Liabilities	0	(535)	(775)
Total non-current liabilities	(612)	(1,147)	(1,461)
Net assets employed	(190,138)	(172,434)	(221,000)
FINANCED BY TAXPAYERS EQUITY			
General fund	(190,138)	(172,434)	(221,000)
Total taxpayers equity	(190,138)	(172,434)	(221,000)

4. ICS Financial summary

Revenue position: The system financial performance is extracted from the month 12 (March) NHSE/I submissions.

The position M12 YTD is a £19.7m deficit, adverse to plan.

The most significant variances are as follows:

- JPUH: deficit of £24.9m is driven by operational pressures impacting the achievement of additional ERF, implementation and recognition of savings and the staffing of additional capacity
- NNUH: The JPUH deficit is partly offset by the surplus of £4.8m at NNUH due to reduced activity against plan resulting in lower levels of variable non pay expenditure.

Revenue surplus/(deficit) £m	Forecast Outturn		
Organisation	Plan	Actual	Variance
JPUH	0.0	(24.9)	(24.9)
NNUH	0.0	4.8	4.8
QEH	0.0	0.0	0.0
NSFT	0.0	0.0	0.0
NCH&C	0.0	0.0	0.0
Provider Subtotal	**0.0**	**(19.9)**	**(19.9)**
ICB	0.0	0.2	0.2
N&W System Total	**0.0**	**(19.7)**	**(19.7)**

Capital position (Capital Delegated Expenditure Limit – CDEL): The M12 YTD system CDEL expenditure as at March was £98.1m, £0.8m lower than plan. (This is based on the NHSE/I M12 submissions)

All organisations have a YTD underspend against plan on 'projects excluding RAAC', this is mainly due to slippage/delays in project roll out. The overspend in RAAC schemes at JPUH & QEH is due to extra funding not being reflected in the PFR plans.

When including the extra RAAC funding of £4m not yet reflected in the PFR plans at JPUH £3.2m & QEH £0.8m, and the allowed 'overplanning' of £2.4m then the 2022/23 underspend is £2.3m.

System CDEL	Forecast Outturn		
Organisation	Plan	Actual	Variance (Under)/ Over
	£m	£m	£m
JPH	24.6	27.6	3.0
NNUH	17.9	14.6	(3.3)
QEH	40.5	41.3	0.7
NSFT	9.8	9.8	(0.1)
NCH&C	6.0	4.9	(1.1)
N&W System Total	**98.9**	**98.1**	**(0.8)**

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: 11

Subject:	**Additional Review of the Governance Handbook- For approval**
Presented by:	**Karen Barker, Executive Director of Corporate Affairs and ICS Development**
Prepared by:	**Amanda Brown, Head of Corporate Governance**
Submitted to:	**ICB Board**
Date:	**30 May 2023**

Purpose of paper:

To present revised terms of reference for the following committees for Board approval:

- Patients and Communities Committee
- Performance Committee

Executive Summary:

Appendix D – Patients and Communities Committee
The Patients and Communities Committee has reviewed its terms of reference and proposes to make the following changes:

- Confirm the second Non-Executive Member of the committee as Deputy Chair
- Add a representative from commissioning (ICB/NCC)
- Have two Healthwatch representatives as members of the Committee, one from Norfolk and one from Suffolk
- Replace the words 'two experts by experience' with 'lived experience representatives
- Add a health inequalities advisor to the membership
- Increase the quorum from 3 members to a minimum of 8 members to include at least one chair or deputy chair, one ICB executive director and at least six additional committee members.

Further minor amendments have been made to the terms of reference and these can be seen in the attached track changes document.

Appendix H – Performance Committee
Amendments have previously been made to membership and attendees which have been approved. This revision has minor amendments to attendees and has also added to the responsibilities of the committee requiring assurance from programme boards.

The Board is asked to note and approve the proposed amendments to the terms of reference as above. It is also proposed to update role titles as appropriate throughout the terms of reference contained in the Governance Handbook. Approved changes will be included in the Governance Handbook and published as version 3.

Recommendation to the Board:

The Board is asked to approve the amendments to Appendix D - Patients and Communities Committee terms of reference and Appendix H - Performance Committee terms of reference contained within the Governance Handbook. Once approved the Governance Handbook will be updated and published as version 3.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	Ensuring that the ICB has appropriate governance processes in place is a key part of maintaining it's reputation.
Legal:	Ensuring that the ICB is compliant with statutory requirements.
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)	For Board approval.

APPENDIX D

Norfolk and Waveney Integrated Care Board
Patients and Communities Committee
Terms of Reference

Revision History

Revision Date	Summary of changes	Author(s)	Version Number
10 March 2023	Tweaks to the Terms of Reference following the meeting held on 23 January 2023	Paul Hemingway	1.1
13 April 2023	Tweaks to the Terms of Reference following the meeting held on 27 March 2023	Paul Hemingway	1.2
28 April 2023	Update to membership	Mark Burgis	1.3
10 May 2023	Changes made to quoracy	Mark Burgis	1.4
16 May 2023	Update to membership	Mark Burgis	1.5

Approvals
This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	ICB Board		1

1. CONSTITUTION

The Patients and Communities Committee ("the Committee") is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a committee of the Board and its members are bound by the Standing Orders and other policies of the ICB.

2. PURPOSE OF THE COMMITTEE

The Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that meets the needs of patients and communities, that is based on engagement and feedback from local people and groups, and that takes account of and reduces the health inequalities experienced by individuals and communities.

The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care.

The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

3. DELEGATED AUTHORITY

The Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

The Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

4. MEMBERSHIP AND ATTENDANCE

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than four members of the Committee, including one who is a Non-Executive Member of the Board (from the ICB). Other attendees of the Committee need not be members of the Board, but they may be.

When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Conflicts of Interest
The Committee shall satisfy 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.

Chair and Deputy chair

If a Chair has a conflict of interest then the co-chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

Members

The Members of the Committee are as follows

- Non-Executive Member of the ICB Board (Chair)
- Non- Executive Member of the ICB Board (Deputy Chair)
- VCSE Board Member on the ICB Board
- Executive Director Patients and Communities ~~Director~~, NHS Norfolk and Waveney ICB
- Executive Medical Director, Norfolk and Waveney ICB ~~or the Director of Nursing~~
-
- A representative from Commissioning (ICB/NCC)
- A ~~person with~~ primary care ~~experience~~representative
- Senior Public Health Officer Norfolk County Council
- A representative from the Place Boards
- A representative from the Health and Wellbeing Partnerships
- A representative from Healthwatch Norfolk
- A representative from HealthWatch Suffolk
- ~~Two experts by experience from local communities~~Lived Experience Representatives
- Health Inequalities advisor

~~- Non-Executive Member of the ICB Board (Chair)Non- Executive Member of the ICB Board VCSE Board Member on the ICB Board Patients and Communities Director, NHS Norfolk and Waveney ICB Medical Director, NHS Norfolk and Waveney ICB or the Executive Director of Nursing, NHS Norfolk and Waveney~~

Davey, Heidi 24/05/2023 11:27:35

~~ICBA primary care representativeA representative from the Place BoardsA representative from the Health and Wellbeing PartnershipsA representative from Healthwatch~~

~~Two experts by experience from local communities~~

5. MEETING QUORACY AND DECISIONS

The Committee shall meet at least on a bi-monthly basis. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

Quoracy

The quorum for the meeting will be ~~3 Members~~a minimum of eight members including at least ~~on~~one Chair or Deputy Chair ~~and~~, one ICB ~~executive~~Executive Director and at least six additional committee members.

Where members are unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate on their behalf. For the avoidance of doubt the deputy will be counted as part of the quorum.

If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. If an urgent decision is required, the process set out below may be followed.

Decision making and voting

Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee or their nominated deputy may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

Urgent decisions

In the event that an urgent decision is required, if it is not possible for the Committee to meet virtually an urgent decision may be exercised by the Committee Chair and relevant lead director subject to every effort having been made to consult with as many members as possible in the given circumstances (minimum one other member).

The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification and noted in the minutes.

6. RESPONSIBILITIES OF THE COMMITTEE

The responsibilities of the Committee will be authorised by the ICB Board. It is expected that the Committee will:

Complaints

- Approve the ICB's arrangements for handling complaints
- Receive regular reports about complaints received by the ICB and performance against the organisation's Complaints Policy.
- Oversee the sharing of lessons learnt from complaints received by the ICB across the organisation and the Integrated Care System.
- Provide assurance to the ICB Board regarding the organisation's performance against its Complaints Policy and processes.

Listening to, engaging and working with people and communities

- Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to promote the involvement of patients, their carers and representatives in decisions about their healthcare.
- Approve ~~an~~ annual ~~communications~~changes to the Norfolk and ~~engagement plan for the ICB~~ Waveney People and Communities Approach that sets out how the ~~organisation~~ICB and wider ICS will ~~help to~~ deliver ~~Integrated Care System's~~on the system wide approach to working with people and communities in Norfolk and Waveney.
- Receive regular reports setting-out the ICB's implementation of its annual communications and engagement plan and the organisation's contribution to delivering the Integrated Care System's approach to working with people and communities in Norfolk and Waveney.
- Consider how the ICB and the Integrated Care System could improve how we listen to, engage and work with people and communities.
- Oversee the sharing of insight gained from engagement with people and communities across the ICB and the Integrated Care System.

- Provide assurance to the ICB Board regarding the effectiveness of the organisation's approach to listening to, engaging and working with people and communities.

- The Patients and Communities Committee will receive and approve any substantial departure from the Norfolk and Waveney People and Communities Approach and national guidance for working with People and Communities, published by NHS England.

Using Population Health Management Approaches and addressing health inequalities

- Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to have regard to the need to reduce inequalities and use population health management approaches to help achieve this.

- ~~Receive~~The Committee will receive regular reports from the Norfolk and Waveney Health Inequalities Oversight Group about the Integrated Care System's work to reduce health inequalities.

- Consider how the ICB and the Integrated Care System could improve its work to address health inequalities.

- Provide assurance to the ICB Board regarding the effectiveness of the organisation's work to address health inequalities.

Integration with the voluntary, community and social enterprise sector

- Receive regular reports about the work of the ICB and the Integrated Care System to improve integration between the statutory and voluntary, community and social enterprise sectors.

- Consider how the ICB and the Integrated Care System could improve integration between the statutory and voluntary, community and social enterprise sectors.

Development funding

- Agree how the ICB should use development funding received from NHS England.

- Agree how the ICB should use any funding received by the ICB as a result of bids to external bodies with regard to health inequalities or patient engagement.

Davey, Heidi 24/05/2023 11:27:35

Place

- Review and approve arrangements as to the delegations to place boards or place Directors.

7. ACCOUNTABILITY and REPORTING ARRANGEMENTS

The Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded. The Chair of the Committee shall report to the Board (public session) after each meeting and provide a written report on assurances received, escalating any concerns where necessary.

The Committee will receive scheduled assurance reports from any delegated groups. Any delegated groups would need to be agreed by the ICB Board.

8. BEHAVIOURS AND CONDUCT

ICB values

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

9. DECLARATIONS OF INTEREST

All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

10. SECRETARIAT AND ADMINISTRATION

The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Attendance of those invited to each meeting is monitored highlighting to the Chair those that do not meet the minimum requirements;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken in accordance with the Standing Orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept;
- The Chair is supported to prepare and deliver reports to the Board;

- The Committee is updated on pertinent issues/ areas of interest/ policy developments;
- Action points are taken forward between meetings and progress against those actions is monitored.

11. REVIEW

The Committee will review its effectiveness at least annually and complete an annual report submitted to the Board.

These terms of reference will be reviewed at least annually from the date the latest version was approved and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Date of approval:

Date of review:

APPENDIX H

Norfolk and Waveney Integrated Care Board

Performance Committee

Terms of Reference

Revision History

Revision Date	Summary of changes	Author(s)	Version Number
26 May 2022	Originate document	A Palmer	1
6 Sept 2022	Attendee's following EMT discussion	T Litherland	2
02 May 2023	Attendees updated & add objective to Section 6	T Litherland	3

Approvals
This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	ICB Board		1
28 March 2023	ICB Board		2

1. CONSTITUTION

The Performance Committee ("the Committee") is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a committee of the Board and its members are bound by the Standing Orders and other policies of the ICB.

2. PURPOSE OF THE COMMITTEE

The Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that ensures a high performing system.

The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB regarding the delivery of key performance standards by commissioned providers, performance of the system against the NHS Outcomes Framework and progress with improving wider population health outcome measures.

The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

3. DELEGATED AUTHORITY

The Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

The Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

4. MEMBERSHIP AND ATTENDANCE

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than three members of the Committee including at least two who are Members or Participants of the ICB Board. Other attendees of the Committee need not be Members or Participants of the Board, but they may be.

When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Conflicts of Interest

The Committee shall satisfy 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.

Chair and Deputy chair

If a Chair has a conflict of interest then the co-chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

Members

- ICB Board Partner Member, Primary Medical Services (Chair)
- Director of Performance, Transformation and Strategy (Deputy Chair)
- Non- Executive Member
- Nursing Director or nominated deputy
- Patient and Communities Director or nominated deputy
- NHSEI Director or nominated deputy (to discharge NHSEI's statutory responsibilities in relation to provider undertakings or other SOF requirements, from time to time the NHSEI Director may need to chair an extraordinary part 2 of the committee)

Other attendees will vary from time to time and may include:

- Chief Executive Officer (ICB)
- Associate Director of Population Health Management (ICB)
- ~~Head of System Transformation~~Associate Director of Planning and PMO (ICB)
- Chief Executive Officer (JPUH) or nominated deputy
- Chief Executive Officer (NNUH) or nominated deputy
- Chief Executive Officer (QEH) or nominated deputy
- Chief Executive Officer (NCHC) or nominated deputy
- Chief Executive Officer (ECCH) or nominated deputy
- Chief Executive Officer (NSFT) or nominated deputy

- Public Health representative or nominated deputy
- Primary Care representative (PCN CD) or nominated deputy
- County Council representative(s)
- Representative of the ICB performance team
- Representative of the ICB business intelligence team
- ~~ICB Non Executive Member~~

5. MEETING QUORACY AND DECISIONS

The Committee shall meet at least six times a year (to be determined by the ICB). Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

Quoracy

The quorum for the meeting will be three members, one of which must be the Chair or Deputy Chair.

Where members are unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate on their behalf. For the avoidance of doubt the deputy will be counted as part of the quorum.
If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. If an urgent decision is required, the process set out at 5.10 and 5.11 may be followed.

Decision making and voting

Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee or their nominated deputy may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

Urgent decisions

In the event that an urgent decision is required, if it is not possible for the Committee to meet virtually an urgent decision may be exercised by the Committee Chair and relevant lead director subject to every effort having been made to consult with as many members as possible in the given circumstances (minimum one other member).

The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification and noted in the minutes.

6. RESPONSIBILITIES OF THE COMMITTEE

The responsibilities of the Committee will be authorised by the ICB Board. It is expected that the Committee will:

a) Conduct and lead oversight of both system and commissioned provider performance, including evaluation of health services, provider resilience and failure and performance review and management.

b) Hold the system's Groups, Place(s) and Providers to account and provide challenge to the system where this is required to address opportunities to improve performance and outcomes.

c) Determine where a Peer Review approach is required to support improvement in the system; overseeing the subsequent review and ensuring the learning is implemented.

d) Determine where a 'deep dive' is required on a particular measure and relevant to one or more providers.

e) Facilitate targeted national support through the System Improvement Director (SID).

f) In line with the System Oversight Framework (SOF) and the system's associated SOF segmentation, where relevant, agree with the SID a Service Improvement Plan (SIP).

g) Direct improvement resources when required in the system, including defining the parameters of any new improvement plans, peer review of existing plans where expected outcomes are not delivered and coordinating with regulators where formal improvement or intervention support is required.

h) Approve the KPIs and outcome metrics for use across the system.

i) Agree the scope and approve the development plan for the system's Integrated Performance Report (IPR) for use at System, Place and Provider level.

j) Negotiate any metrics or improvement trajectories with NHSE/I, relevant to SOF segmentation as may be required from time to time.

k) Support innovation and best practice to be consistently adopted across the system.

l) Ensure the system is optimally using benchmarking data for performance improvement.

m) Work jointly with NHSE/I to lead the oversight of place-based arrangements and individual organisations in line with SOF principles.

n) Agree and coordinate any support and intervention carried out by NHSE/I, other than in exceptional circumstances.

o) Participate in any place-based system, functional or organisational support and intervention carried out by NHSE/I.

p) Create robust cross-organisational arrangements to tackle the systemic challenges that the health and care system is facing.

q) Act as a leadership cohort, demonstrating what can be achieved with strong local leadership, operating with increased freedoms and flexibilities

~~q)~~r) The Committee will require assurance from the Programme Boards in relation to delivery, and highlighting any appropriate risks. Receive and monitor as appropriate robust improvement/recovery plans from the Programme Boards for measures as set out in the 2023/24 priorities and operational planning guidance, including UEC, General Practice and Maternity national improvement plans and other key performance indicators.

7. ACCOUNTABILITY and REPORTING ARRANGEMENTS

The Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded. The Chair of the Committee shall report to the Board (public session) after each meeting and provide a written report on assurances received, escalating any concerns where necessary.

The Committee will receive scheduled assurance reports from any delegated groups. Any delegated groups would need to be agreed by the ICB Board.

8. BEHAVIOURS AND CONDUCT

ICB values

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

9. DECLARATIONS OF INTEREST

All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

10. SECRETARIAT AND ADMINISTRATION

The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Attendance of those invited to each meeting is monitored highlighting to the Chair those that do not meet the minimum requirements;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken in accordance with the Standing Orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept;
- The Chair is supported to prepare and deliver reports to the Board;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments;
- Action points are taken forward between meetings and progress against those actions is monitored.

11. REVIEW

The Committee will review its effectiveness at least annually and complete an annual report submitted to the Board.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Date of approval:28 March 2023

Version 2

Norfolk and Waveney
Integrated Care Board

Agenda item: 12

Subject:	**Board Assurance Framework (BAF)**
Presented by:	**Karen Barker, Executive Director of Corporate Affairs and ICS Development**
Prepared by:	**Martyn Fitt, Corporate Affairs Manager**
Submitted to:	**Integrated Care Board - Board Meeting**
Date:	**30 May 2023**

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 and the associated risk visual.

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.

The BAF categorises risks around its three aims:

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

The BAF has undergone significant review since the last board meeting in March by the associated risk leads and ICB Executive Management Team (EMT). Accordingly, the Board is asked to note the following updates that have been made since the BAF was last presented to Board on 28 March 2023:

- **BAF01 Living with COVID-19**. The mitigated risk rating has reduced to 1x3=3 and the EMT is proposing this risk be closed.

- **BAF02 System UEC Pressures**. The mitigated risk rating has reduced to 4x4=16 (from 4x5=20). The risk actions, controls and mitigations detail the support for the proposed change.

- **BAF03 Providers in CQC Special Measures**. The mitigated risk rating has reduced to 3x4=12 (from 4x4=16). The risk actions, controls and mitigations detail the support for the proposed change.

- **BAF04 Cancer diagnosis and treatment**. Following a detailed review at the Cancer Programme Board it has been agreed that this risk will be split into two elements – with the second part of the risk focusing on Lynch Syndrome. The

Planned Care and Cancer team is working on this, and board should expect to receive a fuller update on this at its next meeting.

- **BAF 06 Health Inequalities and Population Health Management.** Although this risk score has not changed the risk has been reviewed and reworked in line with comments from the Audit and Risk Committee.

- **BAF08 Elective Recovery** The mitigated risk rating has reduced to 4x4=12 (from 5x4=16**)** in line with the update to additional assurances on controls captured.

- **BAF10 EEAST Response times and patient harms**. The mitigated risk rating has reduced to 4x4=16 (from 4x5=20). The risk actions, controls and mitigations detail the support for the proposed change.

- **BAF11 Achieve the 2022/23 Financial Plan.** Is to close following Month 12 and financial year end. A new risk will be added in due course.

- **BAF20 Industrial Action.** The mitigated risk rating has increased 4x4=16 (from 3x4=12) in accordance with ongoing actions

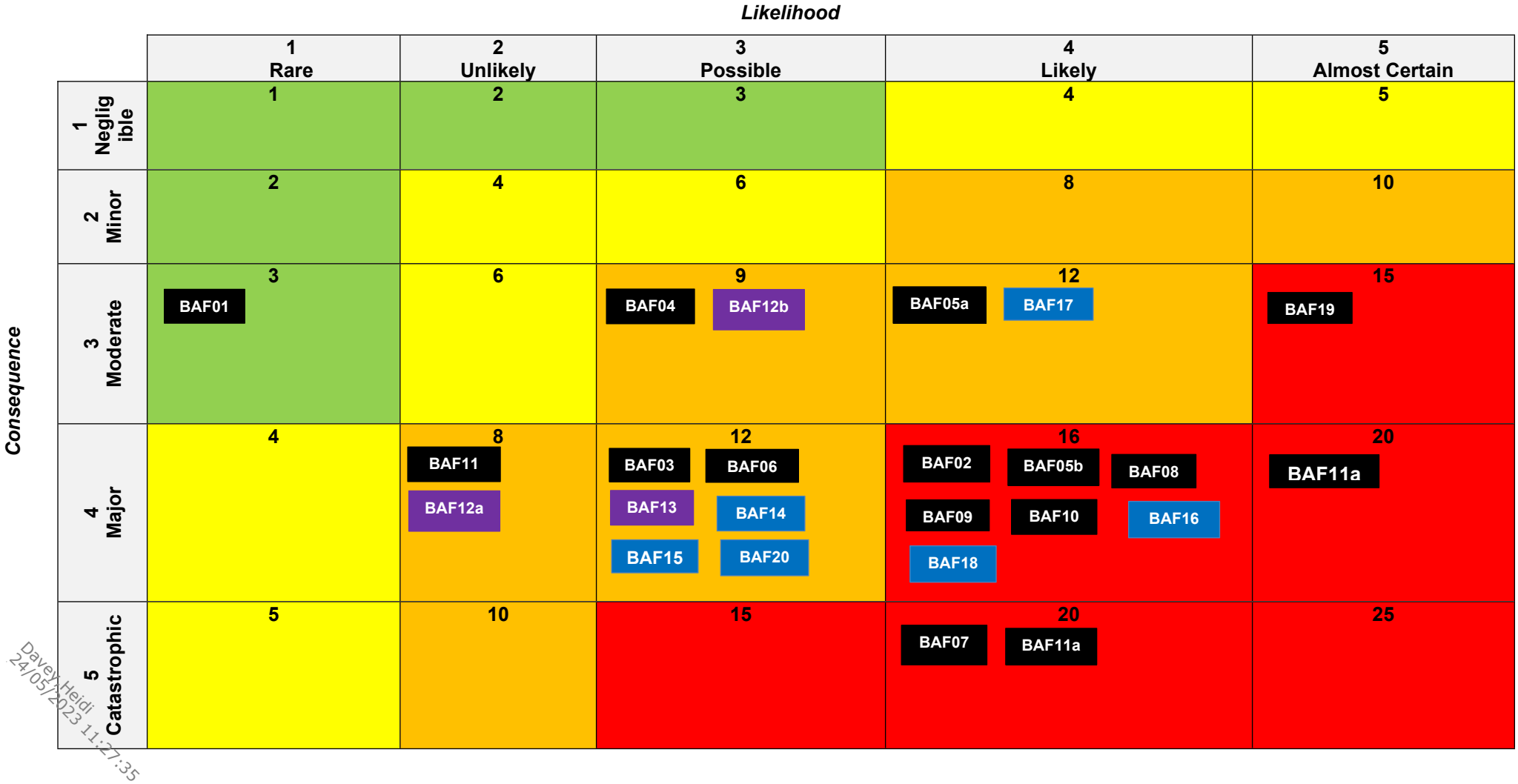
Recommendation to Board:

The Board is asked 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.

APPENDIX 2: RISK VISUAL

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



NHS
Norfolk and Waveney
Integrated Care Board

NHS Norfolk and Waveney ICB – Board Assurance Framework (BAF)

Version:	1	Date:	23 May 2023

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	Risk Owner / Operational Lead	Date risk identified	Target delivery date	2023-2024 Monthly Risk Rating											
					1	2	3	4	5	6	7	8	9	10	11	12
BAF01	Living with COVID-19	Tricia D'Orsi / Karen Watts	01/07/22	31/03/24	3											
BAF02	System Urgent & Emergency Care (UEC) Pressures	Mark Burgis / Ross Collett / Karen Watts	01/07/22	31/03/24	16											
BAF03	Providers in CQC Special Measures (NSFT)	Tricia D'Orsi / Karen Watts	01/07/22	31/12/24	12											
BAF04	Cancer Diagnosis and Treatment	Dr Frankie Swords / Sheila Glenn	01/07/22	31/03/24	9											
BAF05a	Barriers to Full Delivery of the Mental Health Transformation Programme (Adult)	Jocelyn Pike / Mark Payne	01/07/22	31/03/24	12											
BAF05b	Barriers to Full Delivery of the Mental Health Transformation Programme (CYP)	Jocelyn Pike	01/07/22	31/03/24	16											
BAF06	Health Inequalities and Population Management	Dr Frankie Swords / Mark Burgis	01/07/22	31/03/24	12											
BAF07	RAAC Planks	Steven Course	01/07/22	31/03/24	20											

Ref.	Risk Title	Risk Owner / Operational Lead	Date risk identified	Target delivery date	2023-2024 Monthly Risk Rating											
					1	2	3	4	5	6	7	8	9	10	11	12
BAF08	Elective Recovery	Dr Frankie Swords / Janice James	01/07/22	31/03/24	20											
BAF09	NHS Continuing Healthcare	Tricia D'Orsi/Paul Benton	01/07/22	31/03/24	16											
BAF10	EEAST Response Time and Patient Harms	Tricia D'Orsi / Mark Burgis	01/07/22	31/03/24	16											
BAF11	Achieve the 2022/23 Financial Plan	Steven Course / Emma Kriehn Morris	01/07/22	31/03/24	8											
BAF11a	Underlying Deficit Position	Steven Course / Emma Kriehn Morris	01/07/22	31/03/24	20											
BAF19	Discharge from inpatient settings	Tricia D'Orsi	25/10/22	31/03/24	12											

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	31/03/2024

Risk Scores

Unmitigated			Mitigated			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	3	15	1	3	3	2	3	6

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.
- 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.
  1.Pension abatement 'end date' of national extension agreed until end of March 2025 to help retain experienced reservists.
- As of April 2023, new guidance recommends local risk assessment and thresholds for social distancing and other IP&C measures. COVID-19 is now being treated as a 'known' virus and the risk is proposed to close.

Assurances on controls

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.
- The system must continue 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
10/01/23	Delivery of the COVID-19 Winter booster and flu vaccination programme is on target.		31/03/23

Visual Risk Score Tracker – 2023/24

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

BAF02

Risk Title	**System / Urgent & Emergency Care (UEC) Pressures**			
Risk Description	There is 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, delays in being discharged from hospital and as a result potentially poorer outcomes for our patients with associated clinical harms. The above risk manifests itself as worsening ambulance response times for patients with a life threatening and / or life changing condition and an increasing number of patients remaining in hospital when they no longer meet the nationally prescribed 'criteria to reside', The associated increase in longer lengths of stay and higher occupancy levels in all acute and community hospitals results 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 be released to respond to 999 calls.			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Mark Burgis	Patients and Communities Quality and Safety	Ross Collett & Karen Watts	01/07/2022	31/03/2024

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	**5**	**20**	**4**	**4**	**16**	**3**	**4**	**12**

Controls

- **Strategic Oversight:** UEC Programme Board oversees non-elective flow and monitors a system wide transformation programme to improve the responsiveness of our Urgent and Emergency Care pathways to ensure patients receive the right treatment in the right place at the right time; that timely discharge for non-elective patients from inpatient hospital and community beds takes place and that appropriate discharge capacity is available to meet the discharge demand from health settings.
- **Business Continuity:**
  - All Trusts, including community, 111 and primary care have business continuity plans in place to manage the operational response to in-year peaks in demand and periods where demand exceeds 'business as usual' levels.
  - A seven-day System Control Centre (SCC) and East of England Ambulance Service (EEAST) System Oversight Cell (SOC) are in place. The SCC and SOC work alongside Providers to coordinate operational responsiveness when individual or multiple providers are unable to meet patient demand in a timely and safe way and to escalate to appropriate levels of management when decisions to mobilise additional resources are needed.
  - Interim Winter Director in post until end of May to manage the SCC; act as a point of system escalation for operational pressures including management of any critical or major incidents for the ICS and the associated reporting to NHSE; coordinate mutual aid and support between providers at Exec level, and to lead the planning and implementation of non-recurrent "winter funding".

Specific controls to appropriately manage urgent and emergency care demand ensuring patient's needs are met:

Assurances on controls

Internal: ICB Executive Management Team; Norfolk and Waveney UEC Steering Group; Emerging 'Place' UEC Steering Groups; System Control Centre (SCC)

External: ICS Executive Management Team (CEOs Group); Trust Boards; NHSE Regional Strategic Oversight

• **Hospital 'Admissions Avoidance':** A range of 'Admissions Avoidance' schemes are in place across N&W to ensure that those patients who have an 'urgent' need but do not need the full range of services of an acute hospital but may be at risk of an inappropriate admission are managed safely in a community setting, the core services are: o **111 / GP led Clinical Advice Service (CAS):** This service provides advice to healthcare professionals and the general public triaging and referring patients to the most appropriate service and setting that will best meet their needs. o **Urgent Community Response (UCR):** Patients that have been triaged can be referred to this service which provides a face-to-face response within 2 hours for those patients that need this 'urgent' intervention who would otherwise be at risk of admission to hospital. This community led service is underpinned by a plethora of discrete services across each 'place' that the UCR team can access to ensure the immediate need is met and that patients are referred onto appropriate health or social care services that can provide support to prevent or reduce the risk of further exacerbation. o **GP Streaming (ED Front Door):** is in place at all three acute hospitals to reduce the urgent care (minors) demand flowing through our EDs by providing a primary care led service to patients who walk-in to our EDs as well as redirecting them to other appropriate services in the community. o **Call before convey service (MDT Open Room):** Patients that have an urgent need but choose to ring 999 are held in the 999 'stack' for significant periods of time as there are insufficient resources available that can be mobilised by the ambulance service due to handover delays at hospital. The MDT Open which we are aiming to develop into a pre-hospital urgent care hub allows the transfer of these patients to appropriate community services for response both health and social care. o **Same Day Emergency Care (SDEC):** All three acute hospitals have SDECs in place. These are being further developed to include a wider range of symptom groups and referral routes to increase their effectiveness in avoiding 'avoidable' admissions to hospital o **Virtual Ward:** Virtual Ward Project established in Q3 22/23. The project intends to increase the level of acuity of patients that can safely be managed in the community by increasing community capability in a "step up" model. See "discharge" for further information on VW project and "step down". • **Creation of surge / escalation capacity:** o **Cohorting:** A range of cohorting measures are available at acutes to provide ED surge capacity and reduce waiting to handover at hospital. o **Rapid Ambulance Offload:** 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. o Escalation / Surge Beds: Acute and community providers have created additional escalation / surge beds through	

internal operational changes and using some winter funding ○ All acute hospitals have ambulance handover plans to improve handover performance and accommodate surges in demand. • **Specific controls to improve discharge (cross-reference with BAF19):** ○ Discharge Director is supporting Trusts ti ensure best practice is in place via a 30,60,90-day plan and 100-day discharge challenge. ○ Capacity and Demand modelling work is taking place and funding made available to support an increase in capacity using non-recurrent winter funding. ○ Circa 210 beds and 190 domiciliary packages of care equivalent to an acute bed have been mobilised across N&W until 31st March 2023. • The system is now in OPEL 3, with NNUH remaining at OPEL 4. Improvement in offload delays and ambulance response times is reflected in reduced adverse incidents. This prompts a reduction of risk at M1 (2023-24).	

Gaps in controls or assurances

- Clearly defined cross-reference to PHM Strategy that will reduce latent demand for urgent and emergency care through better long-term conditions management reducing condition exacerbation
- Limited alignment with Mental Health non-elective strategy and plans including the mitigation of the impact of Covid 19 which in turn will reduce latent demand on acute hospital EDs
- Central 'Winter Funding' ends on 31st March 2023 and mobilised bed stock and domiciliary care provision will reduce leading to delayed discharges from in-patient hospital and community beds, resulting in an adverse impact on flow and reduction in responsiveness of the community to meet urgent and emergency care needs.
- Winter Director and Discharge Director secondments will end on 31st May and 31st March respectively leaving a gap in system level capacity whilst UEC structure is reviewed.
- Assumptions made by our acute hospitals in the current round of operational planning highlights capacity in wider community (primary care, community, 111/CAS, 999) will be unable to meet the pre-hospital and discharge needs of our population accessing the non-elective pathways
- Insufficient capacity in social care to meet the needs of our population who require timely discharge to complete their onward care journey

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
03/10/22	Management of Operational Pressures (Critical Incident) Critical incident stood down on 26th January 2023.	B	31/03/23
10/01/23	Pre-Hospital Winter Initiatives Most planned schemes implemented and monitored through SCC in terms of impact	B	31/03/23
16/03/23	National UEC Recovery Strategy - Reduce LoS in inpatient settings. This is a core action in the Joint Forward Plan (JFP) to rebalance system flow and meet operational planning target of 76% A&E 4 hour performance. Baseline average LoS is currently 8.1days for non-elective pathway	A	31/03/24
16/03/23	National UEC Recovery Strategy – Recover Ambulance category 2 response time to minimum 30mins. This is a core action in the Joint Forward Plan (JFP). Recovering to this performance will be underpinned by a range of Admissions Avoidance and Discharge initiatives to ensure we have the capacity to release ambulances to respond to category 2 calls	A	31/03/24
16/03/23	National UEC Recovery Strategy – This is a core action in the Joint Forward Plan (JFP) Meet our Virtual ambition to achieve 40 beds per 100,000	A	31/03/24

	population (368 beds). This initiative will support Admissions Avoidance and Early Supported Discharge to meet the 76% A&E 4 hour target											
Visual Risk Score Tracker – 2023/24												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	16											
Change	↓											

BAF03

Risk Title	**Providers in CQC 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	31/12/2024

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	**4**	**16**	**3**	**4**	**12**	**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. Trust CQC Evidence Panel chaired by ICB. **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.

• Evidence Assurance Panel is in place, chaired and supported by ICB Medical Director. • The Trust was reinspected, with its report published in February 2023. The overall rating increased from 'inadequate' to 'requires improvement'. • The Trust will continue to receive enhanced support from NHSE to sustain improvements and to support exit from NOF 4 criteria in 2023-24 Q4. Phase 2 of the Trust's improvement plan is in place. Risk has been reduced to reflect improvements but continues to be 'high' as change embeds. • A new model of care is currently in development.	

Gaps in controls or assurances

- High levels of patient acuity are being reported. Capacity is not currently able to meet demand.
- 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. This is now business as usual.	B	30/03/23
17/12/21	Additional programme governance has been put in place around 12Hr ED breaches in order to meet the requirement for NOF 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.	G	31/07/23
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. This is now business as usual.	B	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. This is now business as usual.	B	31/03/23
13/05/22	Staff engagement visits have been undertaken across sites, supported by the Norfolk and Waveney and Suffolk ICBs.	B	31/03/23
13/05/22	Large scale recruitment events have continued with successful recruitment of support workers.	B	31/03/23
17/06/22	Trust in dialogue with NHSE regarding NOF 4 exit criteria, agreed.	B	31/03/23
17/06/22	Staff engagement with CYPM Team to support quality initiatives. CYP MH collaborative now in place.	B	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. Reinspection evidenced improvements and phase 2 of improvement plan now in place.	G	31/07/23
25/08/22	CQC re-inspection of Section 29a completed, Well-led took place in November 2022. The Trust was reinspected, with its report published in February 2023. The overall rating increased from 'inadequate' to 'requires improvement'.	B	31/03/23

24/06/23	New model of care in development, focussed around standards of care and patient needs. Areas are being selected to pilot. ICB is supporting.	G	31/03/24

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

BAF04

Risk Title	Cancer diagnosis and treatment			
Risk Description	Sustained increase in demand on urgent suspected cancer pathways post Covid pandemic is creating capacity and demand pressure on the diagnostic and treatment capacity. This puts patients at risk of delayed diagnosis and treatment potentially leading to worse long term clinical outcomes.			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Dr Frankie Swords	Quality & Safety	Maggie Tween	01/07/2022	31/03/2024

Risk Scores

Unmitigated			Mitigated			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	3	9	2	3	6

Controls

- Cancer transformation resources supporting diagnostic and treatment capacity to address the backlogs to support recovery and streamlining 2ww pathways and processes to meet the nationally defined optimal pathways.
- GP webinar programme.
- Cancer rapid diagnostic service in place for patients with non specific symptoms.
- Targeted lung health checks in GYW, accelerated roll out for 23/24 focused on deprived communities.
- National Grail trial
- Transformation projects to increase capacity (cytosponge and colon capsule).
- Mutual aid process and clinical prioritisation via Elective Recovery Board.
- SRO has requested monthly update from each trust between Dec 22 and Mar 23 regarding Secretary of State letter priorities.
  PHM techniques used to target groups at highest risk

Assurances on controls

Internal:

- Uncommitted transformation funds re-purposed to support recovery.
- System Mutual Aid policy in place now via ERB. Single PTL for cancer still in progress.
- Screening, diagnostic and treatment backlogs continue to be monitored via the system Cancer Programme Board
- Referral pathways continue to experience high demand impacting on diagnostic and treatment capacity.
- WLI in progress, though with workforce challenges.
- National Tiering Approach for NNUH and QEH, linking to Elective Recovery Board and System Performance Committee continues. QEH tiering now reduced Feb 23
- Support/system oversight/assurance for National Tiering Process for NNUH, continued supportive approach for all three trusts due to high operational pressures.
- Single harm review policy across all providers to assess all patients for physical or psychological harms and to reprioritise if risk of harm identified

External: PHE, NHSE/I, Regional Cancer Network

Gaps in controls or assurances

- There may be additional harm from undiagnosed patients including excess mortality. This will have been exacerbated by pandemic related changes in health behaviours. EOE Cancer Alliances have quantified this risk, with approximately 600 fewer cancer diagnoses made in N&W than expected during the pandemic.
- Environmental and staffing challenge of providing cancer services during continued COVID and UEC pressures compounded by industrial action and BMA rate card related impact on additional activity.
- 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 processes impacting on transformative list management Surges and variability in two-week wait (2ww) demand further affecting performance, notably: Breast, Colorectal and prostate diagnostic pathways.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
03.2023	QEH removed from national tiering	G	31.03.2023

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	9											
Change	→											

BAF05A

Risk Title	**Barriers to full delivery of the Mental health transformation programme (Adults)**
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**
Jocelyn Pike	Quality & Safety	Mark Payne	01/07/2022	31/03/2024

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
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, Board **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
- Impact of continued CQC rating of the well-led domain. Publication of the recent reinspection awaited.
- Organisational development required to drive forward internal cultural change. 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
- The ICB Mental Health Strategic Commissioning Team is predominantly staffed with fixed term posts ending in 2023-24.

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.	G	31/03/23
29/04/22	Joint approach between ICB and NSFT needs to be established and embedded 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.	R	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).	G	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.	G	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. Planning guidance received; draft local plan is being socialised.	G	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.	A	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.	G	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.	G	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, 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	A	31/03/23

	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. Work is continuing across all areas.		
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.	**G**	31/03/23

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

BAF05B

Risk Title	**Barriers to full delivery of the Mental health transformation programme (CYP)**
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
Jocelyn Pike	Quality & Safety	Rebecca Hulme	01/07/2022	31/03/2024

Risk Scores

Unmitigated			Mitigated			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	**4**	**16**	**4**	**4**	**16**	**2**	**4**	**8**

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
- Commitment from system partners to adopting Thrive approach – mental health needs being considered and addressed in wider health and social care settings
- Additional partnership working with VCSE

Assurances on controls

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	G	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	G	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	G	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	G	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.	G	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	G	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	G	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	G	31/03/23
02/05/22	Mobilisation of three focussed waiting list initiatives to support circa 1000 CYP on waiting lists.	A	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.	A	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. Update 10/01/23 – some successful recruitment to crisis team. Anticipated that capacity will be begin to improve in Q4 22/23 as staff complete induction.	A	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.	R	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	A	31/03/23
06/11/22	Current uncertainty following CQC visit, and imminent Well Lead review impacting on capacity and focus to deliver transformation	R	31/03.23
10/01/23	Collaborative working with Suffolk and Norfolk systems to introduce short breaks provision. Capital funding in use to develop estates	G	31/03/23
10/01/23	System planning to ensure alignment of provision in Waveney with Suffolk system colleagues. Task and finish group established	G	31/03/23
10/01/23	Engagement exercise commenced to revisit ambitions and transformation plan with Norfolk and Waveney stakeholders	G	31/03/23
10/01/23	System review of provision commenced across Norfolk and Suffolk – further development of Alliance approach to ensure support accessible in most appropriate part of the system	G	31/03/23

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16											
Change	→											

BAF06

Risk Title	**Health inequalities and Population Health Management**
Risk Description	Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. Some groups of our population are at risk of poorer health outcomes due to these structural inequalities in how health and care is provided as well as the wider determinants of health. This has been exacerbated due to the long-term impact of the COVID pandemic and cost of living pressures putting more people at risk of poor outcomes.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Dr Frankie Swords	Quality and Safety	Dr Frankie Swords	01/07/2022	31/03/2024

Risk Scores

Unmitigated			Mitigated			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	1	4	4

Controls

- A specialty advisor has been appointed to lead on all CORE20PLUS5 priority areas to address inequalities, with two advisors specifically appointed to support PHM and another to lead on addressing HI.
- The NCC deputy director of public health is now leading the ICB team to coordinate and lead this.
- PHM and addressing HI has been identified as a priority in our JFP.
- ICB PH&I Board, HI Oversight Group (HIOG) and PHM Oversight Group (PHMOG) have been established, strategies are under development and key workstreams identified.
- Health Improvement Transformation Group (HITG) focussing on Primary Prevention reporting to the ICP, established with key priorities including smoking and physical activity.
- Protect NoW used to target multiple groups to address inequalities using PHM systems.

Assurances on controls

Internal:
Progress against key national delivery timelines reported and led by appropriate governance structures: Health Inequalities Oversight Group (HIOG), PHM oversight group and PH and Inequalities board.
Quarterly NHSE reporting of NHS Inequalities stocktake
Health Improvement Transformation Group (HITG), Inclusion Health Group, Integration & Partnership team linked to Place, PHM team
Elective Recovery board monthly report on waiting lists per decile of deprivation index
Analysis of patients on admitted elective waiting lists has not detected any systemic health inequalities
Health Needs Assessments for Inclusion Health groups developed to be published on JSNA

External: Health & Wellbeing Partnerships, Place Boards, Clinical and Operational steering groups

Gaps in controls or assurances

- HI & PHM strategies identified as objectives in JFP due to be completed by March 2024
- N&W Plus groups not yet defined to be developed by HIOG and then agreed through PHI board.
- Duplication of effort, energy and resources at Place and system level – lack of coordination of all mechanisms to address inequalities, further alignment required with partners and ICS governance structures.
- Capacity – poor co-ordination relating to HI across the system, particularly with reference to Core20+5 & VCSE integration agenda, resources in wider system (i.e. local government) to support agenda.
- Lack of data, particularly relating to Core20Plus5 monitoring
- NHSE HI funding not ring-fenced to support emerging work programmes and respond to system priorities.
- Evaluation methodology for key work programmes – support required to ensure impact measurement

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
03/03/23	Population Health and Inequalities Board set up April 23	B	Complete

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12											
Change	→											

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	31/03/2024

Risk Scores

Unmitigated			Mitigated			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	5	25	4	5	20	3	5	15

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.

Assurances on controls

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 concluded	G	ongoing

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	20											
Change	→											

BAF08				
Risk Title	**Elective recovery**			
Risk Description	The number of patients waiting for elective treatment in Norfolk and Waveney grew significantly during the pandemic. There is a risk that this cannot be reduced quickly enough to a level that meets NHS Constitutional commitments. This would also contribute to poor patient experience, and may lead to an increased clinical harms 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	Sheila Glenn	01/07/2022	31/03/2024

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**4**	**4**	**16**	**3**	**4**	**12**

Controls	Assurances on controls
• The Elective Recovery Board meets bi-weekly to oversee all workstreams to improve performance and reduce harm. • Each Provider has completed waiting list clinical validation and all patients have been clinically prioritised. • Workstreams are in place to expand capacity, share learning, maximise efficiency and reduce variation in waiting times between different providers, including through mutual aid, and to transform care pathways to accelerate elective recovery, each led by a chief operating officer or medical director. • Unified process of clinical harm review and prioritisation in line with national guidance in place across all providers to ensure that patients' care is undertaken in order to clinical priority and to prevent harm where this is identified as a risk. • EoE funding secured for mutual aid administrative support to contact long wait patients to confirm availability, signpost to While You Wait website and confirm if transfer to alternative provider via mutual aid • National and local patient resources in place to support patients waiting for elective care: https://www.myplannedcare.nhs.uk/ https://norfolkandwaveneyICB.nhs.uk/while-you-wait • EMT agreement to commission elective capacity through independent sector providers.	Initial focus to clear all patients waiting 104 weeks was met by 1 July 2022. The next focus to clear all waiting more than 78 weeks was missed by 292 patients for 1 April 2023. Trusts providing trajectories to ensure delivery of zero 65-weeks by end Mar 24 with additional focus on clearing remaining 78-weeks by end June 23. QEH de-escalated from Tier 2 to non-tier in Feb 2023. **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. Weekly Tiering KLOE return from Trusts to system, region, and national teams, monitored through fortnightly Tiering meetings.

Gaps in controls or assurances

- Cessation/ reduction of elective activity due to RAAC plank works at JPUH and QEH.
- Impact industrial action on elective recovery.
  Administrative resources to support validation and booking processes

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**
31/03/23	Industrial action by nurses and junior doctors led to cancellation of theatre and outpatient activity. Providers reported 292 breaches of 78-weeks target at end of March 23 with 180 due to lack of capacity, 75 due to patient choice, 10 unfit and 6 waiting for corneal graft material. Gynaecology and T&O remain highest areas for breaches.		30/03/23
30/04/23	Target changed to 65-week waits by end of March 24. Further industrial action over Easter led to 188 cancellations of 78-week breach patients with a further 129 urgent suspected cancer patients cancelled. More patients impacted as many patients not booked in preparation for strike. Forecasting 529 x78week breaches in April with 424 due to capacity. SWOT team linked to NNUH: 33% from first tranche of 3000 outpatients requested to be removed from the waiting list with 33% considering transfer to another provider.		31/03/24

Visual Risk Score Tracker – 2023/24												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	16											
Change	➔											

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	31/03/2024

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**4**	**4**	**16**	**3**	**3**	**9**

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.

Assurances on controls

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.	**A**	31/03/23
14/04/22	NSFT Discharge to Assess model to continue; currently funded through CHC. Case made to make this BAU, costing and evidence of effectiveness, shared with executive team.	**G**	31/03/23

Visual Risk Score Tracker – 2023/24												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	16											
Change	→											

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	31/03/2024

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**4**	**4**	**16**	**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. • Interfacility transfers have improved with processes in place between organisations. • The system is now in OPEL 3, with NNUH remaining at OPEL 4. Improvement in offload delays and ambulance response times is reflected in reduced adverse incidents. This prompts a reduction of risk at M1 (2023-24).	**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 has been in a critical incident level 2 since October 2022. 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
21/09/21	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	B	31/03/23

	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. This is now business as usual.		
04/11/22	Five core management pillars (cross-reference BAF02) are in place to support a system response. This is now business as usual.	B	31/03/23
10/01/23	Decompression measures continue to be utilised at each site (cross-reference BAF02). Escalation plan required to reduce use of escalation beds.	G	31/03/24

Visual Risk Score Tracker – 2023/24												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	16											
Change	↓											

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**
Steven Course	Finance	Emma Kriehn Morris	01/07/2022	31/03/2023

Risk Scores

Unmitigated			Mitigated			Tolerated (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**2**	**4**	**8**	**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

1. Identification of risks and associated mitigations reviewed on a monthly basis;
2. Escalation to EMT, Finance Committee and Board if appropriate, should total unmitigated risks crytalise;
3. No contingency reserve in plan;
4. £5.4m of unmitigated risk in the plan;
5. £1.3m of uncrystalised net risks identified at M11 (February 2023). This is a reducing position from £1.4m reported in M10.
6. The draft pre-audit year end position delivered at £0.2m surplus against a break-even plan.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
09/02/23	Review of M10 year to date performance and assess forecast out-turn evaluated risks and mitigations.	G	Closed
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		Closed
18/04/23	The Draft ICB year-end position pre-audit notes a surplus of £0.2m, exceeding the breakeven plan. Propose to close following year-end.		To Close

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	8											
Change	→											

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	Emma Kriehn Morris	01/07/2022	31/03/2024

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
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

- The ICB has an underlying deficit position of c.£71m at M10 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.	A	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.	B	Complete

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	20											
Change	→											

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** (Target in 12 months)		
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 295 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 • Single agreed system dashboard established • New Transfer of Care form and processes approved for use across system Patient Transport meeting weekly x3 (one for each site)	**Internal:** ICB Executive Management Team; UEC Board; Discharge Programme Board; Discharge Steering Group; ICB Quality and Safety Committee; Bi weekly discharge touchpoint meeting. Daily IMT and weekly Patient Transport Meetings. **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 needs to embed fully

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.	G	31/03/23
1/11/22	Discharge hub funding established for 2022-23.	G	31/03/23
1/11/22	Deep dive into hubs their systems and processes completed. Outcome report sitting with system CEOs awaiting next steps.	G	31/01/23
1/11/22	Deep dive into fast-track process for end of life patients has commenced.	A	28/02/23
1/11/22	Daily deep dive into Pathway 1 discharges continues.	G	31/03/23

9/11/22	Roll out of criteria lead discharge to all wards has commenced.	A	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.	A	31/03/23
10/01/23	ICB staff deployed as of 20th December 2022 to support discharge in acute trusts.	G	31/01/23
10/01/23	Funding secured from national £500m budget to support discharge. Business cases submitted and provisional plan agreed.	B	Complete
10/01/23	New 'four weeks of free care' funding (£250m national fund, of which £50m is capital) confirmed. Daily task and finish group established to agree implementation, week commencing 16/01/23.	G	31/01/23
10/01/23	28 Norse beds identified for pathway 2 beds at NCH&C. 9 beds used to date. Unable to fully utilise, due to criteria for admission and environment.	A	31/01/23

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

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	Risk owner / Operational Lead	Date risk identified	Target delivery date	Month risk rating											
					1	2	3	4	5	6	7	8	9	10	11	12
BAF12a	Impact on Business Continuity in the event of a Cyber Attack	Ian Riley/ Anne Heath		31/03/23	8											
BAF12b	Impact on Business Continuity in the event of a specific Cyber Attack	Ian Riley/ Anne Heath		31/03/23	9											
BAF13	Personal data	Ian Riley / Anne Heath	01/07/22	31/03/23	12											

** In accordance with discussions at the ICB's Audit and Risk Committee, it was agreed that BAF12 would be split into two separate risks. Therefore, for the purposes of clarity BAF 12 has closed and BAF12a and BAF12b has been created.

BAF12a	
Risk Title	**Impact on Business Continuity in the event of a Cyber Attack**
Risk Description	Current heightened risk of hostile cyber-attack affecting the UK may, via a ransomware, brute force, DDOS (Distributed denial of service) or social engineering 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.
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
Ian Riley	Board	Anne Heath	01/03/2023	31/03/2024

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	2	4	8	2	3	6

Controls	Assurances on controls
• ICB, NCHC 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, SCCM 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 • As of November 2022, NHSMail is protected by Microsoft Safe Links & Attachments • The local Cyber Resilience group provides early access to Cyber intelligence allowing organisations in the local health community to be better prepared for cyber-attacks. • Annual IT Health checks (Penetration tests) undertaken to identify weaknesses in ICT/Cyber controls • SDWAN (Software Defined Wide Area Network) implemented across the ICB • The ICB's ICT provider are an exemplar in terms of Cyber Security and technical innovation. • Leaver processes for NHS mail accounts are now standardised for the ICB so all leavers have their NHS Mail accounts disabled	**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, NCHC, 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 from April.
- 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 from June 2023.
- 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. This will be avialible in May 2023

- 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. MFA will become mandatory on NHS Mail in June 2023
- 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.
- 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
- 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 ICB or Primary Care staff provided with an NHS Mail address		Complete
10/01/23	Working with NCHC to ensure that MFA mandatory for non ICB or Primary Care Staff provided with an ICB NHS Mail address.		Complete
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.		Complete
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		Complete
16/05/22	Assurance has now been provided by NHS Digital both nationally and regionally to a level that meets DSPT requirements.		Complete
09/03/23	Deploy Zscaler (Could based AI Firewall and security platform) on the three office networks.		Complete

Visual Risk Score Tracker – 2023/24

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

BAF12b				
Risk Title	**Impact on Business Continuity in the event of a specific Cyber Attack**			
Risk Description	Current heightened risk of hostile cyber-attack affecting the UK may, via a Phishing attack resulting in data exfiltration and/or ransomware attack resulting in a data breach of patient/personal information and/or financial extortion, impact on the ICB's ability to maintain business continuity, if access to data stored within Office 365 on the national NHS tenant takes place, by gaining access to and/or corrupting data held within the ICB's section of the national tenant. Through one of the following top three risks identified by the IG Working Group: - 1. Ransomware attack 2. Lack of user awareness 3. Phishing/social engineering			
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**
Ian Riley	Board	Anne Heath	01/03/2023	31/03/2023

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	3	3	9	2	3	6

Controls	**Assurances on controls**
• From June 2023 MFA on NHS Mail will deployed as part of national policy from NHSE • ICB, NCHC and AGEM 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, SCCM 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 • Since November 2022, NHSMail is protected by Microsoft Safe Links & Attachments	**Internal:** Cyber Security Assurance Manager, Head of Digital, IG Working Group, NWICB 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

- MFA on NHS Mail will become mandatory with NHSE Policy from June 2023. In advance this will be piloted with the Digital Team and deployed to Finance and BI as priority areas. In addition in advance advice and guidance for staff on how to activate MFA will be developed and shared widely with staff.
- 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 refresh campaign in April.
- 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 June.
- 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. This will be provided in May.

- 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.
- 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.
- 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
- 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	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		Complete
16/05/22 10/01/23	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 February IG Working Group. Work with NCHC Cyber and Infrastructure leads to plan the rollout of MFA across the ICB by NCHC ICT team. Outline plan to be presented to ICB IG Working group in February 2023.		Complete
09/02/23	Ahead of mandatory MFA on NHS Mail from NSHE implement MFA across the entire ICB as per the plan submitted to the Feb 23 IGWG. NHSE date for national MFA moved to July 2023. Pilot has commenced starting with DIgital and IG MFA enabled. EMT update will provided in May for further ICB roll out plans.		01/07/23
03/02/23	Conduct Phishing Simulation to test user awareness of Phishing, providing specific Phishing Awareness training to those members of staff who click links and/or enter their credentials		30/06/23
09/03/23	Refresh Cyber Awareness following the campaign in October/November to ensure existing staff are reminded of the protocols in place and new staff who missed the campaign are made aware. Inclusion in ICB Newsletter and Staff Briefing.		Complete
09/02/23	Develop process for managing compromised NHSmail accounts with NCHC for ICB staff, including remediation of the user account and review of the potential for data exfiltration.		Complete
09/03/23	Pilot deployment of Zscaler (Cloud based AI Firewall and security platform) on selected end user devices within the ICB prior to deployment across the ICB.		Complete

Visual Risk Score Tracker – 2023/24

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

BAF13

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**
Ian Riley	Audit and Risk	Anne Heath	01/07/2022	31/03/2023

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	**5**	**20**	**3**	**4**	**12**	**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.	**B**	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.	**B**	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.	**B**	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 and continue to chase up for these.	**A**	Awaiting latest list of practices signed up from PHM team
11/01/23	Procuring software to monitor and manage data controllers IG agreements across the ICS. This will enable reporting to be done more easily on which agreements have been signed and a full audit trail.	**G**	31/03/2023
10/01/23	NHSE Section 251 agreement has been extended to September 2023. Invoice validation to be in-housed and ICB has requested a change to ensure the ICB team are covered to continue this processing. The PHM team have an up to date list of practices that have signed up to the data processing contract (awaiting latest list to be sent to IG) which allows the ICB to process data on their behalf. The ICB will not process	**G**	

	data for practices that have not signed up. The ICB has initiated and have all acute providers signed up to a PHM data sharing framework which allows for the primary care and acute data to be combined and the ICB and risk stratification supplier to support PHM projects.		

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

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	Risk owner / Operational lead	Date risk identified	Target completion date	Month risk rating											
					1	2	3	4	5	6	7	8	9	10	11	12
BAF14	#WeCareTogether People Plan	Ema Ojiako / Emma Wakelin	01/07/22	01/04/24	12											
BAF15	Staff Burnout	Ema Ojiako / Jo Catlin	01/07/22	31/03/23	12											
BAF16	The resilience of general practice	Mark Burgis / Sadie Parker	01/07/22	31/03/23	16											
BAF17	Financial Wellbeing	Ema Ojiako / Emma Wakelin	01/08/22	ongoing	12											
BAF18	Transition and delegation of primary care services	Andrew Palmer / Sadie Parker	31/10/22	31/10/23	16											
BAF20	Industrial action	Ema Ojiako / Karen Watts / Emma Wakelin	14/11/22	31/03/23	16											

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** (Target in 12 months)		
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 aligns 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. • 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	**A**	31/3/23
30/03/22	Workforce Dashboard to monitor high level milestones and assess progress in place.	**B**	Complete
01/04/22	EDI lead commenced in role to support focus on WRES and Inclusion across the system.	**B**	Complete
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	**G**	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	**G**	March 2023

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

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** (Target in 12 months)		
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 approach 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 • 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	G	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	B	Complete
May 2022	Communications and engagement review has now completed with findings to be presented to EMT in August/September	B	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 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	G	September 2022

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

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 (including workload associated with secondary care interface issues). 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	31/03/2024

Risk Scores

Unmitigated			Mitigated			**Tolerated** (Target in 12 months)		
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 previously 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 • Interface group with representation from primary, community and secondary care system partners Standard contract requirements on interface – gap analysis and action plans, including monitoring being reviewed by contracts team	**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 Covid and flu outbreaks or positive cases, as well as higher levels of sickness absence in general
- 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
- Progress on interface action planning process across Trusts impacted by ongoing winter pressures
- Reporting process for inappropriate transfers of workload from community and secondary care providers to general practice not yet fully worked through
- Workforce and capacity shortages across community pharmacy and dental practices, and ongoing drug shortages, are having an impact on general practice and the rest of the system

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**
16.02.23	Nationally, routine CQC inspections have been suspended. Practice plans submitted to access local discretionary support contained a number of resilience themes: • Recruitment and retention issues, mainly for GPs, nursing staff, receptionists and clinical pharmacists • High levels of staff sickness • Pressures on estates capacity as a result of increasing PCN ARRS roles • Increased and unsustainable winter demand, eg suspected and actual Strep A cases, flu and Covid • Impact on their ability to manage patients in the community and continue to provide services due to ambulance delays • Inability to undertaken phlebotomy on Saturdays as part of enhanced access Colleagues from workforce, digital and estates have been linking in with individual practices accordingly. Additional £150k funding for each locality is now in place until end of March and ARI hubs have all been established to provide additional capacity. Resilience 'handbook' under development to signpost practices to support available. Additional interim capacity from within the ICB has been identified to support the PID inbox process to enable practices to report interface issues. The LMC office is also lending support to analysing themes reported.	**A**	31/03/2023
25.04.23	• CQC inspections have recommenced. • Practices have declared QOF and IIF achievement and the finance team is working through QSSP calculations, expect to be able to make payments to practices within QOF deadlines. • Interface reporting procedure has been finalised with input from LMC and interface group members. Themes being reported monthly to interface group. Contracts team leading discussions with Trusts on action planning to prevent inappropriate transfer of work. Radiology requesting programme of work ongoing and slow to progress due to complexities identified relating to national IRMER guidelines • Working through new GP contract requirements to identify where support can be provided. • Updated comms campaign being planned to provide information to patients on clinical triage and the different roles now operating as part of the general practice team Awaiting final budgets so programmes of work can be finalised, eg resilience funding		30.06.23

Visual Risk Score Tracker – 2023/24												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	16											
Change	➔											

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 (e.g. 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** (Target in 12 months)		
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	G	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	G	24/12/22

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12											
Change	→											

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** (Target in 12 months)		
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
Jan 2023	Internal governance established Board paper November 2022. Further submission to Board in February 2023 PDAF submitted to NHSE Sept 2023. Safe Delegation checklist updated and submitted to NHSE in Sept and Dec. Final submission due 8/2/23 Terms of Reference for Primary Care Commissioning Committee and proposal for a Scheme of Delegation and establishment of two Operational Delivery Groups for medical and dental services to PCCC Jan 2023 for agreement. To Board in February for approval Complaints model – decision made to delegate to ICBs from April 2023, staff to transfer July 2023. Complaints data has been shared. NHSE ContactUs will be delegated from July 2023, with risk of unknown activity and workload. Memorandum of Understanding with HWE for hosting Pharmacy & Optometry services final draft available for ICB EMT agreement Jan 2023 Understanding of financial risk has improved through information sharing and assurance has improved Regional oversight & decision making provided by ICB PC Directors (fortnightly meetings) Multiple task and finish groups (NHSE and ICBs in region) in place re Finance, Quality, IG & Digital; also weekly General mtg for ICB leads, to discuss concerns and issues, share learning and information NHSE has arranged multiple masterclasses to share learning with ICB teams and will continue	**G**	28/02/23
Mar 2023	Final submission of Safe Delegation Checklist on 8 Feb with a deep dive meeting with NHSE on 21 Feb to discuss progress and concerns. Task and Finish Group with NHSE and ICBs has facilitated shared learning and discussion about concerns and agree resolution or escalation as appropriate, has been beneficial. Audit Committee and Board have received detailed reports in February on progress, risks and mitigations being taken. Governance arrangements through Primary Care Commissioning Committee approved by the Board Finance team continue to work with NHSE team to understand financial controls and budgets. Access to payment and contracting systems to be enabled for ICB staff from 1 April 2023 TUPE process for staff transfer to ICB confirmed. Vacancies being recruited where no staff being transferred including Finance, Quality, Complaints and Primary Care Commissioning teams. The ICB has secured a contract with Primary Care Contracting to provide expert advice, guidance and training during 2023/24.	**G**	30/06/2023

	Delays to national data migration process is resulting in interim arrangements being agreed for continued access to NHSE data with a Data Protection Impact Assessment and updated Data Sharing Agreement to be completed. Complaints model to be completed by July 2023, discussions underway to agree how this will happen. Staff will be aligned from April 2023. Engagement with key stakeholders in each of the professions (pharmacy, optometry and dental) has commenced with regular meetings in place.		
May 2023	Board adopted all necessary governance documentation at its meeting in March 2023 to enable the transfer of responsibilities under the Delegation Agreement with NHS England Transition of primary care services and staff within primary care and Finance teams to ICBs completed on 1 April. Recruitment to the Primary Care Commissioning Team continues. Impact of the additional workload on ICB directorates and teams remains unknown and a risk. Transfer of responsibility for complaints also completed on 1 April with a phased staff transition planned for July 2023 subject to consultation when staff resources will be confirmed Data migration of electronic files to be managed during 2023/24, interim digital and governance arrangements for staff to have continued access to NHSE data in place MOU with HWE ICB commenced for managing ICB responsibilities for pharmaceutical and optometry services Informal Touchpoint meetings with all ICBs in the region continues on a fortnightly basis to share learning & raise concerns. Regional Primary Care Directors Transition forum last meeting 27/4/23. ICB Primary Care Transition project team stood down and replaced with targeted team meetings relating to outstanding transition work. The ICB's Primary Care Commissioning Committee confirmed agreement to the new Terms of Reference on 21 April 2023; plans underway to set up the governance for managing the operational Delivery Groups reporting into the Committee. The Committee received two reports on the transition and provision of pharmaceutical, optometry and dental services at its meeting on 21/4/23. Access to management/reporting and payment systems is in place for dental, pharmacy and optometry contracts Finance to confirm all budgets with NHSE, including primary care delegated services (forecast plans shared with Committee 21/4/23). ICB's Dental Development Group established to engage with clinicians from across Norfolk and Waveney primary, community and secondary care. The Group includes Healthwatch to represent the patient voice. The ICB aims to set out a short term plan for dental services by Sept 2023 and a dental strategy and workforce plan by March 2024 using an evidence based approach (updated Oral Health Needs Assessment and other surveys/intelligence) to identify unmet need and ICB priorities. Workforce data being collated to fully understand the workforce recruitment & retention challenges across primary care services and to begin to develop plans Following successful transition and discussion at EMT, this risk covering the Transition of Services will be refocused towards specific		30/09/23

	dental risks relating to quality, access and workforce, and will be updated to reflect this at the next Board meeting.	

Visual Risk Score Tracker – 2023/24												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	16											
Change	➔											

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	31/03/2024

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**4**	**4**	**16**	**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

• As of April 2023 the system has now managed a number of strike days; for nurses, junior doctors, physiotherapists and ambulance staff. Processes are established for System incident command and control.	

Gaps in controls or assurances

- The impact of ongoing industrial action on staff and service users is significant. Impact on recovery of the elective programme and other high-risk areas such as UEC and discharge is as yet not fully known.
- There is the potential for this to impact on health inequalities.

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.	B	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	B	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	G	30/09/23
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.	G	30/09/23
14/11/22	Testing system preparedness will be coordinated with wider winter planning. Exercise Artic Willow planned for week commencing 14/11/22.	B	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.	G	30/09/23
14/11/22	ICB have reviewed clinical staff for potential deployment. Face to face clinical skills training commenced for ICB staff	B	31/12/22

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16											
Change	↑											

Norfolk and Waveney
Integrated Care Board

Agenda item: 13

Subject:	Individual Funding Request IFR-Drugs Panel Policy
Presented by:	Karen Barker, Executive Director of Corporate Affairs on behalf of Dr Frankie Swords. Medical Director
Prepared by:	Jackie Cotton, Individual Funding Request -Drugs Panel Administrator, Ruth Spencer, Individual Funding Request Manager, Non Drugs Michael Dennis, Associate Director of Pharmacy and Medicines Optimisation (Chief Pharmacist)
Submitted to:	ICB Board
Date:	**30 May 2023**

Purpose of paper:

To request the ratification of the IFR Drugs and Non-Drugs Panel Policies

Executive Summary:

The Drugs-IFR Panel Policy is based on the national template. It was first approved by the CCG Board in 2015 and is now due for review every 3 years.

Minor revisions were made at its first review in November 2020, and the current version was approved by the Board of NHS Norfolk & Waveney CCG in January 2021.

Further revisions to reflect the change in organisation from CCG to ICB and in line with the scheme of financial delegation of the ICB have now also been made. They key change being on page 11 of attached policy:
The Chair of the IFR Panel has delegated responsibility to approve funding requests up to a maximum of £50,000 per annum, after approval by the IFR Panel. Responsibility for approving requests for funding over £50,000 per annum has been delegated to the Chief Executive Officer or Director of Finance after approval by the IFR Panel.

The Non-Drugs IFR Policy has also had minor revisions to the following areas.

- P1. Amended sentence for clarity – 'related clinical threshold policy' (was policy)
- P5. Updated to include a medical qualified Public Health consultant as a voting member.
- P5. Further minor revisions have now been made, in line with the scheme of financial delegation of the ICB as above. The Chair of the IFR Panel has delegated responsibility to approve funding requests up to a maximum of £50,000 per annum, after approval by the IFR Panel. Responsibility for approving requests for funding

over £50,000 per annum has been delegated to the Chief Executive Officer or Director of Finance after approval by the IFR Panel.
- P7. Clarification as to who could make clinically urgent decisions if a formal panel cannot be convened in time.
- P18. Clarification as to the definition of devices.

This revised versions have both been through the required local governance and recommended for approval by the Executive Medical Director Dr Frankie Swords as chair of the Planned Care and Medicines Working Group on 25 May 2023.

The board is asked to approve the updated policies.

Recommendation to the Board:

To approve the revised policies as per the recommendation of the Planned Care and Medicines management working group

Key Risks	
Clinical and Quality:	**Principal risk:** That people in Norfolk will experience poor health outcomes due to suboptimal care. On an individual basis, there may be situations where a clinician believes that their patient's clinical situation is so different to other patients with the same condition that they should have their treatment paid for when other patients would not. In such cases, NHS clinicians can ask NHS England, on behalf of a patient, to fund a treatment which would not usually be provided by NHS England for that patient. This request is called an Individual Funding Request (IFR). If this process is not followed, there is a risk that patients could miss out on treatments so adversely affecting their clinical outcome.
Finance and Performance:	BAF 11 Achieve the 2022/23 Financial Plan If decisions are made outwith this policy and scheme of financial delegation, these could risk our delivery against ICB financial plan.
Impact Assessment (environmental and equalities):	NA
Reputation:	BAF 06 Health Inequalities If there is no clear policy to underline why IFRs are supported or declined this could lead to worsening health inequalities and significant adverse publicity
Legal:	There is a risk of legal challenge against funding decisions if the national process is not fully adhered to.
Information Governance:	NA
Resource Required:	NA

Reference document(s):	NHS England Interim Commissioning Policy – IFRs April 2013
NHS Constitution:	NA
Conflicts of Interest:	NA
Reference to relevant risk on the Board Assurance Framework	**Principal risk:** That people in Norfolk will experience poor health outcomes due to suboptimal care. BAF 11 Financial Plan BAF 06 Health inequalities

Governance

Process/Committee approval with date(s) (as appropriate)	Updates to existing policies recommended for approval at Planned Care and Medicines Management Working Group May 2023

Improving lives together
Norfolk and Waveney Integrated Care System

NHS
Norfolk and Waveney
Integrated Care Board

INDIVIDUAL FUNDING REQUEST-DRUGS PANEL

COMMISSIONING POLICY

DOCUMENT CONTROL SHEET

Name of Document	Individual Funding Requests-Drugs Panel Commissioning Policy
Version	5
Status	Final
Date of this version	15.05.23
Approved by Committee	PCMMWG Dec 22

REVISION HISTORY

Revision Date	Summary of Changes	Author(s)	Version Number
30.12.22	References to CCG changed to ICB and up to date logos added	Jackie Cotton	V4
15.05.23	Details around threshold of delegated responsibility for funding added to P11 – 4th bullet point	Jackie Cotton	V5

Approvals

This document requires the following approvals either individual(s), group(s) or board

Name	Title	Date of Issue	Version Number

Contents

Equality and Diversity Impact Assessment

In reviewing this document, as a minimum, the following questions where considered:

- Are the aims of this document clear?
- Are responsibilities clearly identified?
- Has the document been reviewed to ascertain any potential discrimination?
- Are there any specific groups impacted upon?
- Is this impact positive or negative?
- Could any impact constitute unlawful discrimination?
- Are communication proposals adequate?
- Does training need to be given? If so, is this planned?

Adverse impact has been considered for age, disability, gender, race/ethnic origin, religion/belief/sexual orientation. The ICB have satisfied themselves that the document is non-discriminatory. Please also see detailed EIA

Purpose of the Policy

The NHS Norfolk & Waveney ICB wish to operate a policy for decision making in respect of Individual Funding Requests on a consistent basis across the NHS Norfolk and Waveney area. For that purpose, the ICB has agreed to operate two individual policies and to work within two IFR Panels, one for non-drug requests and one for drug requests.

The ICB will appoint a chair for each IFR Panel and will ensure that there is clinical representation at each IFR Panel meeting. The voting ICB representatives will have delegated authority to make decisions on behalf of the ICB.

The ICB remains accountable for its own decisions made in respect of IFRs in line with the legal duties of ICBs set out in The Health and Social Care Act 2012[i].

The IFR-Drugs Panel will be administered by the ICB Medicines Optimisation Team. Norfolk County Council will provide Public Health advice as part of the Core Offer to the ICB. The ICB may leave the arrangement by giving 3 month's written notice.

The policy will be reviewed every three years or sooner at the request of the NHS Norfolk and Waveney ICB Chair & Chief Officer

This policy outlines these conditions and the criteria which are used for decision making when considering IFR requests and applies to any person for those procedures for whom the ICB is the responsible commissioner for NHS care.

The ICB has a duty to have regard to the need to reduce health inequalities in access to health services and health outcomes achieved as outlined in the Health and Social Care Act 2012.The ICB is committed to ensuring equality of access and non-discrimination, irrespective of age, gender, disability (including learning disability), marriage and civil partnership, pregnancy and maternity, race, religion or belief or sexual orientation. In carrying out its functions, the ICB will have due regard of the Equality Act 2010[ii], the NHS Constitution[iii] and the Human Rights Act1998[iv].

The policy

This policy applies to any patient for whom the NHS Norfolk and Waveney ICB is the Responsible Commissioner for that person or needs medical treatment where the ICB is the responsible Commissioner for the provision of that medical treatment as part of NHS care

Clinicians, on behalf of their patients, are entitled to make a request (an "individual funding request") to the IFR Panel for treatment to be funded by the ICB that is not normally commissioned by the ICB under defined conditions namely:

- The request does not constitute a service development

AND

- The patient is suffering from a medical condition for which the ICB has a policy but where the patient's particular clinical circumstances falls outside the criteria set out in

the existing commissioning policy for funding the requested treatment. – a request for exceptional funding

OR

- The patient is suffering from a medical condition, or requesting a treatment, for which the NHS Norfolk and Waveney ICB has no policy - a request for individual funding

OR

- The patient has a rare clinical circumstance, thus rendering it impossible to carry out clinical trials, and for whom the clinician wishes to use an existing treatment on an experimental basis.

All decisions will be reported to the referring clinician for communication with the patient.

The ICB IFR-Drugs Panel cannot consider any request for indications or therapies commissioned by NHS England (See NHS England 'The Manual' for a list of the prescribed specialised services https://www.england.nhs.uk/commissioning/spec-services/key-docs/ .
Applications should be made direct to NHS England.

SCREENING INDIVIDUAL FUNDING REQUESTS

Screening for service developments
All individual funding requests submitted to the ICB will be subject to screening to determine whether the request represents a service development. Service developments include, but are not restricted to:

- New services
- New treatments including medicines, surgical procedures and medical devices.
- Developments to existing treatments including medicines, surgical procedures and medical devices.
- New diagnostic tests and investigations.
- Quality improvements.
- Requests to alter existing policy (called a policy variation). The proposed change could involve adding in an indication for treatment, expanding access to a different patient sub-group or lowering the threshold for treatment.
- Requests to fund a number of patients to enter a clinical trial and the commissioning of a clinical trial are considered as service developments in this context as they represent a need for additional investment in a specific service area.

What is a Service Development?
A request for a treatment should be classified as a request for a service development if there are likely to be a cohort of similar patients who are:

- In the same or similar clinical circumstances as the requesting patient whose clinical condition means that they could make a like request (regardless as to whether such a request has been made)

AND

- Who could reasonably be expected to benefit from the requested treatment to the same or a similar degree.

What is a "cohort of similar patients"?
A cohort of similar patients for the purposes of this policy has been defined as the number of requests received or likely to be received per year which will require consideration of a commissioning policy. In these circumstances, the IFR route to funding may only be considered if the patient is clinically exceptional to the cohort.

What are the conditions which require consideration of a commissioning policy?
The ICB will consider the development of a clinical commissioning policy where:

The numbers of patients to the IFR-Drugs Panel for whom the treatment will be requested per year is likely to be 2 or more patients in the population served by the Norfolk & Waveney ICB. Upon receipt of the second or third request for funding a business case/clinical commissioning policy will be requested. (The IFR-Drugs Panel will continue to have the right to make decisions on any further similar applications for funding whilst a policy is in the process of being produced, but it should be noted that the time limit on the production of the policy should not be open ended.)

OR

The cost of funding the requested treatment for an individual is likely to result in considerable expenditure to the ICB.

If the numbers of patients for whom the treatment is requested is likely to be below 2 per year the IFR-Drugs Panel will consider the request for funding. Where the numbers of patients are likely to be 2 or (or more) or the costs are likely to be considerable the ICB will be notified.

The IFR-Drugs Panel is not entitled to make policy decisions for the ICB. It follows that where a request has been classified as a service development for a cohort of patients, the IFR-Drugs Panel is not the correct body to decide about funding the request. In such circumstances the individual funding request should not and will not be presented to the IFR-Drugs panel but will be dealt with in the same way as other requests for a service development through ICB due processes.

Where an IFR has been classified as a service development for a cohort of patients, the options open to the IFR-Drugs Panel include:

- To refuse funding and request the provider prioritises the service development internally within the provider organisation that made the request and, if supported, to invite the provider to submit a business case as part of the annual commissioning round for the requested service development

- To refuse funding and initiate an assessment of the clinical importance of the service development within the ICB with a view to developing a policy and determining its priority for funding in the next financial year

- To refer the request for funding for immediate workup of the service development as a potential candidate for in year service development

Screening for incomplete submissions
If a request is not categorised as a service development, it will be subject to a screening process to determine whether the request has sufficient clinical and other information in order for the individual funding request to be considered fully by the IFR-Drugs Panel. Where information is lacking the individual funding request will be declined and returned to the provider specifying the additional information which would be required in order to enable this request to proceed. The request can be resubmitted at any point.

Screening to assess whether the request raises a case which ought to go to the IFR-Drugs Panel
If a request has been accepted as not constituting a service development and the paperwork is sufficiently complete to assess the case, then the request will be forwarded to the IFR-Drugs Panel unless there is no reasonable prospect that the IFR-Drugs Panel (applying the tests set out in this policy) will approve the request

ASSESSMENT OF IFRS WHICH HAVE PASSED SCREENING

Exceptionality requests which seek to secure treatment for a patient whose clinical circumstances do not currently qualify them for funding under an existing commissioning policy

An exceptionality request can be made in relation to a medical condition where the ICB has a Commissioning Policy or has a positive NICE TA recommendation but the patient's clinical circumstances or the requested treatment falls outside the ICB Policy. These exceptionality requests should be completed by the clinician with reference to the relevant generic and/or treatment specific commissioning policy.

The IFR-Drugs Panel shall be entitled to approve funding if the patient has exceptional clinical circumstances. In considering whether or not to fund a patient on grounds of exceptional clinical circumstances, in this situation, the IFR-Drugs Panel will act as follows:

- The IFR-Drugs Panel will use the information provided by the requester to compare the patient to other patients with the same presenting medical condition at the same stage of progression. Specifically, the panel may consider, based upon the evidence provided to it, whether or not the patient has demonstrated exceptional clinical circumstances which lead the panel to believe that the patient would benefit significantly more from the treatment than the other patients not meeting funding criteria.
- When making their decision, the IFR-Drugs Panel is required to restrict itself to considering only the patient's presenting medical condition and the likely benefits which have been demonstrated by the evidence to be likely to accrue to the patient from the proposed treatment.
- The IFR-Drugs Panel shall seek to make decisions in accordance with the NHS ethical framework & principles, including the requirement to have due regard to the obligations of the Equality Act 2010 save where a difference in treatment is based on objectively justifiable factors and is a justified and proportionate response to the needs of different groups of patients.
- The IFR-Drugs Panel shall seek to make decisions in accordance with the 1998 Human Rights Act
- The IFR-Drugs Panel will not make recommendations for treatments available to individual patients, or other clinically similar patients, on the basis of non-clinical factors.
- The IFR-Drugs Panel shall have discretion to determine whether the proposed treatment is a justifiable expenditure for the ICB. The IFR-Drugs panel is however required to bear in mind that the allocation of any resources to support any individual patient will reduce the availability of resources for investments in previously agreed care and treatments.

Exceptionality requests which seek to fund an existing treatment experimentally for one or more patients with a rare clinical condition or rare clinical circumstances.

This patient group represents a distinct group of exceptions and so are assessed in line with the ICB commissioning policy on experimental and unproven treatments.

In the absence of such a policy, the IFR-Drugs Panel shall be entitled to approve funding an experimental treatment for patients with rare clinical conditions or clinical circumstances.

In considering whether or not to agree to fund the treatment the IFR-Drugs Panel's consideration shall include the following factors:

- The potential benefit and risks of the treatment
- The biological plausibility of anticipated benefit for the patient based on evidence of this treatment in other similar disease states
- Value for money
- Affordability and priority compared to other competing needs and unfunded developments
- Where the request is in respect of more than one patient or it is clear from the nature of the request that there is likely to be more than one patient, then the IFR-Drugs panel should consider whether or not the request is a service development or trial

Identification bias
The IFR-Drugs Panel shall take care to avoid identification bias, often called the "rule of rescue". This can be described as the imperative people feel to rescue identifiable individuals facing avoidable death or a preference for identifiable over statistical lives[1].In plain terms this means; supporting intensive effort to prolong life (when prognosis appears poor and death unavoidable) and when there is little research evidence to support treatment options (e.g. in relapsed/refractory stages of disease). The fact that a patient has exhausted all NHS treatment options available for a particular condition is unlikely, of itself, to be sufficient to demonstrate exceptional circumstances. Equally, the fact that the patient is refractory to existing treatments where a recognised proportion of patients with the same presenting medical condition at this stage are, to a greater or lesser extent, refractory to existing treatments is unlikely, of itself, to be sufficient to demonstrate exceptional circumstances

INFORMATION SUBMITTED TO THE IFR-DRUGS PANEL

All applications must be accompanied by written support and evidence provided by the clinical team treating the patient in line with the ICB Procedure for the Management of Individual Funding Requests. It is the clinician's responsibility to ensure that the appropriate information is provided to the ICB according to the type of request being made, in a timely fashion consistent with the urgency of the request. If relevant information is not submitted, then the referring clinician will bear responsibility for any delay that this causes.

In all instances the lead treating clinician must state whether or not they consider there are similar patients (in accordance with the definition set out above) and, if so, how many such patients there are.

All clinical teams submitting IFR requests must be aware that information that is immaterial to the decision will not be considered by the IFR Panel. This may include information about non-clinical factors relating to the patient or information which does not have a direct connection to the patient's clinical circumstances.

An electronic request form must be completed by the referring clinician. The request forms are available on the Knowledge Anglia website or email norfolkicd@nhs.net

Requests for patients covered by NHS England's responsibilities should be sent directly to NHS England. If such requests are sent to the address above, the requesting clinician will be informed that they will need to submit a request to NHS England via england.ifr@nhs.net

[1] McKie J. Richardson J. The rule of Rescue *Soc.Sci.Med.* 2003 June:56(12) 2407-19

It is not within the IFR-Drugs Panel's remit to consider applications which have been refused by NHS England.

If further information is required to prepare the case for consideration by the IFR-Drugs Panel this may delay presentation to the IFR-Drugs Panel. All required information from the provider hospital trust/clinician must be sent to the IFR-Drugs Panel Administrator at least 10 working days before the scheduled date of the IFR-Drugs Panel at which the case is to be considered.

All applications must be accompanied by written support and evidence provided by the clinical team treating the patient explaining:

- Whether the request for funding is an individual request or an exceptional request.
- The clinical circumstance of the patient. The Clinical Team is required to present a full report to the IFR-Drugs Panel which sets out a comprehensive and balanced clinical picture of the history and present state of the patient's medical condition, the nature of the treatment requested and the anticipated benefits of the treatment.
- The planned treatment and the expected benefits and risks of treatment. The Clinical Team shall describe the anticipated clinical outcomes for the individual patient of the proposed treatment and the degree of confidence of the Clinical Team that the outcomes will be delivered for this particular patient.
- The evidence on which the clinical opinion is based. The clinician shall refer to, and include, copies of any clinical research material which supports, questions or undermines the case that is being made that the treatment is likely to be clinically effective in the case of the individual patient.
- The costs of treatment. The Clinical Team shall set out the full attributable costs of and connected to the treatment. The IFR-Drugs Panel shall be entitled but not obliged to commission its own reports from any duly qualified or experienced clinician or other duly qualified person concerning the full attributable costs of and connected to the treatment.
- Whether or not there are likely to be similar patients either within the NHS Norfolk and Waveney ICB area or across the region. For exceptionality requests the clinician must also provide the case for treating this patient and no other apparently similar patients.

APPROVAL OF INDIVIDUAL FUNDING REQUESTS

The IFR-Drugs Panel shall be entitled to approve requests for funding for treatment for individual patients where all the following conditions are met:

- Save in the case of funding requests under the section "Screening for Service Developments" (page 7), the IFR-Drugs Panel is satisfied that there is no cohort of similar patients. If there is a cohort of similar patients the IFR-Drugs Panel shall decline to make a decision because the application is required to be treated as a request for a service development.
- One of the conditions set out under the section "The Policy" (page 5) above is met.
- Exceptional circumstances apply and there is sufficient evidence to show that, for the individual patient, the proposed treatment is likely to be clinically and cost effective or that the clinical trial has sufficient merit to warrant NHS funding.
- The ICB can afford the treatment. **The Chair of the IFR Panel has delegated responsibility to approve funding requests up to a maximum of £50,000 per annum, after approval by the IFR Panel. Responsibility for approving requests for funding**

over £50,000 per annum has been delegated to the Chief Executive Officer or Director of Finance after approval by the IFR Panel.

The IFR-Drugs Panel is not required to accept the views expressed by the patient or the clinical team concerning the likely outcomes for the individual patient of the proposed treatment, but it is entitled to reach its own views on:

- The likely clinical outcomes for the individual patient of the proposed treatment; AND
- The quality of the evidence presented to support the request and/or the degree of confidence that the IFR-Drugs Panel has about the likelihood of the proposed treatment delivering the proposed clinical outcomes for the individual patient.

The IFR-Drugs Panel shall be entitled but not obliged to commission its own reports from any duly qualified or experienced clinician, medical scientist or other person having relevant skills, concerning the case that is being made that the treatment is likely to be clinically effective in the case of the individual patient. Reference to nationally recognised evidence syntheses should be used where they address the specific issues under consideration.

The IFR-Drugs Panel may make such approval contingent on the fulfilment of such conditions as it considers fit.

Very occasionally an individual funding request presents a new issue which needs a substantial piece of work before the ICB can reach a conclusion upon its position. This may include wide consultation. Where this occurs the IFR-Drugs Panel may adjourn a decision on an individual case until that work has been completed.

COMMUNICATION OF DECISIONS

The referring clinician making the request will be informed of the IFR-Drugs Panel's decision as soon as practicable via email and/or by letter within 10 working days (in practice this is likely to be sooner.) Patient confidentiality will be maintained at all times.

All decisions will be sent to the referring clinician for communication to the patient,

REVIEW OF THE DECISION

Where the IFR-Drugs Panel has refused to support funding for a requested treatment or has approved the treatment subject to conditions, the patient shall be entitled to ask that the decision of the IFR-Drugs Panel be reviewed. All requests for a review must be supported by the senior treating clinician in writing to the Chair of the IFR-Drugs Panel and copied to the IFR-Drugs Panel Administrator within 30 working days (i.e. 6 weeks) of the date of the IFR-Drugs Panel's decision. The clinician must clearly outline the reasons as to why the decision taken by the IFR-Drugs panel was:

- procedurally improper and/or
- that it misunderstood the medical evidence and/or
- was in the clinician's opinion a decision which no reasonable IFR panel would have reached.

The IFR-Drugs Panel Chair will consider the clinician's request and refer the case to the IFR-Drugs Panel Administrator within 15 working days. The IFR-Drugs Panel Administrator will then notify the NHS Norfolk and Waveney ICB and arrange for an IFR Review Panel to be set up. The IFR Review Panel for IFR-Drugs Panel applications will be the Non-Drugs Panel. The IFR Review Panel will reach a decision within 30 working days of the IFR-Drugs Panel Administrator referring the case back to the ICB. The IFR Review Panel will set out its decision and the reasons for it as soon as practicable in writing via e-mail or letter to both the IFR-Drugs Panel and the referring clinician. It is the responsibility of the referring clinician to notify the patient in a timely manner of the IFR Review Panel decision

In any case where further relevant information becomes available which has not been considered by the IFR-Drugs Panel, the referring clinician may ask the IFR-Drugs Panel to reconsider the case specifically in the light of this further information

The IFR Review Panel is part of the corporate governance process of the ICB. The role of the IFR Review Panel is to determine whether the IFR-Drugs Panel has followed the ICB procedures, has properly considered the evidence presented to it and has come to a reasonable decision upon the evidence.

The IFR Review Panel shall consider whether:

- The process followed by the IFR-Drugs Panel was consistent with the operational policy of the ICB
- The decision reached by the IFR-Drugs Panel:
  - was taken following a process which was consistent with the policies of the ICB
  - had taken into account and weighed all the relevant evidence
  - had not taken into account irrelevant factors
  - indicated that the members of the panel acted in good faith
  - was a decision which a reasonable IFR panel was entitled to reach.

If the IFR Review Panel considers that there was no reasonable prospect of the IFR-Drugs Panel coming to a different decision, then the IFR Review Panel shall approve the decision notwithstanding the procedural error.

However, if the IFR Review Panel considers that there was a reasonable prospect that IFR-Drugs Panel may have come to a different decision if the IFR-Drugs Panel had not made the procedural error, the IFR Review Panel shall require the IFR-Drugs Panel to reconsider the decision.

The IFR Review Panel shall not have power to authorise funding for the requested treatment but shall have the right to make recommendations to the IFR-Drugs Panel and/or to request one of the Officers authorised to take urgent decisions to consider exercising that power.

Should the referring clinician or patient remain dissatisfied with the IFR Review Panel decision, either of them may pursue the matter through the NHS Complaints Procedure.

CO-OPERATION OF PROVIDER TRUSTS

The ICB requires provider trusts and clinicians to take the ICB commissioning policies into account in the advice and guidance given to patients prior to making the decision to treat a patient. The ICB expects the management of its provider trusts to have oversight of this process. The ICB would expect every individual funding request to be sanctioned by provider trust management and reserves the right to return unsanctioned individual funding requests to the provider trust unassessed and refer recurrent inappropriate funding requests to the Chief Executive of the relevant provider trust.

URGENT TREATMENT DECISIONS

The ICB recognises that there will be occasions when an urgent decision needs to be made to consider approving funding for treatment for an individual patient outside the ICB's normal policies. In such circumstances the ICB recognises that an urgent decision may have to be made before a panel can be convened. The following provisions apply to such a situation.

- An urgent request is one which requires urgent consideration and a decision because the patient faces a substantial risk of death or significant harm if a decision is not made before the next scheduled meeting of the IFR-Drugs Panel.
- Urgency under this policy cannot arise as the result of a failure by the Clinical Team expeditiously to seek funding through the appropriate route and/or where the patient's legitimate expectations have been raised by a commitment being given by the provider trust to provide a specific treatment to the patient. In such circumstances the ICB expects the provider trust to proceed with treatment and for the provider to fund the treatment.
- Provider trusts must take all reasonable steps to minimise the need for urgent requests to be made through the IFR process. If clinicians from any provider trust are considered by the ICB not to be taking all reasonable steps to minimise urgent requests to the IFR process, the ICB may refer the matter to the provider Trust Chief Executive.
- In situations of clinical urgency, the decision will be made by staff authorised to make an urgent decision as set out in the ICB Standard Operational Procedures (SOP) for the Management of Individual Funding Requests.
- Where an urgent decision needs to be made to authorise treatment for an individual patient outside the ICB's normal policies, the decision will be made by an individual authorised to do so by the ICB (the Authorised Senior Health Professional – "ASHP"). The ICB AO or deputy will be contacted in such cases and asked to nominate an ASHP.

- The ASHP or the extraordinary IFR Panel (as described in the ICB's SOP for the Management of Individual Funding Requests) will as far as possible within the constraints of the urgent situation, follow the policy set out above in making the decision. The ASHP shall consider the nature and severity of the patient's clinical condition and the time period within which the decision needs to be taken. As much information about both the patient's illness and the treatment should be provided as is feasible in the time available and this shall be considered for funding in accordance with relevant existing commissioning policies.
- The ASHP and the IFR-Drugs Panel shall be entitled to reach the view that the decision is not of sufficient urgency or of sufficient importance that a decision needs to be made outside of the usual process.
- The ASHP and the extraordinary IFR-Drugs Panel shall be entitled to reach the view that the request is, properly analysed, a request for a service development and so should be refused and/or appropriately referred for policy consideration.
- Where the ASHP considers that there is sufficient time to consult the Chair and/or members of the IFR-Drugs Panel before making an urgent decision, the ASHP shall do so and shall take any views into consideration before making a decision
- A written record must be made of any such urgent request and the decision made, and these will be reviewed and ratified by the full membership of the IFR-Drugs Panel at the next IFR-Drugs Panel meeting.
- For all urgent requests, the IFR-Drugs Panel will aim to make a decision within 10 working days of receipt of the request. Trusts should treat all urgent and life-threatening situations based on the clinical need.
- PLEASE NOTE FOR REQUESTS MARKED AS URGENT A DECISION WILL BE GIVEN WITHIN 10 WORKING DAYS.
- IF THE REFERRING CLINICIAN CONSIDERS THAT TREATMENT CANNOT BE DELAYED AND DECIDES TO TREAT IMMEDIATELY THEN THE COST OF SUCH TREATMENT IS INCURRED AT THE RISK OF THE PROVIDER.

Appendix A

GUIDANCE NOTES

The UK Faculty of Public Health has published a statement describing the concept of exceptionality[v]:

"It is important to distinguish between an exceptional case and an individual funding request.

In an exceptional case, a patient seeks to show that he or she is an 'exception to the rule' or policy and so may have access to an intervention that is not routinely commissioned for that condition. In contrast, an individual funding request arises when a treatment is requested for which the commissioning organisation has no policy. This may be because:

- *It is a treatment for a very rare condition for which the commissioners have not previously needed to make provision or*
- *There is only limited evidence for the use of the treatment in the requested application or*
- *The treatment has not been considered by the commissioners before because it is a new way of treating a more common condition. This should prompt the development of a policy on the treatment rather than considering the individual request unless there is grave clinical urgency."*

In practice, all requests for funding for an individual patient have been called Individual Funding Requests (IFRs) but these sub-categories of request should be recognised. IFRs also need to be understood in the context of routinely funded services.

Most established treatments and services are subject to routine commissioning arrangements: a portfolio of contracts and service level agreements, clinical commissioning policies, mandatory National Institute of Health and Clinical Excellence (NICE) technology appraisal guidance.

This guidance note is intended to distinguish the broad types of request that may be received. These are where the request:

- Represents a service development for a cohort of patients
- Is on grounds of clinical exceptionality where there are commissioning arrangements in place
- Is on grounds of rarity and no commissioning arrangements exist
- Is for a new intervention or for use of an intervention for a new indication, where no commissioning arrangements exist

SERVICE DEVELOPMENTS AND COHORTS OF SIMILAR PATIENTS

Service Developments
A service development is any aspect of healthcare which the ICB has not historically agreed to fund, and which will require additional and predictable recurrent funding.
The term refers to all decisions which have the consequence of committing the ICB to new expenditure for a cohort of patients including:

- New services
- New treatment including medicines, surgical procedures and medical devices
- Developments to existing treatments including medicines, surgical procedures and medical devices
- New diagnostic tests and investigations
- Quality improvements
- Requests to alter an existing policy (called a policy variation). This change could involve adding in an indication for treatment, expanding access to a different patient subgroup or lowering the threshold for treatment.
- Support for establishing new models of care
- Requests to fund a number of patients to enter a clinical trial
- Commissioning a clinical trial.

It is normal to consider funding new developments during the annual commissioning prioritisation round during Horizon Scanning.

An in-year service development is any aspect of healthcare, other than one which is the subject of a successful individual funding request, which the ICB agrees to fund outside of the annual prioritisation and commissioning round.

When a commissioning organisation considers funding a service development outside the normal prioritisation and commissioning process it is particularly important that those taking the decision pay particular attention to the need to take account of the opportunity cost for the ICB to fund other areas of competing health needs.

Unplanned investment decisions should only be made where they have been approved in accordance with the terms of this policy, which will usually be in exceptional circumstances, because, unless they can be funded through disinvestment, they will have to be funded as a result of either delaying or aborting other planned developments.

It is common for clinicians to request individual funding for a patient where the request is, properly analysed, the first patient of a group of patients wanting a particular treatment. For example, a new drug has been licensed for a particular type of cancer and for patients with particular clinical characteristics. Any individual funding request which is representative of this group represents a service development. As such it is difficult to envisage circumstances in which the patient can properly be classified to have exceptional clinical circumstances. Accordingly, the individual funding request route is usually an inappropriate route to seek funding for such treatments as they constitute service developments. These funding requests are highly likely to be returned to the provider trust, with a request being made for the clinicians to follow the normal processes to submit a bid for a service development.

The concept of a cohort of similar patients.
The policy recognises that there needs to be a distinction between cases where the clinical circumstances are genuinely exceptional and those where the presenting clinical circumstances are representative of a small group of other patients.

Where the presenting clinical circumstances are representative of a small group of other patients the position of the ICB is that a decision to fund or not is a policy decision and not a funding decision for an individual patient i.e. it has wider funding implications.

Treating this as a policy decision, to be made in the wider context of ICB commissioning and priority setting ensures that the outcome of the decision is applied equally to all the other patients who have the same presenting clinical circumstances and the principle of prioritisation is upheld.

The ICB has set the level at which cases will require consideration of a commissioning policy. Once this number of requests is met, the IFR route to funding may only be considered if the patient is clinically exceptional to the cohort.

The ICB will consider the development of a clinical drug commissioning policy where the number of patients for whom the treatment will be requested per year is likely to be 2 or more patients in the population served by the ICB.

If the numbers of patients for whom the treatment is requested per year reaches 2 or more, the ICB will treat this as a service development requiring a commissioning policy. If the number of patients presenting per year is less than 2, the ICB will consider whether an IFR is appropriate.

EXCEPTIONALITY

What is meant by exceptional circumstances?

There can be no exhaustive definition of the conditions which are likely to come within the definition of an exceptional individual case. The word ‘exception’ means

‘a person, thing or case to which the general rule is not applicable’.

The IFR-Drugs Panel should bear in mind that, whilst everyone’s individual circumstances are, by definition, unique, very few patients have clinical circumstances which are exceptional, so as to justify funding for treatment for that patient which is not available to other patients.

The following points constitute general guidance to assist the panel. However, the overriding question which the panel needs to ask itself remains: has it been demonstrated that this patient’s clinical circumstances are exceptional?

- It may be possible to demonstrate exceptionality where the patient has a medical condition or circumstance which is so rare that the result of the ICB prioritisation process provides no established treatment care pathway for that treatment.
- If a patient has a condition for which there is an established care pathway, the Panel may find it helpful to ask itself whether the clinical circumstances of the patient are such that they are exceptional as compared with the relevant subset of patients with that medical condition.

- The fact that a patient failed to respond to, or is unable to be provided with, one or more treatments usually provided to a patient with his or her medical condition (either because of another medical condition or because the patient cannot tolerate the side effects of the usual treatment) may be a basis upon which a Panel could find that a patient is exceptional.
- However, the Panel would normally need to be satisfied that the patient's inability to respond to, or be provided with, the usual treatment was genuinely an exceptional circumstance.

For example:

- If the usual treatment is only effective for a proportion of patients (even if a high proportion), this leaves a proportion of patients for whom the usual treatment is not available or is not clinically effective. If there is likely to be a significant number of patients for whom the usual treatment is not clinically effective or not otherwise appropriate (for any reason) the fact that the requesting patient falls into that group is unlikely to be a proper ground on which to base a claim that the requesting patient is exceptional.
- If the usual treatment cannot be given because of a pre-existing comorbidity which could not itself be described as exceptional in this patient group, the fact that the co-morbidity is present in this patient and its impact on treatment options for the requesting patient is unlikely to make the patient exceptional.

The most appropriate response in each of the above two situations, is to consider whether there is sufficient justification (including consideration of factors such as clinical effectiveness, cost-effectiveness, priority and affordability) to make a change to the policy adopted by the ICB for funding that patient pathway so that a change can be made to that policy to benefit a subgroup of patients (of which the requesting patient is potentially one such person). This change needs to be considered as a service development.

To meet the definition of 'exceptional clinical circumstances' there must be a ICB policy in place that describes the availability of the requested intervention and the patient (or their clinician must demonstrate that they are both):

- Significantly different clinically to the group of patients with the condition in question and at the same stage of progression of the condition

AND

- Likely to gain significantly more clinical benefit than others in the group of patients with the condition in question and at the same stage of progression of the condition

Non-clinical factors

The ICB does not discriminate on grounds of social factors (for example, but not limited to: age, gender, ethnicity, employment status, parental status, marital status, religious/cultural factors). Social factors will not be taken into account in determining whether exceptionality has been established.

The ICB does not generally make treatment for patients under its policies dependent on the patient's social or personal circumstances. Accordingly, when making decisions as to whether treatment should be provided to a patient which is not provided to patients generally, the IFR-Drugs Panel shall adopt the same approach.

It is common for an application for individual funding to be on the grounds that a patient's personal circumstances are exceptional. This assertion can include details about the extent to which other persons rely on the patient, or the degree to which the patient has contributed or is continuing to contribute to society. The ICB understands that everyone's life is different and that such factors may seem to be of vital importance to patients in justifying investment for them in their individual case.

However, including non-clinical factors in any decision-making raises at least three significant problems for the ICB:

- The ICB is committed to a policy of non-discrimination in the provision of medical treatment. If for example, treatment was to be provided on the grounds that would enable an individual to stay in paid work then this would potentially discriminate in favour of those working compared to not working. To offer a treatment to one patient and not another on the basis that the funded patient was working and the patient denied funding was out of work breaches a principle on which the NHS was founded and still currently operates. The ICB has not, therefore, been mandated to distribute resources based on these divisions within society. Such a decision would also set a precedent for the ICB to always favour those in work over those not currently in work. The same can be said of many other non-clinical factors such as having children / not having children, being a carer / not being a carer and so on.
- Across the population of patients who make such applications, the ICB is unable to make an objective assessment of material put before it relating to non-clinical factors. This makes it very difficult for the Panel to be confident of dealing in a fair and even-handed manner in comparable cases.
- The essence of an individual funding application is that the ICB is making funding available on a one-off basis to a patient where other patients with similar conditions would not get such funding. If non-clinical factors are included in the decision-making process, the ICB does not know whether it is being fair to other patients who are denied such treatment and whose non-clinical factors are entirely unknown.

Generally, the NHS does not take into account non-clinical factors in deciding which treatment to provide, unless a service is specifically designed to address health inequality or a prevailing inequity of access to normally provided care or treatment. It does not seek to deny treatment to smokers on the grounds that they have caused or contributed to their own illnesses through smoking, nor does it deny treatment to those injured participating in sports in which they were voluntary participants.

In general, the NHS treats the presenting medical condition and does not enquire into the background and lifestyle choices which led to that condition as the basis on which to decide whether to make treatment available or not.

The policy of the ICB is that it should continue to apply these principles in individual applications for funding approval. The ICB will therefore seek to commission treatment based on the presenting clinical condition of the patient and not based on the patient's nonclinical circumstances.

In reaching a decision as to whether a patient's circumstances are exceptional, the Panel is required to follow the principles that non-clinical factors including social value judgements about the underlying medical condition or the patient's circumstances are not relevant.

Clinicians are asked to bear this policy in mind and not refer to non-clinical factors to seek to support the application for individual funding.

Proving the case that the patient's circumstances are exceptional
The onus is on the clinical applicant to set out the grounds clearly for the Panel on which it is said that this patient is exceptional.

The grounds will usually arise out of exceptional clinical manifestations of the medical condition, as compared to the general population of patients with the medical condition which the patient has. These grounds must be set out on the form provided by the ICB and should clearly set out any factors which the clinician invites the panel to consider as constituting a case of exceptional clinical circumstances.

If, for example, it is said that the patient cannot tolerate the usual treatment because of the side effects of another treatment, the referring clinician must explain how common it is for the patient with this condition not to be able to be provided with the usual treatment.

If a clear case as to why the patient's clinical circumstances are said to be exceptional is not made out, then the Panel can do no other than refuse the application.

The Panel recognises that the patient's referring clinician and the patient together are usually in the best position to provide information about the patient's clinical condition as compared to a subset of patients with that condition.

The referring clinician is advised to set out the evidence in detail because the panel will contain a range of individuals with a variety of skills and experiences but may well not contain clinicians of that speciality. The ICB therefore requires the referring clinician, as part of their duty of care to the patient, to explain why the patient's clinical circumstances are said to be exceptional.

The policy of the ICB is that there is no requirement for the Panel to carry out its own investigations about the patient's circumstances in order to try to find a ground upon which the patient may be considered to be exceptional nor to make assumptions in favour of the patient if one or more matters are not made clear within the application.

Therefore, if a clear case of exceptionality is not made out by the paperwork placed before the IFR-Drugs Panel, the panel would be entitled to turn down the application.

Multiple claimed grounds of exceptionality
There may be cases where clinicians and/or patients seek to rely on multiple grounds to show their case is exceptional. In such cases the Panel should look at each factor individually to determine

(a) whether the factor was capable of making the case exceptional and
(b) whether it did in fact make the patient's case exceptional.

The Panel may conclude, for example, that a factor was incapable of supporting a case of exceptionality and should therefore be ignored. That is a judgment within the discretion of the Panel.

If the Panel is of the view that none of the individual factors on their own make the patient's clinical circumstance exceptional, the Panel should then look at the combined effect of those factors which are, in the Panel's judgement, capable of supporting a possible finding of

exceptionality. The Panel should consider whether, in the round, these combined factors demonstrate that the patient's clinical circumstances are exceptional. In reaching that decision the Panel should remind itself of the difference between individual distinct circumstances and exceptional clinical circumstances.

It may be possible to demonstrate exceptionality where the patient has a medical condition or clinical circumstance which is so infrequent or unpredictable that the result of the ICB prioritisation process provides no established treatment care pathway for that patient

RARITY

Assessment of requests to fund existing treatments experimentally for patients with rare clinical circumstances
The assessment of these funding requests should be distinguished from requests on the grounds of exceptionality.

A set of criteria need to be applied when a patient's medical condition is so rare, or their condition is so unusual that the clinician wishes to use an existing treatment in an experimental way. This exception does not routinely apply to rare disorders or small subgroups of patients within a more common disorder because here it would be normal to have a trial involving sufficient patients formally to evaluate the proposed treatment in a trial.

In assessing these cases the Panel should consider the following

- Can this treatment be studied properly using any other established method? If so, then funding should be refused.
- Is the treatment likely to be clinically effective?
- In addition, the usual considerations are included. Whether the treatment is cost effective, and what is this patient's priority compared to patients whose care has not been funded.

In the case of a rare indication, and where the incidence and prevalence are below the agreed threshold figure, the case can be considered by the ICB IFR-Drugs Panel. If the threshold test is not met, the request will be declined on the grounds that funding an individual case would be inequitable for the defined cohort.

REQUEST FOR USE OF A NEW INTERVENTION OR FOR USE OF AN INTERVENTION FOR A NEW INDICATION, WHERE NO COMMISSIONING ARRANGEMENTS EXIST

If the request is for an intervention that is new, or is a new application of an existing intervention, and the number of likely patients exceeds the threshold test (i.e. the patient represents a cohort) the IFR process is not appropriate and the requester will be directed to the process for requesting a service development.

FUNDING FOR CASES FOLLOWING A CLINICAL TRIAL

Save in the most exceptional cases, it is not anticipated that a request will be agreed under this IFR policy to fund patients at the end of a clinical trial. This is because arrangements to continue treatments from which patients have benefited during a trial should be agreed with the sponsor of the research at the outset of the trial and information should have been given to patients as part of the process of patients signing up to participate in the trial. Even if this is not the case, patients coming out of a clinical trial will almost inevitably represent a group of patients for whom a policy should be developed under the Service Development policy, because there will be a number of patients in broadly the same clinical circumstances, and so it is very unlikely that the patient will be able to show clinical exceptionality within this

GIVING REASONS

The NHS Constitution requires NHS organisations to make decisions *'rationally following a proper consideration of the evidence'* and be clear about the reasons for their decisions. The ICB will give reasons for its decisions.

What is the purpose of the duty to give reasons?
The purpose of a duty to give reasons is to tell the patient in general terms why the ICB reached the decision it did and the factors that it took into account in reaching the decision.
The Court of Appeal has said as follows about a duty to give reasons:

"(1) The duty is a function of due process, and therefore of justice. Its rationale has two principal aspects. The first is that fairness surely requires that the parties—especially the losing party—should be left in no doubt why they have won or lost. This is especially so since without reasons the losing party will not know (as was said in Ex p Dave) whether the court has misdirected itself, and thus whether he may have an available appeal on the substance of the case. The second is that a requirement to give reasons concentrates the mind; if it is fulfilled, the resulting decision is much more likely to be soundly based on the evidence than if it is not. (2) The first of these aspects implies that want of reasons may be a good self-standing ground of appeal. Where because no reasons are given it is impossible to tell whether the judge has gone wrong on the law or the facts, the losing party would be altogether deprived of his chance of an appeal unless the court entertains an appeal based on the lack of reasons itself."

Where a public body is required to give reasons for its decision, it is required to give reasons which are proper, adequate, and intelligible and enable the person affected to know why they have won or lost. These can be expressed in a few sentences, but they need to go into sufficient detail so that the patient knows that the main aspects of his case have been properly considered.

What are adequate reasons?
The best statement of the adequacy of reasons is probably set out in South Bucks District Council v Porter where Lord Brown said in the context of a planning appeal:

"The reasons for a decision must be intelligible and they must be adequate. They must enable the reader to understand why the matter was decided as it was and what conclusions were reached on the "principal important controversial issues", disclosing how any issue of law or fact was resolved. Reasons can be briefly stated, the degree of particularity required depending entirely on the nature of the issues falling for decision. The reasoning must not give rise to a substantial doubt as to whether the decision-maker erred in law, for example by misunderstanding some relevant policy or some other important matter or by failing to reach a

rational decision on relevant grounds. But such adverse inference will not readily be drawn. The reasons need refer only to the main issues in the dispute, not to every material consideration. They should enable disappointed developers to assess their prospects of obtaining some alternative development permission, or, as the case may be, their unsuccessful opponents to understand how the policy or approach underlying the grant of permission may impact upon future such applications. Decision letters must be read in a straightforward manner, recognising that they are addressed to parties well aware of the issues involved and the arguments advanced. A reasons challenge will only succeed if the party aggrieved can satisfy the court that he has genuinely been substantially prejudiced by the failure to provide an adequately reasoned decision".

In order to ensure that reasons given for an IFR decision are lawful, the IFR-Drugs Panel ought to ensure that the decision document (which will usually be the letter to the patient or their clinician or GP) goes through the tests under this policy, and explains both the decisions that the IFR-Drugs Panel reached on each element and states a précis as to why the Panel reached that decision.

General advice on discharging the duty to give reasons.
Whether the ICB IFR-Drugs Panel has or has not discharged the duty to give reasons will all depend on the individual circumstances. There will be simple cases where a single sentence is sufficient and there will be more complex cases where a full paragraph or two is needed to explain the thinking of the IFR-Drugs panel.

The duty will usually mean that the decision letter should explain:

- Whether the Panel reached the view that the patient did or did not demonstrate exceptional clinical circumstances, and the basis for that decision. If the Panel felt that the patient's clinical circumstances were broadly in line with the clinical circumstances of those in the cohort of other patients in the same clinical condition, then this should be stated.
- If the patient put forward specific factors which were said to support his or her claim to be in exceptional clinical circumstances, the letter should explain (by reference to the main factors) why the panel did not consider that these amounted to exceptional clinical circumstances.
- The letter should say whether the panel considered if the requested treatment was likely to be clinically effective for this individual patient. If it was then this should be stated. If the panel reached the view that the requested treatment was not likely to be clinically effective for this individual patient, then the letter should explain why this decision was reached.
- The letter should say whether the Panel considered whether the requested treatment will be a cost-effective use of NHS resources. If the panel reached the view that the requested treatment was not likely to be cost effective for this individual patient, then the letter should explain why this decision was reached.

What happens if the reasons given are not adequate?
If the original letter giving reasons is not adequate then, where there is a duty to give reasons there are limited circumstances in which the court allows the public body to expand on the reasons given in the decision letter. The best course is often to hold the Panel again and then, after a reconsideration, to provide a letter with proper reasons explaining the decision that this panel came to.

Adding to the original reasons is occasionally permitted by the Court but it is far better for public bodies to take time to get the statement of reasons original letter right rather than seeking to expand the explanations on a later occasion.

DEFINITIONS

Treatment means any form of healthcare intervention which has been proposed by a clinician and is proposed to be administered as part of NHS commissioned and funded healthcare.

The IFR-Drugs Panel is the committee of ICB clinicians who have been given authority by the ICB Governing Body to make individual funding request decisions on its behalf in line with the legal duties of ICB set out in The Health & Social Care Act 2012

An individual funding request is a request received from a clinician which seeks funding for a single identified patient for a specific treatment.

Clinical circumstances mean a full history of the patient's medical condition, a full description of the patient's present medical condition and as comprehensive an assessment of the patient's future medical condition and prognosis as the Clinical Team treating the patient is able to provide.

Exceptional clinical circumstances refers to a patient who has clinical circumstances which, taken as a whole, are outside the range of clinical circumstances presented by a patient within the normal population of patients with the same medical condition and at the same stage of progression as the patient.

Biological Plausibility is a method of reasoning used to establish a cause-and-effect relationship between a biologic factor and a particular disease

Clinical Commissioning Group is a statutory organisation responsible for purchasing health and care services for patients.

Experimental and unproven treatments are medical treatments or proposed treatments where there is no established body of evidence to show that the treatments are clinically effective. The reasons may include the following:

- The treatment is still undergoing clinical trials for the indication in question.
- The evidence is not available for public scrutiny.

- The treatment does not have approval from the relevant government body.
- The treatment does not conform to an established clinical practice in the view of the majority of medical practitioners in the relevant field.
- The treatment is being used in a way other than that previously studied or for which it has been granted approval by the relevant government body.
- The treatment is rarely used, novel, uncertain or unknown and there is a lack of evidence of safety and efficacy.
- There is some evidence to support a case for clinical effectiveness but the overall quantity and quality of that evidence is such that the commissioner does not have confidence in the evidence base and/or there is too great a measure of uncertainty over whether the claims made for a treatment can be justified.

A policy refers to a written document determining whether or not a particular treatment is commissioned.

A policy variation occurs when an existing policy is changed. When there is a proposal which would result in increased access to a treatment (for example by lowering the threshold for treatment or adding a new indication for treatment) the policy variation is a service development and will be treated as such.

---

[i] http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
[ii] http://www.legislation.gov.uk/ukpga/2010/15/contents
[iii] https://www.gov.uk/government/publications/the-nhs-constitution-for-england
[iv] http://www.legislation.gov.uk/ukpga/1998/42/contents
[v] www.fph.org.uk/policy-reports

Norfolk and Waveney
Integrated Care Board

NON – Drugs
INDIVIDUAL FUNDING REQUEST
POLICY AND PROCEDURE

Author	Ruth Spencer
Date:	May 2023
Approval By	Planned Care & Meds Management Group
Approved date:	Dec 2022 at PCMMG, updated May 2023
Review Date:	May 2026
Version Number:	5.2

NHS
Norfolk and Waveney
Integrated Care Board

Version History

Amendments to the Policy will be issued from time to time. A new amendment history will be issued with each change.

Version Number	Date	Reason for Change		
5.0	June 2019	Annual update		
5.1	November 2022	Revised copy – approved at PCMMWG Dec 2022 subject to minor changes		
5.2	May 2023	Revised copy – incorporating changes recommended in Dec 22 Clarification on urgent clinical decisions Clarity on the definition of a device		

NHS
Norfolk and Waveney
Integrated Care Board

Contents

1. Introduction

Norfolk & Waveney ICB (N&W ICB) wish to operate a policy for decision making in respect of non-drug Individual Funding Requests (IFR). This document sets out the operating policy.

Like any other organisation, the NHS has limited resources, and N&W ICB have a duty to manage them to a robust process.

Clinicians, on behalf of their patients, are entitled to make an individual IFR application to the IFR Panel for treatment to be funded by the N&W ICB that is not normally commissioned under defined conditions, namely;

The request does not constitute a service development

AND

The patient is suffering from a medical condition for which the N&W ICB have a policy but where the patient's particular clinical circumstances fall outside the criteria set out in the existing commissioning policy – this is a request for exceptional funding

OR

The patient is suffering from a medical condition, or requesting a treatment, for which the N&W ICB have no related clinical threshold policy –this is a request for individual funding

OR

The patient has a rare clinical circumstance, rendering it impossible to carry out clinical trials, and for whom the clinician wishes to use an existing treatment on an experimental basis – this is a request for individual funding.

2. Equality Statement

N&W ICB have a duty to have regard to the need to reduce health inequalities in accessing health services and the health outcomes achieved as outlined in the Health and Social Care Act 2012. N&W ICB are committed to ensuring equality of access and non-discrimination, irrespective of age, gender, disability (including learning disability), marriage and civil partnership, pregnancy and maternity, race, religion or belief or sexual orientation. In carrying out its functions, N&W ICB will have due regard of the Equality Act 2010, the NHS Constitution and the Human Rights Act 1998.

3. Information Governance

N&W ICB are the statutory body responsible for funding decisions. The individual funding request form and any other supporting information supplied may therefore be shared with the N&W ICB or other trusted organisations legitimately acting on behalf of the N&W ICB.

When an IFR has been submitted for patients who are aged 25 years or younger, the patient record will be shared securely with N&W ICB Children and Young Peoples Service for the following purposes:

- To ensure that there is a consistent and transparent process to each funding request
- Requests are reviewed by the appropriate funding panel
- Identification of safeguarding concerns
- Enable response to complaints, FOI requests
- Identify specific care needs within adolescent health care by having oversight of requests for funding of treatments

Further Information regarding Child & Young Peoples Services can be found via the following link:

https://norfolkandwaveneyccg.nhs.uk/health-services/children-and-young-people

IFR panel meeting minutes, will not be made available in the public domain. Personal information may be retained only for the purposes of the IFR application and, in some cases, may be used for invoicing and payment reconciliation. Patient's medical records may be used for the purposes of quality audit which will be completed by a Health professional. Anonymised information may also be shared as part of the N&W ICB reporting processes.

4. Clinical Exceptionality

The responsibility is on the clinical applicant to set out the grounds clearly for the panel on which it is said that the patient is exceptional.

The grounds will usually arise out of exceptional clinical manifestations of the medical condition, as compared to the general population of patients with the same medical condition as the patient. These grounds must be set out on the form provided by N&W ICB and should clearly set out any factors which the clinician invites the panel to consider as constituting a case of exceptional clinical circumstances.

Exceptional in IFR terms means a person to whom the general rule should not apply. This implies that there is likely to be something about their clinical situation which was not considered when formulating the general rule. Very few patients have clinical circumstances which are genuinely exceptional.

The fact that a treatment is likely to be efficacious for a patient, is not in itself a basis for exceptionality.

If a patient's clinical condition matches the 'accepted indicators' for a treatment that is not funded, their circumstances are not by definition, exceptional.

Clinical Exceptionality – Non Clinical & Social Factors

The IFR process considers clinical information only. Non-clinical and social factors have to be disregarded for this purpose in order for the IFR Panel, to be confident of dealing in a fair manner in comparable cases. If these factors were to be included in the decision making

process, N&W ICB could not be assured that it was being fair and equitable to other patients who cannot access such treatment and whose non-clinical and social factors would be the same or similar.

Consideration of social factors would also be contrary to N&W ICB policy of non-discrimination in the provision of medical treatment. If, for example, treatment were to be provided on the grounds that this would enable an individual to stay in paid work, this would potentially discriminate in favour of those working compared to those not working. These are value judgements which the IFR screening group and IFR Panel should not make.

A good use of NHS resources

The requesting clinician will be expected to explain why they consider the treatment for which funding has been applied for will be a good use of NHS resources.

This criterion is only applied where the panel has already concluded that the criteria of clinical exceptionality and clinical effectiveness have been met. Against this criterion the Panel balances the degree of benefit likely to be obtained for the patient from funding the treatment against cost. Having regard to the evidence submitted and the analysis they have carried out when considering clinical exceptionality and clinical effectiveness, Panel members will consider the nature and extent of the benefit the patient is likely to gain from the treatment, the certainty or otherwise of the anticipated outcome from the treatment and the opportunity costs for funding the treatment.

This means considering, for example, how significant a benefit is likely to be gained for the patient, and for how long that benefit will last. These factors need to be balanced against the cost of the treatment and the impact on other patients of withdrawing funding from other areas in order to fulfil the IFR. This reflects the fact that the only way to provide the funding for treatment under IFR, i.e. outside commissioned clinical policies which are developed through the structured prioritisation process, is to divert resources away from current services.

5. Policy

5.1 – Consultation Process

All affected Providers, Primary Care and other appropriate stakeholders will be given the opportunity to engage in the policy development process via the Clinical Policy Development Group. The Clinical Policy Development Group will consider all feedback received and where appropriate, are willing to make amendments as suggested.

5.2 – Acute Contract

Revisions are to be agreed using the contract variation in the National Contract. Once agreement is reached between the Provider and the Commissioner, at every amended/new phase, a contract variation proposal to the NHS Standard Acute Contract will be made detailing the changes, updated policy and timescales for implementation in line with relevant contract clauses.

5.3 – Clinical Thresholds Policy

Once the procedures and thresholds for any new or existing phase are decided the Clinical Thresholds Policy will be amended, uploaded on to Knowledge Management and disseminated to appropriate Providers and stakeholders.

5.4 – Knowledge Management

The IFR policy and the IFR template can be found on the Knowledge Management website available for downloading at ;
https://nww.knowledgeanglia.nhs.uk/KMS/Norwich/Home/ClinicalThresholdsPolicy/IndividualFundingRequestsCommissioningPolicy.aspx

6. Roles & Responsibilities

6.1 – Individual Funding Request Process – Providers, Including General Practice

Providers, including General Practice, are to ensure the following;

The Clinical Thresholds Policy, IFR form and other associated documentation is shared and communicated internally with all relevant staff to ensure compliance with the Policy.

Clinicians will take the N&W ICB, clinical threshold policies into account in the advice and guidance given to patients prior to making the decision to request an IFR. The IFR process is discussed with the patient in clinic to ensure the patient understands the process regarding funding requirements and consent to share information. The IFR leaflet should be given to the patient to assist with this discussion.

An IFR form must be completed by the relevant supporting clinician for the patient. The request forms are available on the Knowledge Anglia website at;
http://nww.knowledgeanglia.nhs.uk/KMS.aspx or via email request nw.ifr@nhs.net
The completed IFR form should be submitted using the agreed template.

The IFR form must be completed to indicate patient consent. If this is not confirmed, the form will be returned to the supporting clinician by the IFR Team.

Once a request has been submitted for funding, the clinician will respond to queries and/or requests for further information in a timely manner.

All communication with the patient is the responsibility of the requesting clinician. The requesting clinician is responsible for informing the patient of the ultimate decision.

If an IFR is returned to the referring clinician approved, the patient should be referred or listed for the requested procedure and the relevant authorisation number recorded by the hospital according to their local policies and procedures.

If an IFR is declined, it will be returned to the referring clinician, the patient should not be referred or listed for the procedure.

6.2 – Individual Funding Request Process

Please see Appendix A - Flowchart of the IFR process. In summary;

IFR Panels will be administered by IFR administration team.

IFR Panels will be held on a monthly basis.

Appendix A

Stage	Time Frame
Acknowledgement letter sent to referring clinician	IFR administration to complete within **5 working days** of receipt
Admin Triage - To ascertain if further information is required	Administrate within **15 working days** of receipt
Panel papers circulated to panel members	Administrate within **5 working days** of monthly panel meeting
Decision communicated to referring clinician	Administrate within **5 working days** after panel
Urgent Requests	IFR panel members to provide a decision. Administrate within **5 working days**
If any further information requested by IFR team fails to be submitted the IFR case will be lapsed and referrer will be notified with the option to re-submit.	Cases to be processed within **40 working days** of receipt

The IFR Team will process requests from receipt to decision letter within 40 working days (this timeframe will be subject to any requested information awaited from the referrer/clinician/patient).

6.3 – Individual Funding Request Process N&W ICB

N&W ICB will ensure the following;

N&W ICB will appoint a chair for the IFR (non-drugs) Panel.

N&W ICB will ensure there are clinical representatives at each IFR Panel meeting. The N&W ICB representatives will have delegated authority to make decisions on behalf of N&W ICB.

The Lay-Chair of the IFR Panel has delegated responsibility to approve funding requests up to a maximum of £50,000 after approval by the IFR Panel. Responsibility for approving requests for funding over £50,000 per annum has been delegated to the Chief Executive Officer or Director of Finance after recommendation by the IFR Panel and subsequent approval of the Medical Director.

For a panel meeting to be quorate, there is a requirement for three medically qualified members of the panel to be present. This may include a medically qualifed Consultant in Public Health.

6.4 - IFR Re-consideration Panel

Where the IFR Panel has declined a request or has approved treatment subject to conditions, the patient shall be entitled to ask that the decision of the IFR Panel be re-considered. Requests for re-consideration must be submitted within 6 months of decision. The referring clinician must clearly outline the reasons for the re-consideration and/or the clinician requesting the re-consideration must submit new clinical evidence to the panel.

Re-consideration would be considered on one of the following grounds only;

- That further evidence can be provided by the referring clinician and is duly submitted;

and/or

- It was in the clinician's opinion a decision which no reasonable IFR Panel would have reached.

6.5 - IFR Appeals Panel

Where all relevant information was available to the IFR Panel when the decision was made, but the referring clinician remains dissatisfied with the decision, the referring clinician may request that the case is reviewed by an Appeals Panel. Submission for a case to appeal must be submitted within 6 months of notification of reconsideration decision.

An appeals panel would consist of a designated chairperson supported by a minimum of two other clinical panel members, who are not members of the non-drugs IFR panel. The appeals process remains the responsibility of the N&W ICB.

Appeals process would be considered on one of the following grounds only;

- Due process was not followed;

Or

- The IFR panel failed to give a clear rationale for its decision.

The IFR Team will arrange for either an IFR Re-consideration or IFR Appeals Panel to be set up following receipt of a formal request, within the appropriate timeframes and guidelines.

7. Urgent Requests

Where an IFR request is marked as urgent, the IFR Panel, will aim to make a decision within 5 working days of receipt. An urgent request is one which requires urgent consideration and decision because the patient faces a substantial risk of death or significant harm if a decision is not made before the next scheduled meeting of the IFR Panel. If the referring clinician considers that treatment cannot be delayed and decides to treat immediately then the cost of such treatment is incurred at the risk of the Provider.

The N&W ICB recognise that there will be occasions when an urgent decision needs to be made to consider approving funding for treatment for an individual patient outside the N&W ICB normal policies. In such circumstances the N&W ICB recognise that an urgent decision may have to be made before a panel can be convened. The following provisions apply to such a situation.

- Urgency under this policy cannot arise as the result of a failure by the Clinical Team expeditiously seek funding through the appropriate route and/or where the patient's legitimate expectations have been raised by a commitment being given by the provider trust to provide a specific treatment to the patient, will **not** lead to the circumstances being considered as urgent under this policy. In such circumstances the N&W ICB expect the provider trust to proceed with treatment and for the provider to fund the treatment.

- In situations of clinical urgency, the decision will be made by a nominated clinical member of the panel, or the Executive Medical Director of the N&W ICB.

- The clinical lead will as far as possible within the constraints of the urgent situation, follow the policy set out above in making the decision. The clinical lead shall consider the nature and severity of the patient's clinical condition and the time period within which the decision needs to be taken. As much information about both the patient's illness and the treatment should be provided as is feasible in the time available and this shall be considered for funding in accordance with relevant existing commissioning policies.

- The clinical lead shall be entitled to reach the view that the decision is not of sufficient urgency or of sufficient importance that a decision needs to be made outside of the usual process.

- The IFR administrative team will submit anonymised urgent requests via e-mail to N& W ICB IFR panel members.

- The IFR Panel will aim to make a decision within 5 working days of receipt of the request. Trusts should treat all urgent and life-threatening situations based on the clinical need.

- Urgent requests will also be discussed at the next available panel meeting and a record added to the minutes.

8. Q & A Section

8.1 - What is a service development?

A service development is any aspect of healthcare which the N&W ICB has not historically agreed to fund, and which will require additional and predictable recurrent funding.

Some funding requests may fall within the Experimental and Unproven Treatments Policy the policy is available Experimental-and-Unproven-Treatments.docx (live.com) ,

All individual funding requests submitted to N&W ICB will be subject to screening by the IFR Panel and N&W ICB.to determine whether the request represents a service development. Service developments include, but are not restricted to:

- New services
- New treatments including medicines, surgical procedures and medical devices.
- Developments to existing treatments including medicines, surgical procedures and medical devices.
- New diagnostic tests and investigations.
- Requests to alter existing policy (called a policy variation). The proposed change could involve adding in an indication for treatment, expanding access to a different patient sub-group or lowering the threshold for treatment.
- Requests to fund a number of patients to enter a clinical trial and the commissioning of a clinical trial are considered as service developments in this context as they represent a need for additional investment in a specific service area.

Where there is an identified service development, or an identified gap in commissioning service, the IFR panel will advise the N&W ICB Clinical Policy Development Group (CPDG). This will then be recorded onto CPDG action log for further review. New or amended clinical threshold policies instigated from CPDG, will then be presented at N&W ICB Planned Care & Meds Management Group for final ratification.

A request for a treatment should be classified as a request for a service development if there are likely to be a cohort of similar patients who are:

- In the same or similar clinical circumstances as the requesting patient whose clinical condition means that they could make a like request (regardless as to whether such a request has been made)
  AND
- Who could reasonably be expected to benefit from the requested treatment to the same or a similar degree.

It is common for clinicians to request an individual funding request for a patient where the request is properly analysed, the first patient of a group of patients wanting a particular treatment. Any individual funding request which is representative of this group represents a service development. As such it is difficult to envisage circumstances in which the patient can properly be classified to have exceptional clinical circumstances. Accordingly, the individual funding request route is usually an inappropriate route to seek funding for such treatments as they constitute service developments.

8.2 - What is a "cohort of similar patients"?

A cohort of similar patients for the purposes of this policy has been defined as the number of requests received or likely to be received per year which will require consideration of a commissioning policy. In these circumstances, the IFR route to funding may only be considered if the patient is clinically exceptional to the cohort.

8.3 - When should consideration of a commissioning policy be given?

The N&W ICB have set the level at which cases will require consideration of a commissioning policy. Once this number of requests is met, the IFR route to funding may only be considered if the patient is clinically exceptional to the cohort.

The N&W ICB will consider the development of a clinical commissioning policy where:

- The numbers of patients for whom the treatment will be requested per year is likely to be 5 or more patients in the population served by N&W ICB. Upon receipt of the fifth request for funding a business case/clinical commissioning policy will be requested. (The IFR Panel will continue to have the right to make decisions on any further similar applications for funding whilst a policy is in the process of being produced.)

  OR

- The cost of funding the requested treatment for an individual is likely to result in expenditure to the N&W ICB in excess of £50,000.

If the number of patients for whom the treatment is requested is likely to be below 5 per year, the IFR Panel will consider the request for funding.

The IFR Panel is not entitled to make policy decisions for N&W ICB. It follows that where a request has been classified as a service development for a cohort of patients, the IFR Panel is not the correct body to make a decision about funding the request. In such circumstances the individual funding request should not and will not be presented to the IFR Panel but will be dealt with in the same way as other requests for a service development through N&W ICB due processes (the IFR Panel will continue to have the right to make decisions on further similar applications whilst a policy is in the process of being developed).

Where an IFR has been classified as a service development for a cohort of patients, the options open to the IFR Panel include:

- To refuse funding and request the provider prioritises the service development internally within the provider organisation that made the request and, if supported, to invite the provider to submit a business case as part of the annual commissioning round for the requested service development

- To refuse funding and initiate an assessment of the clinical importance of the service development within the N&W ICB with a view to developing a policy and determining its priority for funding in the next financial year

- To refer the request for funding for immediate workup of the service development as a potential candidate for in year service development.

In practice, all requests for funding for an individual patient have been called Individual Funding Requests (IFRs) but these sub-categories of request should be recognised.

The broad types of request that may be received are;

- Representing a service development for a cohort of patients
- On grounds of clinical exceptionality where there are commissioning arrangements in place
- On grounds of rarity and no commissioning arrangements exist
- For a new intervention or for use of an intervention for a new indication, where no commissioning arrangements exist

There can be no exhaustive definition of the conditions which are likely to come within the definition of an exceptional individual case. The word ‘exception’ means;

‘a person, thing or case to which the general rule is not applicable’.

To meet the definition of ‘exceptional clinical circumstances’ there must be a N&W ICB policy in place that describes the availability of the requested intervention and the patient (or their clinician must demonstrate that they are both):

- Significantly different clinically to the group of patients with the condition in question and at the same stage of progression of the condition

AND

- Likely to gain significantly more clinical benefit than others in the group of patients with the condition in question and at the same stage of progression of the condition

8.4 - What are non-clinical factors?

The N&W ICB do not discriminate on grounds of social factors (for example, but not limited to: age, gender, ethnicity, employment status, parental status, marital status, religious/cultural factors). Social factors will not be taken into account in determining whether exceptionality has been established.

The N&W ICB will seek to commission treatment based on the presenting clinical condition of the patient and not based on the patient's non-clinical circumstances.

In reaching a decision as to whether a patient's circumstances are exceptional, the panel is required to follow the principles that non-clinical factors including social value judgements about the underlying medical condition or the patient's circumstances are not relevant.

Clinicians are asked to bear this policy in mind and not refer to non-clinical factors to seek to support the application for individual funding.

8.5 - How do you prove the patient's circumstances are exceptional?

The responsibility is on the clinical applicant to set out the grounds clearly for the panel on which it is said that this patient is exceptional.

The grounds will usually arise out of exceptional clinical manifestations of the medical condition, as compared to the general population of patients with the medical condition which the patient has. These grounds must be set out on the form provided by the N&W ICB and should clearly set out any factors which the clinician invites the panel to consider as constituting a case of exceptional clinical circumstances. If a clear case as to why the patient's clinical circumstances are said to be exceptional is not made out, then the panel can do no other than refuse the application.

The panel recognises that the patient's referring clinician and the patient together are usually in the best position to provide information about the patient's clinical condition as compared to a subset of patients with that condition.

The referring clinician is advised to set out the evidence in detail because the panel will contain a range of individuals with a variety of skills and experiences but may well not contain clinicians of that speciality. The N&W ICB therefore requires the referring clinician, as part of their duty of care to the patient, to explain why the patient's clinical circumstances are said to be exceptional.

There may be cases where clinicians and/or patients seek to rely on multiple grounds to show their case is exceptional. In such cases the panel should look at each factor individually to determine;

(a) whether the factor was capable of making the case exceptional and
(b) whether it did in fact make the patient's case exceptional

The panel may conclude, for example, that a factor was incapable of supporting a case of exceptionality and should therefore be ignored. That is a judgment within the discretion of the panel.

If the panel is of the view that none of the individual factors on their own make the patient's clinical circumstance exceptional, the panel should then look at the combined effect of those factors which are, in the panel's judgement, capable of supporting a possible finding of exceptionality. The panel should consider whether, in the round, these combined factors demonstrate that the patient's clinical circumstances are exceptional. In reaching that decision the panel should remind itself of the difference between individual distinct circumstances and exceptional clinical circumstances.

8.6 - What is rarity in an IFR?

The assessment of these funding requests should be distinguished from requests on the grounds of exceptionality.

A set of criteria need to be applied when a patient's medical condition is so rare or their condition is so unusual that the clinician wishes to use an existing treatment in an experimental way. This exception does not routinely apply to rare disorders or small subgroups of patients within a more common disorder because here it would be normal to have a trial involving sufficient patients formally to evaluate the proposed treatment in a trial.

In assessing these cases the panel should consider the following;

- Can this treatment be studied properly using any other established method? If so then funding should be refused.
- Is the treatment likely to be clinically effective?
- In addition, the usual considerations are included. Whether the treatment is cost effective, and what is this patient's priority compared to patients whose care has not been funded.

8.7 - What is Triage?

Requests are subject to a triage process to determine whether the request has sufficient clinical and other information for the individual funding request to be considered fully by the IFR Panel.

All requests will be triaged prior to presenting at the IFR Panel. Triage will consider the information provided in the request against any relevant commissioning policies and make recommendations for the panel to consider. Recommendations include;

- Approved
- Declined
- Further clinical debate required at panel

Sometimes, triage will determine that more information is required to progress the request and the referrer will be contacted.

8.8 - What happens with IFRs which have passed triage?

An exceptionality request can be made in relation to a medical condition where the N&W ICB have a Commissioning Policy but the patient's clinical circumstances or the requested treatment falls outside the N&W ICB Policy. These exceptionality requests should be completed by the clinician with reference to the relevant generic and/or treatment specific commissioning policy.

The IFR Panel shall be entitled to approve funding if the patient has exceptional clinical circumstances. In considering whether to fund a patient on grounds of exceptional clinical circumstances, in this situation, the IFR Panel will act as follows:

- The IFR Panel will use the information provided by the requester to compare the patient to other patients with the same presenting medical condition at the same stage of progression. Specifically, the panel may consider, based upon the evidence provided to it, whether the patient has demonstrated exceptional clinical circumstances which lead the panel to believe that the patient would benefit significantly more from the treatment than the other patients not meeting funding criteria.

- When making their decision, the IFR Panel is required to restrict itself to considering only the patient's presenting medical condition and the likely benefits which have been demonstrated by the evidence to be likely to accrue to the patient from the proposed treatment.

- The IFR Panel shall seek to make decisions in accordance with the NHS ethical framework & principles, including the requirement to have due regard to the obligations of the Equality Act 2010 save where a difference in treatment is based on objectively justifiable factors and is a justified and proportionate response to the needs of different groups of patients.

- The IFR Panel shall seek to make decisions in accordance with the 1998 Human Rights Act.

- The IFR Panel will not make decisions for treatments available to individual patients, or other clinically similar patients, on the basis of non-clinical factors.

The IFR Panel shall be entitled to approve funding an experimental treatment for patients with rare clinical conditions or clinical circumstances.

In considering whether to agree to fund the treatment the IFR Panel's consideration shall include the following factors:

- The potential benefit and risks of the treatment

- The biological plausibility of anticipated benefit for the patient based on evidence of this treatment in other similar disease states

- Value for money

- Where the request is in respect of more than one patient or it is clear from the nature of the request that there is likely to be more than one patient, then the IFR Panel should consider whether the request is a service development or trial.

8.9 – Retrospective payments for funding?

Individual Funding Requests will not be accepted where the request is for retrospective funding e.g. requests from clinicians or providers made after a period of care has commenced or request from patients for reimbursement of the costs of a treatment which has been purchased privately.

Treatments that are undertaken, without funding approval or agreement, will be at the risk of the provider.

8.10 - What information is submitted to the IFR Panel?

All applications must be accompanied by written support and evidence provided by the clinical team treating the patient. It is the clinician's responsibility to ensure that the appropriate information is provided to the N&W ICB according to the type of request being made, in a timely fashion consistent with the urgency of the request. If relevant information is not submitted, then the referring clinician will bear responsibility for any delay that this causes.

All clinical teams submitting IFR requests must be aware that information that is immaterial to the decision will not be considered by the IFR Panel. This may include information about non-clinical factors relating to the patient or information which does not have a direct connection to the patient's clinical circumstances.

An electronic request form must be completed by the referring clinician. The request forms are available on the Knowledge Management website atifr_policy_norfolk_waveney.docx (live.com) ; or via email request nw.ifr@nhs.net
Requests for patients covered by NHS England's responsibilities should be sent directly to them.

If further information is required to prepare the case for consideration by the IFR Panel this may delay presentation to the IFR Panel. All required information from the provider hospital trust/clinician must be sent to the IFR Administrator at least 10 working days before the scheduled date of the IFR Panel at which the case is to be considered.

All applications must be accompanied by written support and evidence provided by the clinical team treating the patient explaining:

- Whether the request for funding is an individual request or an exceptional request.
- The clinical circumstance of the patient. The clinical team is required to present a full report to the IFR Panel which sets out a comprehensive and balanced clinical picture of the history and present state of the patient's medical condition, the nature of the treatment requested and the anticipated benefits of the treatment.
- The planned treatment and the expected benefits and risks of treatment. The clinical team shall describe the anticipated clinical outcomes for the individual patient of the proposed treatment and the degree of confidence of the clinical team that the outcomes will be delivered for this particular patient.
- The evidence on which the clinical opinion is based. The clinician shall refer to, and include, copies of any clinical research material which supports, questions or undermines the case that is being made that the treatment is likely to be clinically effective in the case of the individual patient.
- The clinical team shall set out the full attributable costs of and connected to the treatment.

- Whether or not there are likely to be similar patients either within the N&W ICB or across the region. For exceptionality requests the clinician must also provide the case for treating this patient and no other apparently similar patients.

8.11 - How does the IFR Panel approve requests?

The IFR Panel shall be entitled to approve requests for funding for treatment for individual patients where all the following conditions are met:

- The IFR Panel is satisfied that there is no cohort of similar patients. If there is a cohort of similar patients the IFR Panel shall decline to make a decision because the application is required to be treated as a request for a service development. (The IFR Panel will continue to have the right to make decisions on any further similar applications for funding whilst a policy is in the process of being produced.)

- The request does not constitute a service development.

- The patient is suffering from a medical condition for which the N&W ICB has a policy but where the patient's particular clinical circumstances fall outside the criteria set out in the existing commissioning policy for funding the requested treatment.

- The patient is suffering from a medical condition, or requesting a treatment, for which the N&W ICB has no policy.

- The patient has a rare clinical circumstance, this rendering it impossible to carry out clinical trials, and for whom the clinician wishes to use an existing treatment on an experimental basis.
- Exceptional circumstances apply where there is sufficient evidence to show that, for the individual patient, the proposed treatment is likely to be clinically and cost effective or that the clinical trial has sufficient merit to warrant NHS funding.

The IFR Panel is not required to accept the views expressed by the patient or the clinical team concerning the likely outcomes for the individual patient of the proposed treatment, but it is entitled to reach its own views on:

- The likely clinical outcomes for the individual patient of the proposed treatment;

  AND

- The quality of the evidence presented to support the request and/or the degree of confidence that the IFR Panel has about the likelihood of the proposed treatment delivering the proposed clinical outcomes for the individual patient.

The IFR Panel may make such approval contingent on the fulfilment of such conditions as it considers fit.

Very occasionally an individual funding request presents a new issue which needs a substantial piece of work before the N&W ICB can reach a conclusion upon its position. This may include wide consultation. Where this occurs the IFR Panel may adjourn a decision on an individual case until that work has been completed.

8.12 - How are IFR Panel decisions communicated?

The referring clinician making the request will be informed of the IFR Panel's decision as soon as practicable via email within 5 working days. Patient confidentiality will be maintained at all times.

8.13 - Will the IFR Panel give reasons as to why a decision has been made?

The NHS Constitution requires NHS organisations to make decisions 'rationally following a proper consideration of the evidence' and be clear about the reasons for their decisions. The N&W ICB will give reasons for its decisions.

The purpose of a duty to give reasons is to tell the patient in general terms why the N&W ICB reached the decision it did and the factors that it considered in reaching the decision.

Where a public body is required to give reasons for its decision, it is required to give reasons which are proper, adequate, and intelligible and enable the person affected to know why they have been approved or declined. These can be expressed in a few sentences, but they need to go into sufficient detail so that the patient knows that the main aspects of their case have been properly considered.

Whether the N&W ICB IFR Panel has or has not discharged the duty to give reasons will all depend on the individual circumstances. There will be simple cases where a single sentence is sufficient and there will be more complex cases where a full paragraph or two is needed to explain the thinking of the IFR Panel, and the rationale for the panel's decision.

The duty will usually mean that the decision letter should explain:

- Whether the panel reached the view that the patient did or did not demonstrate exceptional clinical circumstances, and the basis for that decision. If the panel felt that the patient's clinical circumstances were broadly in line with the clinical circumstances of those in the cohort of other patients in the same clinical condition, then this should be stated.

- If the patient put forward specific factors which were said to support his or her claim to be in exceptional clinical circumstances, the letter should explain (by reference to the main factors) why the panel did not consider that these amounted to exceptional clinical circumstances.

8.14 - Can the IFR Panel decision be reviewed?

Where the IFR Panel has declined a request or has approved the treatment subject to conditions, the patient shall be entitled to ask that the decision of the IFR Panel be reviewed. All requests for a review must be supported by the senior treating clinician in writing to the IFR Administrator within 6 months from the date of notification of the date of the IFR Panel's decision. The clinician must clearly outline the reasons as to why a review is requested. It will be either;

- That further evidence can be provided by the referrer and is duly submitted; and/or
- It was in the clinician's opinion a decision which no reasonable IFR Panel would have reached.

The IFR Administrator will prepare the additionally submitted evidence for discussion at the next available panel meeting. The IFR Panel will then review its initial decision based on any

additional information received. The result of the review will be communicated to the referring clinician who must then notify the patient of the panel's decision.

Should the referring clinician or patient remain dissatisfied with the IFR Panel decision, the matter may be pursued through the NHS Complaints Procedure. This can be done by contacting: nwicb.contactus@nhs.net or by telephone 01063 595857.

8.15 - Can the IFR Panel decision be appealed against?

Where all the relevant information was available to the IFR Panel when the decision was made, but the referring clinician remains dissatisfied with the decision, they may request that it be reviewed by an IFR Appeals Panel on one of the following grounds only:

a) Due process was not followed
OR
b) The IFR Panel failed to give a clear rationale for its decision

In the case of failure to follow due process or an inadequate rationale for the IFR Panel decision, the referring clinician may request an IFR Appeals Panel review by making a formal request in writing to the IFR Administrator within 6 months of the date of the IFR Panel's decision.

The IFR Administrator will arrange for an IFR Appeals Panel to be set up. This will normally be the next available IFR Drugs Panel.

The IFR Appeals Panel will review the process followed by the IFR Panel. The IFR Appeals Panel will reach a decision within 30 working days of the IFR Administrator referring the case to them.

The role of the IFR Appeals Panel is to determine whether the IFR Panel has followed its own procedures, has properly considered the evidence presented to it and has come to a reasonable decision upon the evidence.

In the event that the IFR Appeals Panel considers that the IFR Panel has:

- Failed in a material way to follow its own procedures; and/or
- Failed in a material way properly to consider the evidence presented to it (e.g. by taking account of an immaterial fact or by failing to take account of a material fact); and/or
- Failed to give a clear rationale for its decision;

The IFR Appeals Panel shall uphold the patient's appeal and shall refer the case for reconsideration by the IFR Panel.

The IFR Appeals Panel shall not have power to authorise funding for the requested treatment but shall have the right to make recommendations to the IFR Panel.

The IFR Appeals Panel will set out its decision and the reasons for it as soon as practicable in writing via e-mail or letter to the IFR Panel and the referring clinician. It is the responsibility of the referring clinician to notify the patient in a timely manner of the IFR Appeals Panel decision.

Should the referring clinician or patient remain dissatisfied with the IFR Appeals Panel decision, the matter may be pursued through the NHS Complaints Procedure. This can be done by contacting: nwicb.contactus@nhs.net or telephone: 01063 595857.

8.16 – Decisions on Funding

The IFR panel is committed to ensuring that decision making is transparent, fair and equitable. At all times, decision to fund treatments will be based upon both national and local guidance. Where there is no guidance available, or to be ratified, the panel will make decisions based upon rational and supporting evidence submitted to support the IFR application.

The standard policy is available on N&W ICB website and is accessible to all.

Glossary

Appeal refers to the process where the referring clinician can request that the IFR Panel decision is assessed, either on the basis that due process was not followed by the IFR Panel

or that the IFR Panel failed to give a clear rationale for its decision.

Clinical circumstances means a full history of the patient's medical condition, a full description of the patient's present medical condition and as comprehensive an assessment of the patient's future medical condition and prognosis as the Clinical Team treating the patient is able to provide.

Cohort of similar patients for the purposes of this policy has been defined as the number of requests received or likely to be received per year which will require consideration of a commissioning policy.

Device in the context of this non-drug policy is something that isn't prescribable on NHS primary care prescription (FP10) or via hospital electronic prescribing (EPMA) and is for the treatment of a specific condition and provided under medical supervision. Items that are not medicines but are prescribable by the above methods are in the scope of the drugs IFR policy.

Exceptional clinical circumstances refers to a patient who has clinical circumstances which, taken as a whole, are outside the range of clinical circumstances presented by a patient within the normal population of patients with the same medical condition and at the same stage of progression as the patient.

IFR Panel is the committee of N&W ICB clinicians who have been given authority to make individual funding request decisions on its behalf in line with the legal duties of ICBs set out in The Health & Social Care Act 2012.

Individual funding request is a request received from a clinician which seeks funding for a single identified patient for a specific treatment.

Integrated Care Board is a statutory organisation responsible for purchasing health and care services for patients.

NHS Constitution refers to the established principles and values of the NHS in England.

NICE refers to the National Institute for Health & Care Excellence. They provide national guidance and advice to improve health and social care.

Policy refers to a written document determining whether or not a particar treatment is commissioned.

Policy variation occurs when an existing policy is changed. When there is a proposal which would result in increased access to a treatment (for example by lowering the threshold for treatment or adding a new indication for treatment) the policy variation is a service development and will be treated as such.

Rarity refers to a patient whose medical condition is so rare, or their condition is so unusual that the clinician wishes to use an existing treatment in an experimental way.

Review refers to the process where the referring clinician can request the IFR Panel decision is reviewed, either on the basis that further evidence can be provided in support of the IFR or that the decision, in the clinician's opinion, was one which no reasonable IFR Panel would have reached.

Service Development refers to any aspect of healthcare which the ICB has not historically agreed to fund, and which will require additional and predictable recurrent funding.

Social factors are, for example, (but not limited to) age, gender, ethnicity, employment status, parental status, marital status, religious/cultural factors.

Treatment means any form of healthcare intervention which has been proposed by a clinician and is proposed to be administered as part of NHS commissioned and funded healthcare.

Triage is a process to determine whether the request has sufficient clinical and other information in order for it to be fully considered by the IFR Panel.

Urgent request requires urgent consideration and a decision because the patient faces a substantial risk of death or significant harm.

Agenda item: 14

Norfolk and Waveney
Integrated Care Board

Subject:	**Quality and Safety Committee Report**
Presented by:	Aliona Derrett, Quality and Safety Committee Chair Tricia D'Orsi, Executive Director of Nursing
Prepared by:	Evelyn Kelly, Quality Governance & Delivery Manager
Submitted to:	Integrated Care Board Meeting
Date:	30 May 2023

Purpose of Paper

To provide the Board with an update on the work of the Quality and Safety Committee for the period of 28 March to 30 May 2023.

Committee:	**Quality and Safety**
Committee Chair:	Aliona Derrett
Meetings since the previous update on 24 January 2023:	**06 April 2023,15:00 – 17:00** **04 May 2023, 15:00 – 17:00** An additional Development Session was held on 04 April 2023 to review and agree the Committee Work Plan for the year ahead, as per the recommendation from the annual self-assessment.

Overall objectives of the committee:

To seek assurance that the Norfolk and Waveney system has a unified approach to quality governance and internal controls that support it to effectively deliver its strategic objectives and provide sustainable, high-quality care and to have oversight of local implementation of the NHS National Patient Safety Strategy. To be assured that these structures operate effectively, that timely action is taken to address areas of concern, and to respond to lessons learned from all relevant sources including national standards, regulatory changes, and best practice.

To oversee and monitor delivery of the ICB key statutory requirements, including scrutiny of the robustness and effectiveness of its arrangements for safeguarding adults and children, infection prevention and control, medicines optimisation and safety, and equality and diversity. To ensure that patient outcomes from care are collected and measured, to inform outcomes-based commissioning for quality.

To review and monitor those risks on the BAF and Corporate Risk Register which relate to quality, and the delivery of safe, timely, effective, and equitable care. To consider the effectiveness of proposed mitigations and to escalate concerns to risk owners and operational leads/forums as agreed by Committee Members.

To approve ICB arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and secure continuous improvement in quality. To seek assurance that commissioning functions act with a view to supporting quality improvement; developing local services that promote wellbeing and prevent adverse health outcomes, equitably, across all patients and communities in Norfolk and Waveney.

Main purpose of meeting:	**06 April 2023: regular meeting of the Committee covering all standing items plus the following focus areas:** • Risk focus on Urgent and Emergency Care, including ambulance response times and adverse incidents. • Risk focus on Neurodevelopmental Disorder provision. • Risk focus on Local Commissioning issues. • Update on the Adult Mental Health Transformation Programme, including crisis provision, out of area placements and a draft set of mental health metrics for the system Quality BI Dashboard. • Update from the Local Maternity and Neonatal System (LMNS). **04 May 2023: regular meeting of the Committee covering all standing items plus the following focus areas:** • Briefing on the new national PCN Infection Prevention and Control (IP&C) Education Framework. • Risk focus on Discharge and Care Market Support, including a briefing on the Living Well Together review. • Deep dive report on healthcare 'Never Events'. • Update and assurance report on Safeguarding Adults & Children. • Update and assurance report on Research and Innovation. • Update from the Learning Disabilities & Autism Programme Board.
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 BAF05b: CYP Mental Health Transformation Programme BAF06: Health Inequalities BAF08: Elective Recovery BAF09: NHS Continuing Healthcare BAF10: EEAST Response Time and Patient Harms BAF19: Discharge from Inpatient Settings BAF20: Industrial Action **Quality and Safety Committee Significant Risks:** SR03: EEAST Special Measures & Workforce Resilience SR04: Surge Capacity to Support Local Acute Trusts SR05: Workforce Absence and Moral Injury SR06: Public Trust and Reputational Damage SR07: BCG Immunisation SR08: Eye Care (Ophthalmology)

	SR09: Elective Long Waits SR10: Care Provider Capacity System-Wide Impact SR11: Compliance with Deprivation of Liberty Standards SR12: 12 Hour Decision to Admit Breaches SR13: Neuro-Developmental Service Provision SR14: CYP Mental Health (Allocation of Case Managers) SR15: CYP Mental Health (Crisis Team Capacity) SR16: CYP Mental Health Waiting Lists SR17: CYP Mental Health Integrated Front Door SR18: LD CAMHS Psychiatry Provision SR19: CYP Podiatry Provision in Central Norfolk SR20: CYP Speech and Language Therapy Provision SR21: CYP Service Disruption (Changes in Workforce) SR22: Digital Maternity Care Records SR26: Deconditioning and Hospital Acquired Infections SR43: Tuberculosis Service Capacity SR44: Wheelchair Service Waiting Times Committee also has oversight of a small number of risks that do not currently meet the BAF or Significant Risk threshold: • Learning Disability and Mental Health Hospitals Discharge • s117 Mental Health Act Aftercare Personal Health Budgets • Local Commissioning Issues* **Proposal for Risk Closure** As of the May 2023 meeting, Committee has recommended the closure of BAF01 'Living with COVID-19'. Infection prevention and control measures are in place across the system, to ensure that we can respond safely and effectively.
Key items for assurance/noting:	**<u>April 2023</u>** **Urgent and Emergency Care (UEC)** Committee received an overview of learning from adverse incidents, effecting service users and staff. Acute teams continue to coordinate their rapid release processes, led by QEHKL; this function provides an immediate escalation to release an ambulance crew waiting at a hospital emergency department, to attend a critical call in the community. The ICB continues to facilitate the standardisation of processes across the three local acute hospital sites. EEAST has recently undertaken a 'all things Stroke' clinical update as well as a project to develop staff skills and confidence around the ReSPECT end of life tool, delivering an e-learning package and podcast exploring the ambulance crew role in supporting people's plans and choices for end-of-life care. Committee were also briefed on the wider system programme of enhanced support, to improve safety and patient experience, increasing access to pre-hospital community care as well as supporting ambulance and emergency department flow, including the establishment of a System Control Centre to support operational management and escalations and potential expansion of Hospital Ambulance Liaison Officer (HALO) provision to deliver a consistent 24hr, seven day a week service across the hospital sites. Additional staff have been put in place to support patient cohorting,

	which releases ambulances from emergency department queues, and additional funding has been allocated to support hospital discharge and improve flow. Committee reflected on the challenges ahead but noted that the system is already coming together to have conversations about sustainable pathways of care and developing a system response to achieving improved response targets. Supporting and developing the UEC workforce continues to be a key factor. Committee will continue to receive bi-monthly updates on UEC to seek assurance that improvement is sustained. **Neurodevelopmental Disorder (NDD) Provision** Committee were updated on progress since the last reporting period. The NDD waiting list procurement has been completed with a go-live of 01 April 2023. A visit to NCH&C has been completed to review the clinical pathway and explore efficiency. Parent and carer engagement workshops have taken place, providing specific support and information. Funding has been confirmed for the autism spectrum disorder Puffins Parent Programme. The ICB Children's commissioning team continues to work with the local authority to review an integrated support offer to families. ***Local Commissioning Issues** The Local Commissioning Team presented a deep dive on gaps in service provision, which potentially reflect an inequity of access to appropriate and timely care. Committee discussed challenges and opportunities for improvement in relation to the following community service areas: • Adult Speech & Language Therapies • Epilepsy Provision in Great Yarmouth & Waveney • Neurology Provision in Greater Norwich • Support for Patients with Short-Term Feeding Tubes Committee set an action for Commissioning and Quality in Care leads to explore the need for a Neurological Rehabilitation Community Pathway to improve access and resource management in Norfolk and Waveney. Committee also reflected on the risk associated with inequities in provision are managed across a commissioning and quality matrix. **Adult Mental Health Transformation Programme** Committee received an update on the three strands of the programme: 1) Prevention and Wellbeing 2) Community Transformation 3) Mental Health UEC and the current plan to integrate these elements. Committee received a demonstration of the draft mental health metrics that are being developed for the new System Quality BI Dashboard. Attendees reflected on the importance of metrics that look at patient outcomes as well as process and performance measures and the value in capturing data on mental health presentations from across the wider system including UEC and hospital emergency departments. Committee will continue to have oversight of the metric development work.

LMNS Update
Committee received an update on progress made in all areas of the local maternity programme. The LMNS continues to bring the system together collectively to jointly learn and implement solutions to quality, safety, and equality issues. Learning from the national Ockenden, East Kent and Morecambe Bay investigations will be presented at a future meeting to detail what the focus areas will be, moving forward, in a new system Maternity Single Plan.

May 2023

PCN IP&C Education Framework
Committee were briefed on the new national framework, which is a part of the National Action Plan for Antimicrobial Resistance. The purpose of the framework is to support national and local commissioning, design, and delivery of education to ensure it meets the needs of the workforce and demonstrates the required expectations for effective and safe practice in a consistent, evidence-based way. This will be implemented locally through the ICS IP&C and Antimicrobial Stewardship Partnership, reporting into the ICS System Quality Group.

Discharge and Care Market Support
Committee received an update on the review that is being undertaken in collaboration with clinicians, managers, and leaders across the system and involves a deep diagnostic look at the care that has been delivered to over 100 patients, with the aim of understanding whether the patients received the best possible outcome at every point along their journey and interaction with care services. The work has added evidence to the existing understanding that delays to discharge are leading to poorer patient outcomes, deconditioning and less choice for onward recovery and reablement. The establishment of the system Discharge Programme Board is an important step forward to enable joined up action across providers and commissioners. Attendees heard that a digital patient tracking system is being piloted to help optimise hospital discharge and transfer of care processes, and there is a significant amount of work being undertaken within the community, around admission prevention and post-discharge reablement support. The ICB Executive Director of Nursing highlighted demographic needs, including Dementia, Stroke and Neurological Rehabilitation and spoke to the review as an opportunity to identify and address barriers that have made sustainable change difficult in the past, and plan and create services that support people to be discharged 'home first' whenever that safe and appropriate. An action was set by the Committee for the Palliative Care and Ageing Well Boards to explore opportunities to support families and care settings to advocate for patients and negotiate support to look after people in their own homes (which includes residential care), particularly as part of planning for end-of-life care.

Healthcare 'Never Events'
The NHS Never Events Policy and Framework is part of continuing efforts to build a learning culture and maximise opportunities to keep our patients safe. All incidents on the NHS Never Events List should

	be avoidable if available preventative measures have been implemented. Committee received a report over the last three years, detailing local incidents. Attendees noted learning and mitigations put in place for three events reported so far in 2023, all relating to wrong site or wrong implant surgery. Learning from two oxygen and air cylinder incidents reported in 2020-2021 has been embedded, with no further incidents of this nature reported since mitigations were put in place. **Safeguarding Adults & Children** Committee received an update report on safeguarding, across age ranges, with a family focus, providing an overview of statutory compliance and the work of the ICB Safeguarding Teams. **Research and Innovation** Committee noted that 81% of General Practices in Norfolk and Waveney participated in research during the last financial year, against a national target of 44%. With over 19,600 patients recruited into research across our local NHS organisations, attendees reflected on the value of being a 'research active' system, for both patients and staff. The ICB Research & Evaluation Team is coordinating system Research Capability Funding, in line with national guidance, to help build capacity and capability, working closely with the UEA and focusing locally on research in out-of-hospital settings. **Learning Disabilities & Autism Programme Board** Committee received an update from the Learning Disability and Autism Partnership Board, brings together commissioners and providers, with an agenda that is driven by 'experts by experience'. Alongside this, there is an independent piece of work currently in progress to fully understand the opportunities for integration, with a focus on the learning from the Cawston Park Safeguarding Adults Review (SAR) and the Building the Right Support Review. The ICB has progressed its SAR Action Plan significantly, with only two remaining actions; input to the NCC 'ethical commissioning' workstream and practice guidance around Continuous Positive Airway Pressure which is being progressed by our Respiratory Working Group. The ICB reports good performance against Learning from Lives and Deaths reviews (LeDeR) and the team has progressed a backlog of cases while also delivering 93% of reviews within the current target of 6 months. Committee heard that NHS Digital are implementing a new Reasonable Adjustment Flag and a national training initiative is due to commence soon. Committee reflected on the improvements in offer and uptake of Annual Health Checks, with Norfolk and Waveney meeting their 75% target. The ICB is delivering regular Commissioner Oversight Visits for LD&A patients in hospital care, alongside bi-annual Care and Treatment Reviews, so that there is good oversight of placement safety and quality. Discharge continues to be impacted by challenges within the specialist community care market; we continue to work with the local authorities around shaping and building the care market to be able to meet some of those more complex and 'forensic' needs.

	System Quality Group Update Committee continues to receive regular reports from SQG and received the recent system report into the Regional Quality Group. Operational quality issues escalated to region from the local group included ongoing impact of ambulance delays, industrial action, enhanced monitoring of medical education at NNUH and the recent maternity Section 29a Warning Notice at JPUH. A regional escalation has been put forward around the potential fire safety risk around emollient creams. Other issues discussed at SQG include: • Regional Healthcare Student Attrition Rates • NHS Patient Safety Strategy (PSS) Implementation • NHS System Oversight Framework • Transition of Pharmacy, Optometry and Dental Services
Items for escalation to Board:	No additional escalations were requested. See risks and issues noted above.
Items requiring approval:	Committee approved the following ICB policies: • **New** Fabricated or Induced Illness Policy (April 2023) • Annual Review of Adult Safeguarding Policy (April 2023) • **New** ICS Research & Innovation Strategy (May 2023)
Confirmation that the meeting was quorate:	**Quoracy (as per Governance Handbook):** there will be a minimum of one Non-Executive Board Member, plus at least the Director of Nursing or Medical Director. The April and May 2023 meetings were 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:	**Finance Committee Report**
Presented by:	**Hein van den Wildenberg, Non-executive Member, Finance Committee Chair**
Prepared by:	**Emma Kriehn-Morris, Interim Director of Commissioning Finance**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**30th May 2023**

Purpose of paper:

To provide the Board with an update on the work of the Finance Committee up to the 25th April 2023

Committee:	Finance Committee
Committee Chair:	Hein van den Wildenberg
Meetings since the previous update	Last update provided: 28.03.2023 Subsequent Meetings: 25.04.2023
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 main items discussed at the Finance Committee were as follows, **ICS** 1. The Unaudited Revenue System outturn for 2022/23 is £(20)m deficit. This is £(20)m adverse to the break-even plan, but consistent to forecasts presented in recent months.

	Two significant variances to plan arose with JPUH reporting a £(24.8)m deficit, and the NNUH reporting a £4.8m surplus. 2. The Capital (CDEL) System outturn for 2022/23 was £98.2m, £0.7m less than the plan. **ICB** 1. The Unaudited Revenue ICB outturn for 2022/23 is £0.2m surplus. 2. The ICB leaves 2022/23 with an underlying deficit of £(65)m. 3. The final 2023/24 ICB financial plan is a break-even position. The financial plan includes £72m of mitigations to achieve break-even which is required by NHS England. A further £75m of risks are considered possible above those costs planned for.
Items for escalation to Board:	1. The ICB underlying exit position and significant financial risk in the 2023/24 financial plan.
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.

Main messages for Finance Committee report to ICB Board.

The points below follow from the April finance committee. The May finance committee scheduled for the 23rd falls after submission of board papers. Any relevant update or escalations from that meeting, will be provided verbally.

Part 1 (System overview)

- The 2022-23 financial positions were noted as being draft and pre-external audit.

- The year-end outturn for NHS organisations in the ICS reported an aggregate £(20.0)m deficit, adverse to a break-even plan but consistent to previous months forecasts.

- The JPUH reported a £(24.8)m deficit driven by operational pressures impacting the achievement of additional ERF, implementation and recognition of savings and the staffing of additional capacity. Partially offset by a £4.8m surplus reported at the NNUH.

- It should be noted that (nearly) all NHS organisations in the ICS required significant use of non-recurrent measures, which demonstrates the underlying strain on the finances.

- The 2022-23 year-end outturn for capital expenditure (CDEL)reported a spend of £98.2m, £0.7m less than plan, largely a result of slippage/delays.

- The Committee discussed the draft financial plan for 2023/24, which had already undergone challenge internally and by NHS England. The presented Revenue deficit at system level for 2023/24 had improved from £(55.7)m deficit to £(13.7)m deficit, but still not achieved the required break-even. *Post meeting the ICS final submitted financial plan has now achieved a break-even position.*

  Elements of the draft financial plan were explored in relation to efficiencies and risks.

  - Efficiencies included in the plan totalled £113m of which £49m (43%) had been identified.

  - Risks included in the plan totalled £172.7m gross and £94.5m net (when considered against mitigations). Of the £78.3m mitigations included in financial plans, some are considered high risk or unidentified.

  It also assumes significant risks are absorbed by each organisation. The committee will closely monitor these risks during next financial year.

  It was noted that the challenges start now to deliver this 2023/24 financial plan and the significant risks within, at both an ICS and ICB level.

- Works, will also commence in approaching the 2024/25 financial plan in detail as part of the wider Medium Term Financial Planning (MTFP) exercise required for submission to NHSE in July 2023.

- The Better Care Fund was presented to the committee represented by both ICB and Norfolk County Council colleagues. Details were provided on the scheme purpose and mandatory natures. Funding was noted as being made by the ICB directly to the council and also by way of independently commissioned schemes which contribute towards the programme ambitions and are aligned to scheme priorities and principles developed by the Health and Wellbeing Board in 2021/22.

  Outcomes regards the 2022/23 investments and related metrics are being completed.

  Areas of focus for the 2023/24 agreement were noted as being, alignment to the ICS priorities, evidencing Value for money (of BCF spend), and consistency of application across Place. The committee will be kept informed on outcomes through future metric reporting.

Part 2 (ICB specific)

- The 2022-23 financial positions were noted as being draft and pre-external audit.

- The year-end outturn reported a £0.2m surplus immaterially ahead of the break-even plan. This was achieved by significant non-recurrent measures to include £28m of prior year benefits unlikely to be achieved again in future years.

- The efficiency programme reported successful delivery of £18.9m savings against plans of £18.6m. Recognition of success was noted especially for key delivery portfolios of CHC, GP Prescribing and Corporate functions.

- Spotlights covered included,

  - The successful external audit outcomes of the 2021/22 Mental Health Investment Standard (MHIS) whereby compliance and standards were noted as being completed. A draft pre-audit delivery of the 2022/23 MHIS standard reporting spend of £184.3m against a target of £183.7m.

  - The development of Place, to include production of timelines and programme plans as part of the Joint Forward Plan delivery from July 2023 onwards.

Norfolk and Waveney
Integrated Care Board

Agenda item: 16

Subject:	**Primary Care Commissioning Committee Report**
Presented by:	**James Bullion, Local Authority Member** **Hein van den Wildenberg, Non-Executive Member**
Prepared by:	**Sadie Parker, Director of Primary Care**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**30 May 2023**

Purpose of paper:

To provide the Board with an update on the work of the Primary Care Commissioning Committee for the April and May 2023 meetings.

Committee:	Primary Care Commissioning Committee
Committee Chair:	James Bullion, Local Authority Member Deputy is Hein van den Wildenberg, Non-Executive Member
Meetings since the previous update on 28 March	21 April 9 May
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	BAF16 – the resilience of general practice Current mitigated score – 4x4=16

relevant / aligned to this Committee:	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 (including workload associated with secondary care interface issues). 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. BAF18– the transition and delegation of primary care services Current mitigated score – 3x4=12 Primary Care Services became 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. Further work has been undertaken to mitigate these risks. Following discussion at the ICB Executive Management Team meeting and the May PCCC meeting, it has been agreed to refocus this risk on the provision of dental services to the Norfolk and Waveney population.
Key items for assurance/noting:	<u>April</u> • Updated committee terms of reference, including the establishment of a medical and a dental delivery group to enable committee to focus on more strategic areas • Learning disability health checks – provisional year end data indicated the ICB had reached the 75% uptake target for the first time • ICS quality strategy – members noted the strategy and how this aligns with committee remit • Delegated commissioning transition – members received a report on the completed transition and

	the new responsibilities around community pharmacy, dental and optometry services. A baseline position was provided along with early plans for developing our approach to address the known challenges • Care Quality Commission report for Mattishall and Lenwade surgeries, who had been rated as inadequate. Committee noted the action planning and progress made to address the areas highlighted by the CQC • GP contract – members were updated on the national changes to the GP contract this year and the resulting requirements on practices • Prescribing Report • Finance Report <u>May</u> • Winter resilience schemes – members received an update on the impact of the £750k investment in general practice over the winter period, and the additional capacity this had brought • Locally commissioned services – an update was provided on the five LCS under review and the plans for issuing these to practices following approval by the committee in March • Enhanced access – members were updated on the implementation of plans agreed in October with PCNs. It was noted practices would be written to with the aim of ensuring plans remained fit for purpose and to update the time requirements following changes in list sizes • 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 (654,000 appointments in March, 44.7% same or next day and 76.7% of appointments provided within two weeks of request. 77.4% of appointments are face to face compared to 70.1% nationally).
Items requiring approval:	<u>April</u> • Members approved the appointment of a dental attendee to the committee and the role specification, in line with the revised PCCC terms of reference •

	<u>May</u> • Members approved the risk register, including the reduction in risk score for the risk relating to learning disability health checks following achievement of the uptake target for the first time in 2022/23. Members also agreed to refocus the BAF18 risk towards the specific dental risks of access, workforce and quality • Workforce and training report – members approved the primary care workforce strategy and the communications and engagement strategy • Resilience funding for community pharmacy integration - members approved the distribution of £263k NHSE Integration funding to support the community pharmacy integration programme and in turn support delivery of the vision of the East of England Partnership Strategy for Community Pharmacy • Norwich Walk-in Centre Consultation – members received and expressed support for the recommendation to keep the walk-in centre open following publication of the consultation report. Members noted the formal decision would be taken by the ICB Board and recommended they approve a decision to keep the walk-in centre open. Members also approved a 3-month extension to the contract to enable specific engagement work to be completed with the registered list of the Rouen Road GP practice to determine if capacity could be released by bring its opening hours in line with other Norfolk and Waveney practices
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, detailed performance reports are reviewed on learning disability and severe mental illness health checks uptake. Access data is reviewed annually through the GP Patient Survey report
Impact Assessment (environmental and equalities):	N/A

Reputation:	The committee meeting is held monthly in public and includes membership from the Local Representative Committees, 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, delegation agreement with NHS England
NHS Constitution:	N/A
Conflicts of Interest:	Arrangements are in place to manage conflicts of interest

Norfolk and Waveney
Integrated Care Board

Agenda item: 17

Subject:	**Performance Committee Report**
Presented by:	**Hilary Byrne**
Prepared by:	**Tessa Litherland, Associate Director of Planning and PMO**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**23 May 2023**

Purpose of paper:

To provide the Board with an update on the work of the Performance Committee for the period 28 March 2023 to 23 May 2023.

Committee:	Performance Committee
Committee Chair:	Hilary Byrne
Meetings since the previous update on 24 January 2023:	• 18 May 2023
Overall objectives of the committee:	1. Oversee the implementation of the IPR system as the primary source of performance metrics for the ICB Board, Performance Committee, Tier 3 and 4 Boards and Groups. 2. Assure NHSE/I of progress against SOF4 measures and improvement of SOF segmentation. 3. Assure the system and programme areas use benchmarking and best practice to improve areas of concern and drive ambition. 4. The Committee will require assurance from the Programme Boards in relation to delivery and highlighting any appropriate risks. Receive robust improvement/recovery plans from the Programme Boards for measures as set out in the 2023/24 priorities and operational planning guidance, including UEC, General Practice and Maternity national improvement plans and other key performance indicators.

Main purpose of meeting:	The Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that ensures a high performing system. The Committee exists to scrutinise the robustness of and gain and provide assurance to the ICB regarding the delivery of key performance standards by commissioned providers, performance of the system against the NHS Outcomes Framework and progress with improving wider population health outcome measures.
BAF and any significant risks relevant / aligned to this Committee:	No BAF items currently aligned to this committee.
Key items for assurance/noting:	• Updated Terms of Reference agreed • Year end performance of key metrics tabled, and role/remit of the Committee discussed • Performance against NOF4 metrics reviewed. Deadlines and process for decision of formal exit plan was discussed. • Update from SROs for Elective and Cancer Care. Reduction in 78 week waits by March 2023 overachieved against plan. • Deep Dive on Urgent and Emergency Care and feedback on a system wide UEC event agreeing priorities. • Update slides received from Mental Health. Discussion regarding fragmentation and continuity of care for patients with physical and mental health. Agreed for Deep Dive next meeting.
Items for escalation to Board:	Items to note: Review our approach to the strategic commissioning and alignment of care across physical and mental health services, to ensure continuity and consistency in pathways for patients and avoid disjointed care where more than one provider is involved. For initial consideration by the ICB Executive Management Team.
Items requiring approval:	Nothing requiring approval.
Confirmation that the meeting was quorate:	Yes, meeting was quorate.

Key Risks	
Clinical and Quality:	Not applicable.
Finance and Performance:	It is important that there is scrutiny of performance and its management across the ICB and this function is performed by the Performance 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:	Performance Committee is a 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: 18

Subject:	**Patients and Communities Committee Report**
Presented by:	**Aliona Derrett**
Prepared by:	**Rachael Parker, Executive Assistant - Norfolk and Waveney ICB**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**30 May 2023**

Purpose of paper:

To provide the Board with an update on the work of the Patients and Communities Committee for the period January to May 2023

Committee:	Patients and Communities Committee
Committee Chair:	Aliona Derrett, Non-Executive Director
First update for this Committee:	Monday 23 January 2023, 3-5pm Monday 27 March 2023, 3-5pm Monday 22 May 2023, 3-5pm
Overall objectives of the committee:	Currently in development
Main purpose of meeting:	To provide the ICB with assurance that it is delivering its functions in a way that meets the needs of patients and communities, that is based on engagement and feedback from local people and groups, and that takes account of and reduces the health inequalities experienced by individuals and communities. To scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care.

BAF and any significant risks relevant / aligned to this Committee:	NA
Key items for assurance/noting:	<u>January:</u> **People and Communities Approach including co-production** Committee members were updated on the work undertaken in line with the Working with People and Communities ICS Framework Guidance. Norfolk and Waveney has developed an approach that recognises the importance of building existing good practice across the system, working with local people, stakeholders and partners to develop sustainable and mutually supportive partnerships. Following assessment by NHSE our approach received very positive feedback and was highlighted as a regional exemplar in relation to Inclusion Health Groups and the Community Voices pilot **Community Voices** NHS Norfolk and Waveney continues to work with partner organisations across the system, including our local VCSE sector and District Councils to develop and deliver a new engagement programme which looks to listen to our communities, and better understand experiences and opinions of accessing healthcare. This pilot, known as Community Voices, will work with trusted communicators to speak with communities who may not already engage with the NHS to hear what is important to them. **Lived Experience Representative Recruitment** Lived experience representatives will be joining the Patients and Communities Committee to ensure the voice of local people and communities are represented at all levels within Norfolk and Waveney ICS. The recruitment process and recruitment pack were presented and agreed by the committee. The ambition is for the representatives to be recruited in time for July's meeting. **Complaints Report** The committee received the complaints report for Q1-3. The experience of housebound patients during Covid was highlighted and the challenges they faced accessing the Covid-19 booster vaccination in some parts of Norfolk and Waveney. The committee also discussed response times for formal complaints and the number of primary care queries already being received prior to the ICB taking these over from NHSE on 1 July.

	Population Health Management and Health Inequalities The Committee received a detailed presentation on the work of the Protect NoW team, understanding how Population Health Management approaches and addressing inequalities had a direct link to improving uptake of the COVID-19 vaccination, increasing the number of people who self-referred onto the national Diabetes Prevention Programme (NDPP), as well as increasing the number of people who have since elected to take part in cervical screening. In one example, the Committee heard how more than 3,000 people who would not normally have engaged, had self-referred onto the NDPP, reducing and virtually eliminating the opportunity of developing Type 2 diabetes. <u>March:</u> **Commissioning and Contracting in NHS Norfolk and Waveney** The Committee received a brief update on the commissioning and contracting of healthcare services by the ICB following its creation. The importance of moving to outcomes based commissioning and contracting was acknowledged, and building into the procurement the requirement for providers to demonstrate how they are going to make a difference to our communities. The committee heard that changes to the procurement for heathcare services are anticipated by July, this will see a provider selection regime come into effect which will hopefully make collaboration easier to deliver. **Inequalities Overview and Update** The committee received an update on the key achievements and initiatives in reducing health inequalities in our local system including the Health Inequalities Strategy and the Wellness on Wheels bus (WoW). The committee suggested integrating other mobile services with the WoW bus as some are targeting the same areas. The committee heard about Core20Plus5 which is a approached designed to support ICSs to drive targeted action in healthcare inequalities improvement. The ICB is making progress in addressing the priority areas with key achievements and initiatives being implemented across the ICS. **Healthwatch Updates** Healthwatch Norfolk and Healthwatch Suffolk provided updates on work currently being undertaken across Norfolk and Waveney. Healthwatch Norfolk highlighted the three biggest concerns from the public are primary care,

	dentistry and pharmacy services. The committee discussed the use of digital tools to help people with hearing difficulties and reaching out to people who are digitally excluded. **Spotlight on: Mental Health Transformation** At May's meeting the committee welcomed colleagues from Rethink Mental Illness and heard about mental health transformation, particularly the mental health transformation coproduction model which brings together information from a wide range of people through community conversations. The committee was also joined by two Experts by Experience who, through their own experiences, are trying to influence change, and to shape mental health services to become more holistic and integrated. <u>May:</u> **Joint Forward Plan (JFP)** The committee received an update on the JFP and the engagement undertaken with local people and communities. Key points discussed include sense checking that the eight objectives are right for our population, mechanisms for sharing what else is happening but isn't included in the plan and giving the public opportunities to contribute to this. The committee noted that an engagement exercise had received 700 responses; social care, GP access and NHS dentistry were the top three areas which are important to the people of Norfolk and Waveney. **Healthwatch Updates** Healthwatch Norfolk updated it had successfully agreed some multi-year programmes of work with some key providers in the system, which will focus on engaging with patients, service users and carers about their experiences of accessing services. The Healthwatch Norfolk Team were also spending a week at each of the acute hospitals gathering feedback from patients, staff, relatives, and carers about their experiences. The is a first for a Healthwatch organisation in the country. Healthwatch Suffolk have been working with the Suffolk Dementia Action Partnership to help gather people's experience of living with or caring for someone with Dementia. From the comments received 36 learning points have been identified across seven main areas which include diagnosis, support from health professionals, social care support, hospital care, and services working together.

	Complaints Report The committee received an update about the ICBs complaints and information enquiries, lessons learnt and performance against the organisations complaints handling policy. The volume of work significantly reduced during 22/23, however volumes are likely to exponentially increase due to the full transfer of primary care complaints and concerns to the ICB. The committee shared concerns regarding the timescale (45%) for responding to complaints within 30 days, but an escalation route had been identified to support this. Themes and trends are critical and are helpful for us to identify areas which we need to focus and act upon. **UEC Update** The committee heard some of the key aspects of the work around urgent and emergency care, these include prevention and keeping people well and out of hospital, improving out of hospital community services. Emergency admissions have reduced, the work of partnerships and place has also contributed to this. It was noted that category 2 ambulance response times and long waiting times at hospital are areas of focus.
Items for escalation to Board:	None
Items requiring approval:	None
Confirmation that the meeting was quorate:	Yes

Key Risks	
Clinical and Quality:	The committees Chair is also the Chair of the Quality and Safety Committee so can bring oversight and awareness of both agendas to each committee as required.
Finance and Performance:	The committee has attendees from the Integrated Commissioning Team to input in relation to provider performance.
Impact Assessment (environmental and equalities):	N/A
Reputation:	The committee is held bi-monthly in public and includes membership from: - Healthwatch Norfolk and Suffolk - VCSE

	- Health and Wellbeing Boards in Norfolk and Suffolk - Public Health - Primary Care - Place - Health Inequalities Recruitment of Lived Experience representation is in progress and should be complete by July 2023
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	The report supports the Patient and Communities 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: 19

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:	**30 May 2023**

Purpose of paper:

To provide the Board with an update on the work of the Audit and Risk Committee for the period 9 February 2023 to 11 May 2023.

Committee:	Audit and Risk Committee
Committee Chair:	David Holt, Non-executive Member
Meetings since the previous update on 28 March 2023	• 11 May 2023
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:	This was a busy meeting, with key agenda items covering the following areas: • **TIAA Counter Fraud Annual Report and Functional Standard Report** The report noted that counter fraud is well embedded within the ICB, and that work undertaken in year has successfully addressed all areas of the counter fraud strategy. It also advised that there were no significant system failures or control weaknesses that would impact on the ICB's annual governance statement and confirmed that there were no frauds received subject to investigation that met the materiality thresholds.

	The annual Counter Fraud Functional Standard return is due to be submitted on 31 May with all the information uploaded to the portal ready for review and approval. The return is positive with just one amber rating remaining. This was the last meeting by TIAA counter fraud who was thanked for all her work and contribution to the Committee over the last few years. • **Executive Medical Director Report** The Executive Medical Director presented this report to the Committee (EMD). The report provided an overview of the remit and portfolio responsibilities of the EMD as well as the main areas of risk and concern from the EMD's perspective. The report also mapped whether these areas of concern were currently reflected in the BAF or significant risk register. This identified that the majority of concerns are already reflected in these registers with actions underway to address any gaps identified through this process. • **Data Sharing Report post COPI legislation** The Director of Digital and Data presented this paper and advised the Committee of the work undertaken to securely and appropriately share patient data between health and care providers since Control of Patient Information (COPI) regulations ended. The ending of COPI has meant that the processing of data has returned to be covered through the UK General Data Protection Regulation (UK GDPR) and Common Law Duty of Confidentiality in relation to direct care. Norfolk and Waveney ICS are continuing to work to ensure that the benefits of data sharing seen through the pandemic are retained whilst ensuring the correct agreements and legal basis are in place for sharing data. A number of projects and programmes on the current Digital Roadmap will deliver the capability and data assets seen in the pandemic. These programmes will bring data together from care settings across Norfolk and Waveney to support a variety of use cases with some requiring access to patient identifiable data and some anonymised data. • **Freedom to Speak Up Guardian update** This update confirmed that an internal advert is currently live inviting staff to apply for the Freedom to Speak Up Guardian (FTSUG) role. The role currently sits within the People Directorate where wider support can be provided to the Guardian and the team of freedom to speak up champions. Members debated the independence and perception of this

	reporting line, particularly as we enter a period of restructuring, and recommended that it be kept under review. The FTSUG role has historically provided support to primary care. Advice has been provided by NHS England that national guidance is being developed on how best to support primary care. Support will continue to be provided to primary care pending national guidance. Members restated the importance of the FTSUG role and emphasised the importance of getting the correct support in place as soon as possible. • **Internal Audit** The Internal Audit progress report was presented. This advised that 5 audit reports have been concluded since the last meeting: Patient and Public Engagement, Key Financials, Efficiency Savings, Risk Management and Data Security and Protection Toolkit audit all receiving reasonable assurance or above. There has been one change to the 2022/23 audit plan – The Collaborations and Partnership audit planned for 2022/23 has been carried forward to the 2023/24 audit plan. o Draft Head of Internal Audit Opinion TIAA confirmed that it is satisfied that for the areas reviewed during the year the ICB has reasonable and effective risk management, control and governance processes in place. A final HOIAO will be presented to the Committee in June. o Final Indicative Audit Strategy 2023/26 and Annual Plan The Audit Strategy and Annual Plan was presented to the meeting. The Annual Plan is subject to ongoing review and can flex as the organisational risks change. The meeting suggested that an advisory review of the restructure be considered as well as system area audits for 2024/25. It would also be useful to map the audits against the ICB's six priority areas to ensure that these are being addressed. The plan was noted. • **Counter Fraud Proactive Work Plan 2023/24** The draft work plan was reviewed noting that it was aligned with the counter fraud functional standards. The key priority for the first quarter is completing the fraud risk assessment which will highlight any key risks. A comprehensive handover had taken place with TIAA. There is one investigation outstanding. The draft plan was approved. • **Annual Governance Statement**

	The draft ICB AGS was discussed with suggestions made to incorporate risk mitigations against relevant risks and to give more detail on the 'deep dive' discussions that had taken place in Committee meetings. Reference to patient safety to be included on the freedom to speak up section. The AGS forms part of the Annual Report and Accounts (ARA) and it was noted that both the former CCG and ICB draft ARAs are due to be presented to the May Board meeting for comments. • **Draft Statutory Accounts and Technical Briefing Paper** The meeting was advised that the draft ICB Statutory Accounts were submitted to NHS England on 27 April 2023 as per the formal timetable. The Committee received a copy of these and noted that the ICB's external auditors had also received them to commence their review. The Committee agreed the Going Concern basis on which the draft ICB Statutory Accounts had been prepared but noted it was a challenging plan. It also noted the provision and change in accounting policy adoption regards lease accounting and transfer by absorption accounting. Noted the draft Statutory Accounts as presented ahead of submission to NHSE and external auditors. • **External Audit – Interim ICB Plan and fees** External audit confirmed that the ICB audit plan is similar to the 3-month CCG plan and that the risks remain the same. The materiality threshold has been set on the same basis as the CCG audit of 2% gross expenditure using the outturn in the draft accounts of £1.724bn and will report to the Committee any audit differences above £300k. A query remains nationally within the ICB accounts re pension disclosures and this is still pending. • **Board Assurance Framework** The Board Assurance Framework (BAF) was presented to the meeting. The Committee was advised that management of risk is coordinated through MS Teams which enables clearer line of sight and the ability for teams to access and update a single document. Further that a full suite of documents that support risk leads has been created and has been supplemented by training on the basic principles of risk management that took place in April. The executive team have discussed tolerated risks scores and mitigated risk scores which identified risks for discussion with Board. • **Losses and Special Payments** This is a standing agenda item and the Committee was advised that there were no new items of bad debt, accounts

	payable, ex gratia payments, phb fraud to report. A special payment has been made and noted by the Committee. • **Gifts and Hospitality Register** The register was received for information and noted. • **Mental Health Investment Standard Audit 21/22** This paper informed the Committee of the external auditor's (Grant Thornton) opinion on the 2021/22 MHIS position declared by the former Norfolk and Waveney CCG. The opinion found that the compliance statement was properly prepared in all material respects although there were a small number of issues identified. The ICB must publish a statement after the end of the financial year to state whether their consider their predecessor CCG to have met its obligations regarding MHIS and this is being prepared. • **Items for information** The Committee also received updates on the following matters: o Information Governance Work Group o Conflicts of Interest Committee Update o Audit and Risk Committee Terms of Reference o Internal Audit Reports with reasonable assurance or above and advisory reports o Procurement update and Tender Waiver Briefing o Policy Status Report o Audit and Risk Committee Annual Plan o Report on any urgent Board decisions and non-compliance with the Standing Orders o Items from other committees o TIAA client briefing note – *fraud and bribery against the NHS*
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 dives, internal audit assurance reports
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:	It is a statutory requirement for the ICB to have an audit and risk committee.
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.

Norfolk and Waveney
Integrated Care Board

Agenda item: 20

Subject:	**Remuneration, Culture and People Committee Report**
Presented by:	**Cathy Armor**
Prepared by:	**Ben Smith - Associate Director of Workforce Efficiencies**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**30 May 2023**

Purpose of paper:

To provide the Board with an update on the work of the Workforce directorate with regards to it works across its People functions, organisational developments, workforce transformation and efficiency and productivity for the period April 2023 to 30 May 2023.

Committee:	**Remuneration, Culture and People Committee**
Committee Chair:	Cathy Amor
First Committee update to Board on 30 May 2023:	• 17 May 2023
Overall objectives of the committee:	The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. In summary: • Confirm the ICB Pay Policy including adoption of any pay frameworks for all employees including staff on very senior managers grade, including all board members, excluding the Chair and Non-Executive Members. The ICB Board has also delegated the following functions to the Committee: The Committee will hold a part 1 meeting to cover issues as to system people and culture priorities only. This section of the meeting will contribute to the overall

	delivery of the ICB objectives by providing oversight and assurance to the Board on the strategic People and culture agenda for the ICB and its partner constituents. It will do this by scrutinising the delivery of the strategic people priorities in order to provide assurance to the ICB Board that risks to the delivery of the people agenda are being managed appropriately. The committee will receive relevant risks from the Board Assurance Framework (namely those relating to People and Culture agenda) to review assurance on risk mitigation and controls including any gaps in control for the risks allocated to the Committee; The Committee will also have oversight and provide assurance to the Board that the ICS is delivering against the ten outcomes-based functions with their partners in the ICS against an agreed set of Key Performance Indicators; namely: 1. Supporting the health and wellbeing of all staff 2. Growing the workforce for the future and enabling adequate workforce supply: 3. Supporting inclusion and belonging for all, and creating a great experience for staff 4. Valuing and supporting leadership at all levels, and lifelong learning. 5. Leading workforce transformation and new ways of working 6. Educating, training, and developing people, and managing talent 7. Driving and supporting broader social and economic development 8. Transforming people services and supporting the people profession 9. Leading coordinated workforce planning using analysis and intelligence 10. Supporting system design and development: It will also play a key role in ensuring that NHS partner organisations meet expectations in relation to the system people and culture strategic priorities and committee will ensure compliance against any obligations outlined in the NHS People Plan. The part 1 duties of the Committee will be driven by the system's objectives, performance, and the associated risks. An annual programme of business will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks.

Main purpose of meeting:	To provide an update on key actions relating to the ICS workforce over the previous 2-month period. Specifically: • Issues relating to Industrial action. • Workforce planning • ICB Change Management Programme • Staff survey results • Improving Lives Together Programme (Newton Europe) • Recruitment and Retention • Productivity • ED&I • ICS workforce performance and scrutiny • Health & Wellbeing strategy
BAF and any significant risks relevant / aligned to this Committee:	N/a
Key items for assurance/noting:	**Industrial Action** • continued to add operational pressures to the system during action in March and April. No further IA action currently scheduled **Workforce Planning** • Workforce plans submitted on May 4th. As a system, N&W submitted highest growth figures for next 12 months and had highest negative implied productivity levels within EoE Region. **Productivity** • Productivity now becoming a key focus from National and Regional teams – Workforce team have already started work reviewing system in one with 19/20 levels. **Bank & Agency** • There is a large focus on agency reduction within the system with very aspirational plans to reduce costs across the system • A collaborative programme has been developed to seek assurances on delivery with finance and ops. **ED&I** • Regional/N&W Inclusion lead started April 20th and is leading on a refreshed workplan inline with national mandates **Improving Lives Together Programme (Newton Europe)** • Initial findings report published which presented opportunities around sharing best practice, delivering at scale, and creating a great

	employee experience. Next steps now being developed **ICB Change Programme** • Programme being developed to include development and design of new operating model, formal consultation and implementation • We have developed our operating framework and are now progressing with the broader design of functions and structures • Support from ICS partners will be required in the coming months as part of the Organisation Redesign process including suitable alternative employment of staff **Staff Survey Results** • N&W organisations largely scored lower than their national organisation average at a People Promise and Theme level, with the exception of NCHC and NWICB. • However when looking at a year on year comparison, EEAST and NCHC also reported improvements across the board • Looking across the Norfolk and Waveney ICS, three key themes of safety, recognition and compassion were identified **Recruitment & Retention** • International Recruitment – A business case is in development to secure Partner investment for continuation of N&W IN Hub from 2024 onwards. • Successful return visit to Sri Lanka undertaken in May 2023 • Overall turnover is below regional average but key groups remain disproportionately high • There is considerable focus currently on flexible working and stay interviews at a trust level • Flexible working workshop planned for end of May 2023 **H&W strategy** • Final version of ICS strategy to be available May 2023 • Currently reviewing arrangement for the Wellbeing Hub following announcement of cessation of national funding
Items for escalation to Board:	N/a
Items requiring approval:	N/a

Confirmation that the meeting was quorate:	Yes

Key Risks	
Clinical and Quality:	International Recruitment key part of system workforce plans but IR hub not funded from 2024
Finance and Performance:	Large reduction in agency costs required to meet system finance plan
Impact Assessment (environmental and equalities):	N/A
Reputation:	N/A
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A

Norfolk and Waveney
Integrated Care Board

Agenda item: 21

Subject:	**Conflicts of Interest Committee Report**
Presented by:	**David Holt**
Prepared by:	**Martyn Fitt, Corporate Affairs Manager**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**30 May 2023**

Purpose of paper:

To provide the Board with an update on the work of the Conflicts of Interest Sub - Committee since the last meeting of the Board on 28 March 2023.

Committee:	Conflicts of Interest Committee
Committee Chair:	David Holt, Non Executive Member
Meetings since the previous update on 28 March 2023.	• 27 April 2023
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 conflict of interest arrangements within the ICB.
Main purpose of meeting:	In addition to the standing items, the main purpose of the meeting was to brief and assure the committee on the following items: **1.Conflicts of Interest general update** A detailed report was submitted to the Committee for assurance and scrutiny. The report presented the Committee with a refreshed Work Plan for 2023/24, provided an update on work delivered in Q4 (of 2022/23) and Q1 (of 2023/24), and outcome of TIAA's Internal Audit. The Committee discussed the importance of having sight of the issues and advice log at future meetings to enable a 'deeper dive' into the themes and trends on conflicts of interest.

	Finally, the Committee received an update in regards HEE's removal of conflicts of interest training modules (1-3). The Committee received assurance that the ICB has taken all reasonable steps to ensure staff remain aware of the importance of conflicts and that module one is expected to land soon (possibly in Q1). • **2.Conflicts of Interest Forward Plan and Horizon scan** The Committee was presented with an outline draft plan which was based on the contracts and procurement work plan. Members (and attendees) held a rich and healthy debate around the risks and horizon scanning. A meeting is to be planned between the Conflicts of Interest Committee Chair and ICB Corporate Affairs Manager to explore options for development of the plan. • **3. Learning from breach near-miss** An update and visual tracker was presented to the Committee to demonstrate the open and closed actions in regard to the near-miss incident discussed at January's Committee. Members were assured by the tracker. A discussion was subsequently held in respect of an item referenced in the tracker regarding whether members should declare their dental surgery. After debating the issue, members agreed that this would not be necessary to declare, and that declaration of GP Practice was only necessary for a particular group. The Committee agreed this would be for Board, EMT/ELT.
Key items for assurance/noting:	• Conflicts of Interest general update • Conflicts of Interest Forward Plan and Horizon scan • Learning from breach near-miss
Items for escalation to the Board:	None
Items requiring approval:	No items for approval
Confirmation that the meeting was quorate:	Yes