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

Tue 28 November 2023, 13:30 - 15:30

Agenda

13:30 - 13:30 0 min

Meeting agenda

00. 2023.11.28 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. NW ICB Board Part 1 Minutes 26092023.pdf (9 pages)

13:30 - 13:30 0 min

3. Declarations of interest

03. ICB Board Register Nov 23.pdf (4 pages)

13:30 - 13:30 0 min

4. Chair’s Action Log

04. Chairs Action Log November 2023 -.pdf (1 pages)

13:30 - 13:30 0 min

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

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

Learning from people, staff, and communities

13:30 - 13:30 0 min

7.

13:30 - 13:30 0 min

Items for Sharing and Board Consideration

13:30 - 13:30 0 min

8. Primary Care Recovery Plan

08. Primary Care Access Recovery Plan and Primary-Secondary Care Interface FINAL.pdf (22 pages)

08. The Norfolk and Waveney System Capacity and Access Improvement Plan FINAL.pdf (56 pages)

13:30 - 13:30
0 min

Finance and Corporate Affairs

13:30 - 13:30
0 min

9. Financial Report for Month 7 and financial plan submission

09. ICB Finance Report - Month 07 - Board.pdf (8 pages)

13:30 - 13:30
0 min

10. Emergency Planning Resilience and Response (EPRR)

10. NWICB Board Report-EPRR Annual Assurance Nov 23.pdf (6 pages)
10.1 NHSE_EPRR annual_assurance for23-24_.pdf (4 pages)

13:30 - 13:30
0 min

11. Governance Handbook

11. Governance Handbook.pdf (12 pages)

13:30 - 13:30
0 min

12. Board Assurance Framework

12. BAF Paper for ICB Board Part 1- Nov 23.pdf (4 pages)
12. ICB Board Assurance Framework (BAF) 2023-24 LIVE V5.pdf (51 pages)

13:30 - 13:30
0 min

Committees Updates and Questions from the Public

13:30 - 13:30
0 min

13. Report from the Quality and Safety Committee

13. 2023 11 28 - Quality and Safety Committee Report to Board v2.0.pdf (9 pages)

13:30 - 13:30
0 min

14. Report from the Finance Committee

14. Fin Com Chair Report to Board - Final version.pdf (7 pages)

13:30 - 13:30
0 min

15. Report from the Primary Care Commissioning Committee

15. 23-11-28 PCCC for ICB Board.pdf (5 pages)

13:30 - 13:30
0 min

16. Report from the Performance Committee

16. Performance Committee Report to Board - Nov 2023.pdf (4 pages)

13:30 - 13:30
0 min

17. Report from Patients and Communities

17. Patients and Communities Committee Update November 2023.pdf (6 pages)

13:30 - 13:30
0 min

18. Report from the Audit and Risk Committee

13:30 - 13:30
0 min

19. Report from the Remuneration, People and Culture Committee

19. REMCO Committee Report to Board template - Nov 2023.pdf (5 pages)

13:30 - 13:30
0 min

20. Report from the Conflicts of Interest Committee

13:30 - 13:30
0 min

21. Questions from the Public.

13:30 - 13:30
0 min

22. Any other business

13:30 - 13:30
0 min

NHS
Norfolk and Waveney
Integrated Care Board

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

Tuesday, 28 November 2023 1.30pm – 3.30pm

(In Public)

Council Chamber, North Norfolk District Council, Holt Road, Cromer, Norfolk, NR27 9EN

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.	Chair
5.		**Action log – things we have said we will do** To make sure the ICB completes all the actions it agrees are needed. There are no outstanding actions from the last meeting held in public.	Chair
6.	1.40	**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.	2.00	**Just over 2,000 Carers Identity Passports have been issued to unpaid carers in Norfolk and Waveney since they were introduced just over a year ago.** We will hear the lived experience of people in Norfolk and Waveney who have used the Carers Identity Passports and learn about how this has helped them with their caring role.	Tricia D'Orsi
		Items for Sharing and Board Consideration	
8.	2.20	**Primary Care Recovery Plan** To provide an update on progress with the development of the system capacity and access recovery plan.	Mark Burgis
		Finance and Corporate Affairs	
9.	2.30	**Financial Report for Month 7 and financial plan submission** To receive a summary of the financial position as at month 7	Steven Course
10.	2.55	**Emergency Planning Resilience and Response (EPRR)** To share and update on the arrangements for the Integrated Care Board in an emergency.	Steven Course
11.	3.00	**Governance Handbook** To share details of amendments to two committee terms of reference for Board approval. • Audit Committee Terms of Reference • Integrated Care Partnership Terms of Reference	Karen Barker
12.	3.05	**Board Assurance Framework** A review of the risks (things that might go wrong and how we can alleviate them) within the Integrated Care system.	Karen Barker
		Committees Updates and Questions from the Public	
13.	3.10	**Report from the Quality and Safety Committee**	Aliona Derrett
14.		**Report from the Finance Committee**	Hein Van Den Wildenberg
15.		**Report from the Primary Care Commissioning Committee**	Debbie Bartlett
16.		**Report from the Performance Committee**	Dr Hilary Byrne
17.		**Report from Patients and Communities**	Aliona Derrett
18.		**Report from the Audit and Risk Committee** The update for this period will be received by the Board in the private meeting due to sensitive information included in the report.	David Holt

Item	Time	Agenda Item	Lead
19.		**Report from the Remuneration, People and Culture Committee**	Cathy Armor
20.		**Report from the Conflicts of Interest Committee** Verbal update as the meeting date of 16 November did not allow time for preparation of a full written report.	
21.	3.20	**Questions from the Public.** Where questions in advance relate to items on the agenda.	Chair
	3.25	**Any other business**	Chair
Date, time and venue of next meeting: Virtual meeting via Microsoft teams, 1.30pm – 3.30pm, 23 January 2024			
Any queries or items for the next agenda please contact: nwccg.corporateaffairs@nhs.net			

Note of future ICB Board public meeting dates for diaries:

Date	time	Virtual or face to face
22 May 2024	13.15 – 16.30	Virtual x3
17 July 2024	13.15 – 16.30	Face to Face
25 September 2024	13.15 – 16.30	Virtual x3
27 November 2024	13.15 – 16.30	Face to Face
29 January 2025	13.15 – 16.30	Virtual x3
26 March 2025	13.15 – 16.30	Face to Face

Some explanations of terms used in this Agenda.

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

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

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

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

Integrated Care Partnership (ICP) - a statutory committee bringing together all system partners to produce a health and care strategy. Representatives include voluntary, community

and social enterprise (VCSE) organisations and health and care organisations, and representatives from the ICB board.

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

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

NHS Norfolk and Waveney Integrated Care Board

DRAFT Minutes of the meeting on Tuesday, 26 September 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
- Patricia D'Orsi (PD'O), Director of Nursing, NHS Norfolk and Waveney ICB
- Dr Frankie Swords (FS), Medical Director, NHS Norfolk and Waveney ICB
- Hein Van Den Wildenberg (HvdW), Non-Executive Member, NHS Norfolk and Waveney ICB
- David Holt (DH), Non-Executive Member, NHS Norfolk and Waveney ICB
- Cathy Armor (CA), 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
- 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)
- Debbie Bartlett (DB), 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
- Ian Riley (IR), Director of Digital and Data, NHS Norfolk and Waveney ICB
- Ema Ojiako (EO), Director of People, NHS Norfolk and Waveney ICB
- Alex Stewart (AS), Chief Executive, Healthwatch Norfolk
- Stuart Lines (SL), Director of Public Health, Norfolk County Council

Attending to support the meeting:

- Andrew O'Connell (AO'C), Senior Nurse Manager – LeDeR, NHS Norfolk and Waveney ICB (for item 8)
- Gary Heathcote (GH), Director of Commissioning for Adult Social Care, Norfolk County Council (for item 11)
- Chris Williams (CW), Senior Support Manager, NHS Norfolk and Waveney ICB (Minutes)

1.	**Welcome and introductions - apologies for absence**	
	The Chair welcomed everyone to the meeting and thanked SCol for all his work as Chief Executive of Norfolk and Community Health and Care NHS Trust, and as a member of the ICB Board. She welcomed to the meeting Stuart Keeble, Director of Public Health at Suffolk County Council, noting that he would shortly be replacing Sue Cook as a Board member, once the necessary formalities had been completed. There were no apologies from Board members.	
2.	**Minutes from previous meeting and matters arising**	
	Agreed: The draft minutes from the meeting held on 18 July 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**	
	TB introduced the item by highlighting key points from the report. The Chair commented that it was a challenging time for the whole system. She thanked colleagues, particularly ICB staff for their professionalism as the organisation goes through its restructure. Questions and comments from Board members: • CA asked why we now have a number of chief executives who are shared with other organisations outside of Norfolk and Waveney. • TB commented that it is important to recognise that both of the chief executives being shared with other organisations are interim appointments and that this approach enabled us to get people in post quickly. She added tha the two interims know our system well, which is a good thing. • The Chair noted that the NHS is a large organisation and it is quite common for chief executives to have a role in another organisation, for example in NHS England. The report was noted.	
	Annual Reports and Accounts	
7.	**Annual Report and Accounts Presentation**	
	TB and SCou introduced the item by highlighting key points from the report.	

Questions and comments from Board members:

- DH praised the finance team for the hard work they had done to produce two sets of accounts.
- The Chair recorded the thanks of the Board to the finance team and external auditors for the work done to produce two very clear sets of accounts.

Agreed:
The ICB Board noted the first Annual Report and Accounts for NHS Norfolk and Waveney Integrated Care Board for the period 1 July 2022 to 31 March 2023 and the final Annual Report and Accounts for the former NHS Norfolk and Waveney Clinical Commissioning Group for the period 1 April 2022 to 30 June 2022.

Main items

8. LeDeR Annual Report

AO'C introduced the item by highlighting key points from the report.

Questions and comments from Board members:

- AD noted that the report had been scrutinised at the ICB's Quality and Safety Committee. She commented that the report said data collection and analysis had been improved over last year. She asked how the learning from this was shared across the system, and how families are involved in shaping the changes we make.
- AO'C highlighted that there was an amazing commitment from parnters across the system. He explained that information was shared at the Learning Interaction Group, which has representation from health and social care organisations, as well as Family Voice, who support the system in hearing the voice of parents and carers. He added that over the past year an extensive engagement and teaching programme had been put in place. He had spoken to different groups of students at UEA, including social work, occupational therapy and medical students, health and care partners, commissioning teams and quality boards.
- HvdW welcomed the encouraging progress with health checks. He commented that there was a risk we could see the same c70-75% of the 7,000 plus people on the LD register each year and that there could be a group of people that had not received a health check recently. He noted that the ICB did not hold a central database, but that this would be an issue worth exploring.
- AO'C explained that the take-up of health checks was closely monitored, with people who hadn't received a health check in the past year being focused on.
- PD'O commented that the report provides an opportunity to think differently and is part of series of reports, including reports about health checks and prescribing. She highlighted that she was heartened by people's response to the report.

	• DB highlighted that this is an area where integration really can transform the lives of people. She added that the transition from children services to adult services is a significant point and that we should be think about transitions as a whole, not health and social care separately. • AS welcomed the report and offered to help facilitate and support the rollout of the programme, noting that Healthwatch Norfolk had close links with Out and About in Cromer. • PD'O explained that last year's performance for health checks was better than the previous year and was in line with national performance. She added that this year we were slightly behind where we needed to be for the first half of the year, but that a recovery action plan had been put in place and that any support Healthwatch Norfolk could offer would be very welcome. **Agreed:** The ICB Board: • received and approved the LeDeR Annual Report. • considered the recommendations for system learning from the report.	
9.	**Learning from Deaths Report**	
	FS and SL introduced the item by highlighting key points from the report. Questions and comments from Board members: • CA asked which interventions had resulted in the reduction in suicides noted in the report. • FS explained that the report notes the reduction in suicides happened at the same time the suidicide prevention strategy was implemented, but that she couldn't confirm that the implementation of the strategy had caused the reduction in suicides. She added that the strategy was focused on identifying those most at-risk. • AD asked what was being done to help address unmet need and whether the ICB was linked in with Healthwatch Norfolk regarding the work being done related to drugs, alcohol and severe mental illness. • FS explained that in terms of palliative care, in the past more people in Norfolk and Waveney had died in hospital than in other areas of the country, however the place of death was now in line with the England average. She added that there was a perception that people close to the end of their lives had unmet need and were having repeated hospital admissions, but that there had been a dramatic fall in these kinds of admissions as a result of better planning. • DH commented that the report was a rich source of data. He added that we need to consider how we measure our success in	

	addressing some of the issues highlighted and how the Board is kept sighted on where there is pressure and where the Board can help. • The Chair noted that a lot of the issues related to improving and transforming services and support for mental health and wellbeing across the system, as well as within the mental health trust. She added that the Board should ensure that on the forward plan they look at how we are transforming mental health and wellbeing, including the community support that can be offered to those at risk of serious mental illness and premature death. She explained that we know from other industries that when it comes to improving safety it is important to look at near misses. • FS highlighted that in terms of near misses, the Patient Safety Incident Review Framework had just been implemented across the whole of the NHS. **Action:** FS to confirm whether there was service user involvement in the Palliative Care Programme Board. **Action:** FS to check if the ICB and the Health Improvement Transformation Group was linked in with Healthwatch Norfolk regarding the work being done related to mortality from drug and alcohol related deaths and mortality in people living with severe mental illness. **Action:** CW to add mental health transformation to the Board's forward plan. The report was noted.	**FS** **FS** **CW**
10.	**Winter Plan**	
	MB introduced the item by highlighting key points from the report. Questions and comments from Board members: • AD asked how the voluntary, community and social enterprise (VCSE) sector was supporting the discharge programme and admission avoidance. • ER explained that quite a lot of the current VCSE providers were involved in discussions around urgent and emergency care and discharge, developing plans, sharing what had not worked or was not working for both the sector and individual patients. • SK noted that these plans can lose sight of the patient sometimes, but that was where our focus should be. He asked if work was being done to look further ahead and to plan for future years. • MB highlighted that the system wouldn't work over winter without VCSE input and the learning from the sector was critical too. He added that when more difficult conversations were being had, these were often resolved by going back to focusing on what would be better for patients. He noted that he preferred the term seasonal	

resilience to winter planning, and that the system was doing more to look ahead to future years.

- HvdW noted that the system working was evident from the draft submission and asked what the big increase in virtual ward capacity would mean for the system.
- FS explained that what had been done so far with the virtual ward had made a significant impact, but that it was a drop in the ocean. She added that the main benefit would come from preventing people coming into hospital and that the step-up approach had been launched on 18 August.
- DB welcomed the focus on keeping people at home and preventing people going into hospital when it wasn't the right place for them to be.
- SCol commented that it was important to keep consistent with the findings of our Improving Lives Together plan and that there was a danger we always feel we have to change and come up with new ideas, but that we have really good practice here and we could do more to share that.
- PD'O reinforced the importance of keeping focused on our plan, and that while we may have to adjust our approach to some degree, we had committed to a plan and we needed to deliver it.
- The Chair noted that the Board had received a public question about Benjamin Court that was relevant to the item.
- MB explained that we had provided a written response to the question. He noted that as part of winter planning we had put in place some additional capacity in central Norfolk in intermediate care beds in care homes, with wraparound support from multi-discplinary teams. He added that we were committed to engaging with stakeholders in North Norfolk regarding Benjamin Court.
- DB explained she wanted to reassure the Board that the change to Benjamin Court would enable Norfolk County Council to refocus the reablement service. She added that most people would rather be cared for at home and that as a result of this change, more people would be cared for. She explained that 'double-up' care is when people need two carers and more investment had been made in this.
- BB commented that people would continue to have access to reablement services, they would just access it differently.
- MB concluded by explaining we do anticipate a challenging winter. He added that it would be important to communicate our plan clearly to stakeholders and local people.

Agreed:
The ICB Board agreed:

- To approve the submission of the winter narrative.
- To note the emerging themes related to dedicated increase in winter capacity.

	• To note the planned mitigations. • To receive a further update detailing any further risk, mitigations and finalisation of operating plans via the Integrated Care System's Executive Management Team.	
11.	**Proactive interventions**	
	DB and GH introduced the item by highlighting key points from the report. Questions and comments from Board members: • FS endorsed the approach and commitment to prevention. • ER asked whether Suffolk was connected or involved in the piece of work. • BB praised the work and highlighted that it was about keeping people healthy and out of the NHS. • HB asked if there were other mechansisms or changes needed to which would improve uptake. • SK explained that Suffolk and Norfolk county council work closely together, and that Waveney does benefit from innovation coming from Norfolk and Suffolk. • The Chair highlighted that Norfolk and Waveney is becoming a bit of a centre for some exciting innovations. She asked whether when doing this work on proactive interventions colleagues had looked at the similar approaches being used by primary care and the work being done to proactively reaching out to their most vulnerable patients. She added that if we could combine data the work could be more effective. She also asked whether they had looked at the innovations in domiciliary social care, particularly from our largest provider, Cera, who are using AI to predict people at greatest risk of a fall. She also encouraged council colleagues to work with IR regarding the Shared Care Record as it could help develop this innovation faster. • GH explained that the council did stop halfway through the project and change some of the language used with service users in order to increase uptake. He added that he had met with Cera and that support to engage more with primary care would be welcome. • DB noted that it had not been an easy journey to go on and that this work had to be managed carefully in terms of data protection and information governance. She explained that it is part of the reason the County Council kept the project focused on its own data. The report was noted.	
	Finance and Corporate Affairs	
12.	**Financial Report for Month 4**	
	SCou introduced the item, noting that the forecast outturn position for the ICB for the year remained a break-even position in line with our plan. He explained that the forecast outturn position for the Integrated Care System	

	was also break-even as planned, but that the system had a year-to-date deficit position of £20.3m at month four, which was adverse to our plan by £9.5m. He clarified that by Integrated Care System this referred to the combined position of the five NHS trusts in Norfolk and Waveney and the ICB. He noted that we had put the system into 'double-lock' which means that any investment decision over £50,000 needed to be approved by an investment panel. The report was noted.	
13.	**Board Assurance Framework**	
	KB introduced the item by highlighting key points from the report. She noted that BAF 21 had been updated since the papers had been published the previous week. FS explained BAF 21 had been updated in light of the NSFT Mortality Review item at the Board's previous meeting and the risk was that if the system failed to learn from the review then opportunities could be missed to prevent future deaths. She confirmed that a task and finish group had been established to co-produce an action plan with representatives from NHS Norfolk and Waveney ICB, NHS Suffolk and North East Essex ICB, Healthwatch, Norfolk and Suffolk NHS Foundation Trust and the authors of the 'Forever Gone' report. The Board received and reviewed the risks presented on the Board Assurance Framework.	
	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 the Patients and Communities Committee**	
	The report was noted.	
19.	**Report from the Audit and Risk Committee**	
	The report was noted.	
20.	**Report from the Remuneration, People and Culture Committee**	
	The report was noted.	
21.	**Questions from the public**	

	Richard Chilvers commented on and asked questions about a number of points raised during the meeting and explained that correspondence regarding Lowestoft Hospital would be received by the ICB shortly. The Chair invited Richard Chilvers to submit their questions in writing so that the ICB could provide written answers.	
22.	**Any other business**	
	No other business was raised.	

Date, time and venue of next meeting:

Tuesday, 28 November 2023, 13:30-15:30, Council Chamber, North Norfolk District Council, Holt Road, Cromer, Norfolk, NR27 9EN

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
Debbie Bartlett	Partner Member - Local Authority (Norfolk), Norfolk and Waveney ICB	Norfolk County Council		X		Direct	Interim 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.
		Diss Parish Fields			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	
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
Bill Borrett	Norfolk Health & Wellbeing Board Chair	North Elmham Surgery			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Norfolk County Council	X			Direct	Elected Member of Norfolk County Council, Elmham and Mattishall Division	Ongoing		Low risk. In attendance as a representative of the Local Authority. Chair will have overall responsibility for deciding whether I be excluded from any particular decision or discussion.
		Norfolk County Council	X			Direct	Cabinet Member for Adult Social Care and Public Health	Ongoing		
		Norfolk County Council	X			Direct	Chair of Norfolk Health and Wellbeing Board	Ongoing		
		Breckland District Council	X			Direct	Elected Member of Breckland District Council, Upper Wensum Ward	Ongoing		
		Norfolk County Council	X			Direct	Chair of Governance and Audit Committee	Ongoing		
		Manor Farm	X			Direct	Farmer within Dereham patch	Ongoing		Low risk. If there is an issue it will be raised at the time.
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	
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
Aliona Derrett	Non-Executive Director	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

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	
		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
		St Stephen's Gate Medical Practice			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice
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
		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
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.
		High Street Surgery, Lowestoft			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	
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
		University of East Anglia (UEA)		X		Direct	Honorary Associate Professor at UEA	Ongoing		Inform Chair and will not take part in any discussions or decisions relating to UEA
		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 mental health counsellor and undertakes private work as well as voluntary work with N&W VCSE provider Emerging Futures	Sep-22	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of counselling services by Emerging Futures
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 Chairs Action Log - Tuesday 28 November 2023				
Date	**Matter**	**Details of discussion**	**Decision**	**Date Reported to ICB Board**
21-nov	Extraordinary Board on 21 November 2023	An urgent decision was required on a financial submission due to an NHS England deadline which needed to be met.	The ICB Board approved the recommendation of the Finance Committee to submit an H2 reset plan as per discussions with regional and national NHS chief finance officers- further details will be presented at this meeting in the finance report at item 9.	28-nov-23

Norfolk and Waveney
Integrated Care Board

Agenda item: 06

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:	**28 November 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. OneNorwich Practices
C. Benjamin Court
D. CQC assessments of Integrated Care Systems
E. ICB organisational review and restructure
F. Investing in our buildings and technology
G. Appointments
H. Meetings and visits

Report

A. System pressures

Last winter was very challenging for health and care services right across the country, particularly because for adults we had two strains of flu, COVID-19 and norovirus circulating, as well as strep A for children to contend with. We learnt a lot from last winter and that has informed our seasonal resilience plans for this year.

Our biggest challenge is making sure that people are cared for in the right place and by the right person, rather than demand for urgent and emergency care. For example, we need to make sure that people aren't being cared for in hospital when they would be better served by being cared for at home.

We have three key objectives for this winter:

- To reduce the length of stay of patients (in all inpatient settings)
- To improve category two response times by reducing ambulance handover delays
- To increase use of the virtual ward

To achieve these objectives, we have a set of priority areas that we are working on as a system, combined with some provider specific actions. The priority areas we are working on as a system are:

- Admission avoidance – including through our unscheduled care coordination hub, which launched in August, to ensure that people are cared for in the most appropriate setting, reducing the number of conveyances to our emergency departments.
- Primary care resilience – general practice delivers c80% of urgent and emergency care, so it is vital that we support the resilience of general practice and the other primary care services.
- Expanding virtual ward capacity – both increasing the number of patients who are monitored at home following discharge from hospital, as well as starting to use virtual wards as a way of preventing emergency admissions to hospital.
- Improving flow and reducing length of stay – for example by streaming people to Same Day Emergency Care Services and reviewing processes to increase the number of discharges taking place earlier in the day (pre-12:00 and pre-17:00), including changes to transport to support earlier discharge.
- Capacity for pathway two patients needing reablement through ICB beds and community winter plans.
- Capacity for pathway one patients through commissioning of services and first response services.

It is important to know that the new modular build at Norwich Community Hospital that will provide 48 community beds will not be ready until April 2023, and so it will not have an impact this winter.

We expect a challenging winter; it is vital that we are absolutely focused on achieving our three key objectives. The pressure on the health and care system has increased over the past month. One symptom of this is that two of our hospitals have recently declared critical incidents, however the pressure is being felt across the whole system.

As a system we are planning that all ambulances will be offloaded within 30 minutes by 1 December. This was trialled at the Norfolk and Norwich University Hospital over the weekend of 18 and 19 November, which went well. Of course, this creates challenges within the hospitals and we are very grateful to staff for being adaptable and changing how they work at an already busy time. It is safer for patients to be in a hospital than at home alone waiting for an ambulance.

We have a further set of actions that we are developing and which we would like to implement in order to support services over winter. These include:

- Increasing the number of pathway two beds for patients being discharged from hospital who need reablement support.
- Increasing GP front door streaming to reduce the number of patients attending our emergency departments.
- Investing in alternatives to our emergency departments for patients with mental health conditions, based on the learning from last winter.
- Setting-up Acute Respiratory Infection Hubs, which offered over 10,000 face-to-face appointments last year.
- Investing in the unscheduled care coordination hub to ensure consistent seven day a week working and outreach support.
- Investing in transport to support discharges from hospital earlier in the day.

B. OneNorwich Practices

The ICB has been working closely with the Board and executive management team at OneNorwich Practices Limited (OneNorwich Practices) in recent months to support the organisation while it undertook an internal review of its financial position.

The directors of OneNorwich Practices have now agreed that the best way to protect services and jobs is to transition staff and services to other providers in the system over the coming months, and then close down the organisation.

Ensuring continuity of primary medical care services to the registered patients of Norwich Practices Health Centre, and all the patients who access services provided by OneNorwich Practices, are the ICB's and OneNorwich Practice's top priorities.

OneNorwich Practices delivers primary medical services in Norwich and the surrounding areas through the following commissioned services: Norwich Practices Health Centre; the Norwich Walk-in Centre; the Vulnerable Adults Service; the Lymphoedema Service and Asthma in Schools pilot in Norwich and the surrounding areas, as well as other targeted patient services.

The ICB is now working closely with OneNorwich Practices to safeguard the continued provision of these services so patient care is not impacted, and to protect the wellbeing of its staff.

This is difficult for OneNorwich staff and the patients who rely on these services. We are doing everything possible to ensure the safe transition of staff and services to alternative providers, and we will be communicating more details in the coming days and weeks.

C. Benjamin Court

There is a history of providing good services from Benjamin Court which have helped many people living in North Norfolk. We are in the process of considering what services could be provided from Benjamin Court in future. This will take some time as we want to work with the community and we want to do this properly.

It is vital that we ensure any services located in the building help to meet the needs of people living locally and fit with the model for how we want to care for people in Norfolk and Waveney. We are planning a programme of engagement to discuss with the local community what services could be provided from Benjamin Court in future and further information will be shared about this shortly.

D. CQC assessments of Integrated Care Systems

The CQC is now piloting its proposed approach to its new statutory duty to assess Integrated Care Systems, working with Dorset and Birmingham & Solihull ICSs. They are also consulting on the charges they propose to levy on ICBs to fund the assessment work. Through the Confed, as ICB Chair I am closely involved in discussions with CQC colleagues - including James Bullion, interim chief inspector of systems and local government commissioning (adult social care) - and ICS/ICB colleagues on both issues. Given that CQC now inspects all providers of NHS and social care services in Norfolk and Waveney, as well as adult social care commissioning, and will in future assess our ICS as a whole, I would like to get colleagues' views on the idea of a 'whole system' budget for the CQC's work within a system, rather than the current case-by-case or trust-by-trust approach.

E. ICB organisational review and restructure

We would like to thank our colleagues for their professionalism and continued dedication as we go through our organisational review and restructure. We know this is difficult and the uncertainty is hard; we will continue to support staff throughout the process.

The ICB is carrying out the review and restructure 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 are currently going through the voluntary redundancy process. The Board should note that the process is not completely in our hands though, as NHS England has to give final approval of applications for voluntary redundancy.

The results of the voluntary redundancy process will be considered alongside the feedback from the staff consultation and the engagement exercise we've run about the Prescription Ordering Direct service. We will take all of this into account before publishing a final staff structure.

F. Investing in our buildings and technology

We are making significant investments in our estate and technology. The New Hospitals Programme is important and has received a lot of coverage in the media, but there is a whole range of other building work being conducted.

For example, on 23 October the new Emergency Department was opened at the Queen Elizabeth Hospital, and this will be followed by new paediatric operating theatres at the Norfolk and Norwich University Hospital in December and a state of the art orthopaedic centre (NANOC) in January 2024.

We're making good progress with our digital projects too. For example, the Shared Care Record can now be accessed by appropriate staff from:

- Norfolk County Council (Adult Social Services)
- Norfolk and Suffolk NHS Foundation Trust
- Integrated Care 24
- East Coast Community Healthcare CIC
- Norfolk Community Health and Care NHS Trust
- The three acute trusts

We currently have 33 GP practices accessing the Shared Care Record via SystmOne and we are expecting the remaining practices to be accessing it by the end of the year. The record was accessed by 3,000 frontline colleagues in October, who securely viewed 13,000 patient / service user records. We expect this number to continue to increase over time.

This diagram shows some of the key dates for the investments we're making in our buildings and technology:

G. Appointments

We welcome the appointment of Professor Lesley Dwyer as the new Chief Executive of the Norfolk and Norwich University Hospitals NHS Foundation Trust. She will bring significant experience to our system, both from her current work in Australia, as well as from her time as Chief Executive of Medway NHS Foundation Trust in Kent, where she helped lift the organisation out of quality Special Measures and into a well-led 'Good' rating from the Care Quality Commission.

Caroline Donovan has now joined the Norfolk and Suffolk NHS Foundation Trust as its interim Chief Executive, bringing with her a strong track record of working with staff at all levels to bring about cultural change. A nurse by background, Caroline is passionate about improvement and transformation and is committed to working with staff and patients to design and deliver high quality services.

H. Meetings and visits

We wanted to highlight some of the meetings we've attended and visits we've made to interesting local organisations.

As Chair, meetings and visits have included:

- As part of the Connected Leadership programme, I spent a very interesting day shadowing Frances O'Callaghan, Chief Executive of North Central London ICB. In particular, it was helpful to visit St Pancras Hospital and hear about their plans for its redevelopment in light of the significant investment we're making in our hospitals.
- Along with a couple of colleagues from the ICB, I met with Lord Markham, who is the nominated minister from the Department for Health and Social Care for Norfolk and Waveney. It was a good opportunity to talk through our

progress as a system, how we are addressing the challenges we face and what the Government could do to support us.

- Tracey and I spoke at the Health Service Journal's (HSJ) Integrated Care Summit, and I also went to the King's Fund Annual Conference. National colleagues from NHS England and the Health Minister, Helen Whately, both singled out Norfolk and Waveney for praise during their sessions at the HSJ Summit. Both events provided a chance to meet with colleagues from across the country to learn more about what they are doing, innovations they are making and how they are approaching similar issues to the ones we are experiencing.
- We held our own ICS Conference, which brought together leaders from across our system, together with some people with lived experience of different conditions. It was heartening to hear about some of the areas in which we are making real progress and which are national examples of good practice, to discuss what we need to do next as a system and to further strengthen relationships with each other.
- Tracey and I spoke at an NHS England event for all first-time appointed chairs and non-executives. The event was designed to provide them with a clear view of the key elements needed to be a collaborative board member. It was set-up in response to last year's NHS management and leadership review (The Messenger Review), which highlighted the need to increase the level of development support provided to chairs and non-executive directors across provider trusts and ICBs.
- I have accepted an invitation to join the advisory group for a taskforce established by the independent think tank, Demos, on Future Public Services. Other members include Lord Adebowale.

As Chief Executive, a significant focus has been on ICB's organisational review and managing operational pressures, but other meetings and visits have included:

- I spent two days with Sarah-Jane Marsh and NHS England colleagues for the 'tier one' visit of our urgent and emergency care services. It was a really helpful visit, not just the more formal elements meeting colleagues at each of the providers, but also the time spent in the car getting to know her better and building that relationship.
- I am passionate about volunteering and the benefits it can bring to the community, as well as those volunteering. I was very proud to be asked to be part of the Helpforce Volunteering Senior Leaders Group, which is looking at how we can increase volunteering opportunities in health and care. The meetings are a good opportunity to understand what more we could be doing locally.
- I really enjoyed attending the Healthwatch Norfolk Live Event that celebrated ten years since the organisation was launched. It was interesting to hear about their recent work, as well as their plans for the future. I was part of a panel answering local people's questions, which was a good way for me to hear about what matters to people and the issues affecting people's lives.

- I met with the Priscilla Bacon Lodge chair and chief executive, Tom Spink (the Chair of the Norfolk and Norwich University Hospitals NHS Foundation Trust) and Lynda Thomas (Chair of Norfolk Community Health and Care NHS Trust) to discuss next steps. Patricia and I also both attended when the King opened the new hospice.
- I attended a full-day regional meeting to discuss medium term strategy, and an all-day NHS England strategy meeting with ICB and trust chief executives and the NHS England Executive Group.
- Together with Cathine Morgan, I have continued to co-chair the ‘vertical integration’ workstream looking at how we can get the most out of the huge investment being made through the New Hospitals Programme in East of England.

Norfolk and Waveney
Integrated Care Board

Agenda item: 08

Subject:	**Primary care access recovery plan and improving the issues across the primary-secondary care interface**
Presented by:	**Mark Burgis, Executive Director of Patients and Communities**
Prepared by:	**Sarah Harvey, Head of Primary and Community Care Strategic Planning**
Submitted to:	**ICB Board**
Date:	**28 November 2023**

1. Introduction

The purpose of this paper is to provide an update on progress with the development of the system capacity and access recovery plan in response to the Delivery plan for recovering access to primary care; and, as part of this, the work on-going to support improvements across the primary-secondary care interface.

2. Background

The delivery plan for recovering access to primary care, published on 9 May, outlines NHS England's commitments to "tackling the 8am rush" for GP appointments making it easier for patients to get the help they need from primary care and the asks of ICBs to support delivery.

The plan builds on the GP contract changes announced in March, while reaffirming the commitment to embed the Fuller stocktake vision for integrated primary care.

The Fuller Stocktake built a broad consensus on the vision for integrated primary care services and for this to be realised, actions are required to relieve the burden on general practice by transforming how services are delivered.

The General practice and secondary care: Working better together report was published alongside the delivery plan for recovering access to primary care and focuses on reducing barriers between general practice and secondary care. The report includes case studies from across the country of collaborative working to improve communication or clinical processes across organisations.

An overview of the key ambitions of both reports is included in Appendix 1.

3. Primary Care Access Recovery Plan

a. Actions required by systems to support delivery

As part of the Primary Care Network Contract Direct Enhanced Services (PCN DES) for 2023/24, PCNs and practices are asked to complete a baseline assessment against the following metrics and develop a Capacity and Access Improvement Plan:

1. Patient experience of access
2. Ease of access and demand management
3. Accuracy of recording in appointment books

Following completion of the PCN local capacity and access improvement plans, ICBs are expected to develop their own system-level access improvement plan, which includes a summation of the actions their PCNs and practices have committed to, confirmation of the funding and offers available for practices, and the outcomes expected through the transformation work being undertaken by general practice. The plan should also reflect the strategic direction of the ICB in relation to the implementation of the Fuller stocktake recommendations.

ICBs are required to report these plans to their public board meetings by November 2023 with a further update in February or March 2024.

b. Progress update

Aligned to the Norfolk and Waveney Joint Forward Plan published earlier this year, the system access recovery plan articulates our ambition to ensure all our primary care services are delivered in a way that is sustainable, prioritising transformation of services locally, to provide care that meets the needs of our population.

The plan outlines our strategic vision for delivery over the next three to five years. Our aspiration is to make it easier for people to access our services, addressing variation in access across the system. We also want to harness digital technology, such as home monitoring solutions for patients, to free up time to care in practices and to streamline access to care provision.

We want to support people to understand and manage their health and wellbeing through enabling self-care where appropriate, providing coordinated care and support networks and, as far as possible, we want people to be able to manage their health and wellbeing where they live, in their homes and local communities.

Through working at scale and in partnerships with other health and care providers, we will design integrated pathways of care, that focus not only on a patient's health

needs, but also their socio-economic needs, to provide more holistic and joined up care across all partners, focussing on patients only having to tell their story once.

One of the key underpinning principles to the plan is utilising a population health management approach focussed on prevention, reducing inequalities, delivering equitable access, excellent experience and optimal outcomes, improving the quality of care for all our people and communities.

Initially, the aim is to increase our primary care workforce capacity through ambitious recruitment and retention initiatives. We want to maximise use of the whole general practice multidisciplinary team and integrated working between all our primary care teams, encourage use of digital tools and care navigation, and promotion of self-care, to ensure that patients see the most appropriate person to meet their heath or care needs, earlier in their patient journey.

The plan includes details of how we will promote the new ways of working in general practice to the general public through the “Support Primary Care” campaign which aims to make it easier and quicker for patients to understand what services are available to help them based on their health needs, help them better understand the different roles working in general practice, and to help patients to understand how they can get the best from these services.

Recognising resilience of primary care services as fundamental to delivering our aspirations, we want to encourage greater collaboration within PCNs, increasing “at scale” working to deliver patient care in each neighbourhood in an integrated way and in partnership with other health and care providers, based on local population needs.

The plan shows strong alignment to a number of key local strategic plans including the Norfolk and Waveney Clinical Strategy, Quality Strategy and the Digital Transformation Strategic Plan.

The vision also shows strong alignment to the ambitions of the Fuller stocktake report of:

- Streamlining access to care and advice for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it.
- Providing more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions.
- Helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention.

Over the next six months we will be setting out some clear milestones to support the delivery of our longer-term strategic plan. The system access recovery plan focuses on the changes we aspire to deliver within general practice over the next 12 months.

The ICB has received funding to support 34 practices to update their telephony system to a cloud-based system to support practices to better manage their call demand, so patients get a better experience of contacting the practice.

One of the major benefits of cloud-based telephony is to support at scale working. Our intention is to work with practices within a PCN to have the same system to support this way of working across the system, in line with our future strategic plans.

We also want to support as many practices as possible to transition to the modern general practice access model by the end of 2024/25, utilising the available support funding from NHS England, as the building blocks for increasing “at scale” working and more collaboration within PCNs and across all primary care services.

The full Norfolk and Waveney system capacity and access improvement plan is included as Appendix 2.

4. Primary-Secondary Care Interface

a. Actions required by systems to support delivery

The Delivery plan for recovering access to primary care asks ICBs to address these four key areas in relation to the primary-secondary care interface:

- **Onward referrals:** if a patient has been referred into secondary care and they need another referral, for an immediate or a related need, the secondary care provider should make this for them, rather than sending them back to general practice which causes a further delay before being referred again.

- **Complete care (fit notes and discharge letters):** providers should ensure that on discharge or after an outpatient appointment, patients receive everything they need, rather than leaving patients to return prematurely to their practice, which often does not know what they need.

- **Call and recall:** for patients under their care, providers should establish their own call/recall systems for patients for follow-up tests or appointments. This means that patients will have a clear route to contact secondary care and will no longer have to ask their practice to follow up on their behalf, which can often be frustrating when practices also do not know how to get the information.

- **Clear points of contact:** ICBs should ensure providers establish single routes for general practice and secondary care teams to communicate rapidly such as single outpatient department email for GP practices or primary care liaison officers in secondary care. Currently practices cannot always get prompt answers to issues with requests, such as advice and guidance or referrals, which results in patients receiving delayed care.

ICBs are also expected to provide an update to their public board by November 2023 on their plans for improving the issues faced across the primary-secondary care interface.

b. Progress Update

The ICB has an established Clinical Interface Group, chaired by the ICB Executive Medical Director. This was developed in October 2021 with the purpose of bringing system partners together to discuss interface issues requiring escalation and resolution, which have not been resolved through business as usual processes. It also aims to build relationships between clinicians working across primary care, our community, mental health and acute providers. It provides an opportunity to consider emerging issues and develop shared strategies to address such issues, and to identify opportunities for improved system collaboration. The principle that all system partners are equal underpins discussions along with ensuring the best outcome for patients.

Membership of the group includes:

- ICB Executive Medical Director (chair)
- ICB Associate Medical Director for Primary Care (deputy chair)
- ICB Director for Primary Care
- ICB Head of Primary Care Strategic Planning
- Norfolk and Waveney Local Medical Committee (LMC) representation
- Clinical Care Professional Primary Care Place leads
- PCN Clinical Directors
- Medical Directors (or appropriate deputy) from the acute, community and mental health providers
- Representation from Planned Care and other ICB directorates are invited to attend depending on agenda items

Working jointly with the LMC, a process for general practices and providers to raise interface issues has been developed, supported by a standard operating procedure, with the aim of raising the profile of these issues across the system, to monitor themes and trends and to work across organisations to find resolutions.

This process enables any clinician to report issues considered to be breaches in the standard contract, examples of inappropriate shifts of work between secondary and primary care or any other examples for potential improvement in communication or

process which have not been dealt with locally. At every Clinical Interface Group meeting, a report outlining the themes and numbers of reports is presented and task and finish groups are set up to address themes as appropriate.

Our interface work to date has focused on seeking to address areas identified as themes through our reporting process, which could improve the way providers work as a multi-disciplinary team, or where work has been inappropriately transferred.

The key themes to date include:

- Ensuring appropriate health professionals working in the community, can request laboratory tests via the WebICE system (for example for wound swabs, urine cultures, nutrition monitoring bloods) and similarly to receive their own results directly, to reduce clinical risk and prevent duplication of work in practices
- Ensuring appropriate health professionals working in the community, can request other diagnostic tests via the WebICE system after appropriate training in line with Ionising Radiation (Medical Exposure) Regulations (for example first contact physiotherapists being able to request plain X-rays) and similarly to receive their own results directly, again reducing time, errors and additional work for practices
- Enabling private consultants to refer patients directly into Trusts, rather than requesting the GP makes that onward referral to hospitals
- Trusts offering complete care e.g. making onward referrals as appropriate, sending urgent prescriptions directly to patients rather than asking them to seek these from primary care, arranging their own follow up phlebotomy, and checking and acting on results as well as other necessary follow up care instead of asking the patient's GP to act on or arrange these.
- Trusts issuing fit notes for the full duration of absence as opposed to passing these requests back to GPs
- Improving communication, such as timely discharge letters which appropriately and clearly signal any actions or important information for general practice
- Developing and implementing a process for reviewing and agreeing new pathways of care, to ensure there are no unintended consequences on general practice
- Providing a forum for escalation of individual service issues which have not been agreed through business as usual routes

Providers are also required to undertake a gap analysis and develop an action plan for improving the effectiveness of their interface working arrangements, in line with the NHS standard contract requirements. Recognising that contractual issues are significantly under-reported, the ICB has also been using the data collected from the reporting process to support the trusts with these.

Providers respond to issues raised by general practice through the agreed reporting route and are sighted on any themes and learning from other providers as these are

shared directly with their contracting teams and presented at the monthly Clinical Interface Group.

All six main providers have completed their gap analyses and provided draft action plans to outline how they currently meet the contractual requirements, how they assure themselves that the processes they have in place are working and how they will act if any issues with compliance are identified.

Some of the key areas of progress are outlined below.

The Clinical Interface Group approved a recommendation to support referrals from private providers directly to secondary care, to reduce unnecessary administrative workload being placed on general practice when they have no clinical involvement in a referral. This has been agreed by the medical directors of all trusts. Work is underway to operationalise this within the provider organisations, although it has proved difficult to address technical issues with the electronic referral system and so help has been sought from the NHS England national team to address this. They have fed back that we are the only ICS seeking to make this change.

The QEH older people's department have been working with NSFT so that onward referrals can be made directly to the memory clinic consistently, without the need for patients to be referred by their GP.

NCHC have been working with the ICB to undertake a pathway review of the neurodevelopment service with the aim of increasing direct referrals from schools which will reduce the administrative burden on GPs who are often called upon to make these referrals by schools and families.

Thematic analysis of reports from practices have confirmed that the number of cases where a fit note should have been issued but was missed by secondary care has dramatically reduced and this no longer features as a significant theme across our system.

Following a recommendation to the Clinical Interface Group, the acute Trust providers agreed allow non-medical referrers working in general practice access to request pathology and radiology tests on WebICE to ensure competently trained staff can have access to timely diagnostic testing with the ability to view results and avoid unnecessary duplication of workload within a practice. This has been implemented at the QEH, the work is in progress within NNUH and JPUH.

The ICB is co-ordinating a project to improve referral optimisation and access to specialist advice as part of the Elective Recovery programme of work. The work is being driven by both primary and secondary care colleagues who want to improve the pathways across the interface. Initially, the work is being progressed across five high volume specialties, but with the potential to roll out the principles across many other specialties.

The General practice and secondary care: Working better together report also outlines potential quick win actions for systems to implement to improve the working across the primary-secondary care interface. We have already made good progress with implementing the suggested actions, a summary of our progress is included below.

Recommended action	Progress
Provide easy access to general practice for secondary care clinicians via non-public phone numbers and shared email mailboxes.	Complete Practices have shared mailboxes that can be used for queries from secondary care.
Provide easy access to individual hospital departments via non-public phone numbers/shared mailboxes to help in the resolution of administrative queries (ideally any correspondence should link directly with the electronic health record).	Complete Providers have shared mailboxes for each department so that queries can be sent to a central point.
GPs giving trainee doctors regular 'show and tell' sessions on how to fill out discharge summaries in the most informative and accessible way.	On-going Providers have suggested they include information about the interface requirements within their junior doctor inductions and teaching sessions. This is currently in progress.
Establish outpatient helplines where administrative queries about hospital appointments can be directed.	Complete All providers have departmental phone numbers published on their websites and included on clinic letters to patients.
Make 'fit notes' more accessible on inpatient wards and in outpatient clinics and produce guidance for secondary care clinicians on their use.	Complete Providers have actioned this and we have seen a sustained improvement in reported issues with fit note compliance over the last six months
Consider establishing regular 'interface groups' which include balanced representation from general practice and secondary care. The precise specifications should be locally determined	Complete Our monthly interface group has been established for the last two years and includes representation from the ICB, primary care and secondary care.
Provide clinicians with read-only access to health record systems across the interface.	On-going The Norfolk and Waveney Shared Care Record is currently being rolled out across the system, supporting this action.

Employ a Primary Care Liaison Officer to help in the resolution of queries between secondary care and general practice	On-going This has been highlighted to our providers for consideration. One of our providers is currently in the process of recruiting a GP to be their Associate Medical Director supporting Primary Care Liaison. Other providers are developing local interface forums to resolution of queries between secondary care and general practice.
Provide patients with a written update on where they are on the waiting list, asking if they still require or want treatment	On-going This recommendation has been shared with our providers. Providers already contact patients, either by phone or letter, when they have been waiting for extended periods to confirm they wish to remain on the waiting list. The ICB regularly provide practices with updates on waiting times per specialty and provider so that this information can be shared with patients at the time of referral.
Standardise outpatient clinical letters where possible (placing particular emphasis on concise GP recommendations)	On-going There is work ongoing currently led by the ICB to review the content of clinic letters, including the requirement for clinic letters to be addressed directly to patients rather than referrers. This action is being considered alongside this work.

5. Challenges

a. System Capacity and Access Improvement Plan

Delivery of the core ambitions of the plan requires changes to how practices currently operate, delivering alternative models of care using the wider practice multi-disciplinary team. This requires development of a culture of quality improvement and a transformational approach to be successful.

Nationally, all primary care services are facing greater challenges than ever before due to an increasingly complex workload and demand for services exceeding capacity, alongside significant workforce shortages. As a result, not all practices currently have the capacity to respond to national policy and transformational ambitions due to the day-to-day operational and resilience challenges they are faced with.

To be truly successful in delivering our ambitions, we need to provide support to practices, where it's most needed, to harness the tools and resources available to them to support the implementation of the plans ambitions and develop a culture of improvement within their practice.

b. Primary-secondary care interface

Whilst some good progress has been made in relation to the high priority areas for improving the working across the primary-secondary care interface, the under-reporting of issues and the capacity within the secondary care providers to address the issues raised across the interface is limited, due to focus on other national priorities such as Elective Recovery and Urgent and Emergency Care. This may be further limited over the winter period due to the expected challenges for all providers.

Progress with implementing some of the key initiatives, such as ICE requesting and enabling private referrals, has been slow, and continues to have a sustained impact on general practice and community providers. Practices, nationally, report that interface issues make up approximately 20% of their current workload with an already over-stretched workforce, and our local practices report the same.

6. Conclusions

Whilst there is a clear vision for implementing the ambitions outlined within the Delivery plan for recovering access to primary care, the resilience of general practice remains a significant issue and, without addressing some of these challenges, delivery of our system capacity and access improvement plan will be limited.

The ICB has made some good progress with establishing a structure and framework for supporting management of issues across the primary-secondary care interface, with good attendance from both primary and secondary care colleagues. However, progress with implementing improvements has been slow and greater focus is needed by all system partners to make the progress we need to support the overall resilience of general practice and this will be reflected in the review of our Clinical Interface Group effectiveness at the conclusion of the ICB Organisational Change programme.

7. Recommendation

The ICB Board is asked to note the report and the progress made in delivering the ambitions of the Delivery Plan for Recovering Access to Primary Care and the General Practice and Secondary Care: Working better Together reports.

8. Risks

Key Risks	
Clinical and Quality:	Quality and capacity of care can be impacted due to inefficient working arrangements across the primary-secondary care interface.
Finance and Performance:	Capacity of care can be impacted due to inefficient working arrangements across the primary-secondary care interface.
Impact Assessment (environmental and equalities):	Reduced capacity could constrain the ability to target health inequalities
Reputation:	Non-delivery of the ambitions outlined within the plan poses a significant system reputational risk due to the high profile of the plan nationally.
Legal:	N/A
Information Governance:	Managing information governance across system partners has been challenging. System IG group established.
Resource Required:	Existing workforce for Primary Care Workforce Transformation and Digital First Primary Care must be retained to support the delivery of this plan. Dedicated capacity within the ICB and secondary care providers is required to ensure timely progress with improving issues across the primary-secondary care interface. There is an ICB capacity risk relating to the organisational change process, due to vacancy management processes.
Reference document(s):	Delivery Plan for Recovering Access to Primary Care General practice and secondary care: Working better together
NHS Constitution:	NHS Standard Contract
Conflicts of Interest:	None identified
Reference to relevant risk on the Board Assurance Framework	The resilience of general practice

9. Governance

Process/Committee approval with date(s) (as appropriate)	The plan has been approved by Primary Care Commissioning Committee.

Appendix 1 – Overview of the National delivery plan for recovering access to primary care and the General practice and secondary care: Working better together reports

The Delivery plan for recovering access to primary care seeks to support recovery of primary care by focusing on four areas:

1. **Empowering patients** to manage their own health including using the NHS App, self-referral pathways and through more services offered from community pharmacy.
2. **Implement Modern General Practice Access** to tackle the 8am rush and avoid asking patients to ring back another day to book an appointment.
3. **Build capacity** through recruitment to additional roles with increased flexibility for the types of staff recruited and how they are deployed.
4. **Cut bureaucracy** and reduce the workload across the interface between primary and secondary care so practices have more time to meet the clinical needs of their patients.

Included below is a summary of the key ambitions outlined within the each of the four key areas of the plan.

1. Empowering patients to manage their own health

The delivery plan outlines three key areas of focus for helping the public to manage their own health:

A. Improving information and NHS App functionality

This ambition is to provide the public with access to health information they can trust, find local services, and use the NHS App, where this is their preference, to see their medical records, order repeat prescriptions, manage routine appointments with their practice or local hospital and see messages from their practice.

By 31st Oct 2023, practices are contractually required to provide prospective access to records for all eligible patients and by March 2024 the NHS England ambition is for patients at 90% or more of practices to be able to see their records and have use of the NHS app.

B. Increasing self-directed care where clinically appropriate

The delivery plan outlines the ambition to increase the number of self-referral pathways for patients, guided by clinical advice, where general practice involvement in managing a patient's condition is not necessary. This is more convenient for patients and frees up valuable practice time.

As originally outlined within the 2023/24 operational planning guidance, by September 2023, ICBs are asked to expand self-referral routes to seven key community services (falls prevention and response, musculoskeletal physiotherapy, audiology-including hearing aid provision, weight management, podiatry, wheelchair and equipment services).

C. Expanding community pharmacy services

NHS England have outlined their ambition to increase services offered by community pharmacy. It is anticipated that Pharmacy First will launch by the end of 2023 which will enable pharmacists to supply prescription-only medicines, including antibiotics and antivirals where clinically appropriate, to treat seven common health conditions (sinusitis, sore throat, earache, infected insect bite, impetigo, shingles and uncomplicated urinary tract infections in women).

There is also a proposal to expand the existing blood pressure and oral contraception services within Community Pharmacy, however this is subject to consultation.

2. Implementing modern general practice access

The plan's central ambitions are to tackle the "8am rush" in general practice by making it easier for the public to contact their practice by phone and online, and to know on the same day how their request will be handled.

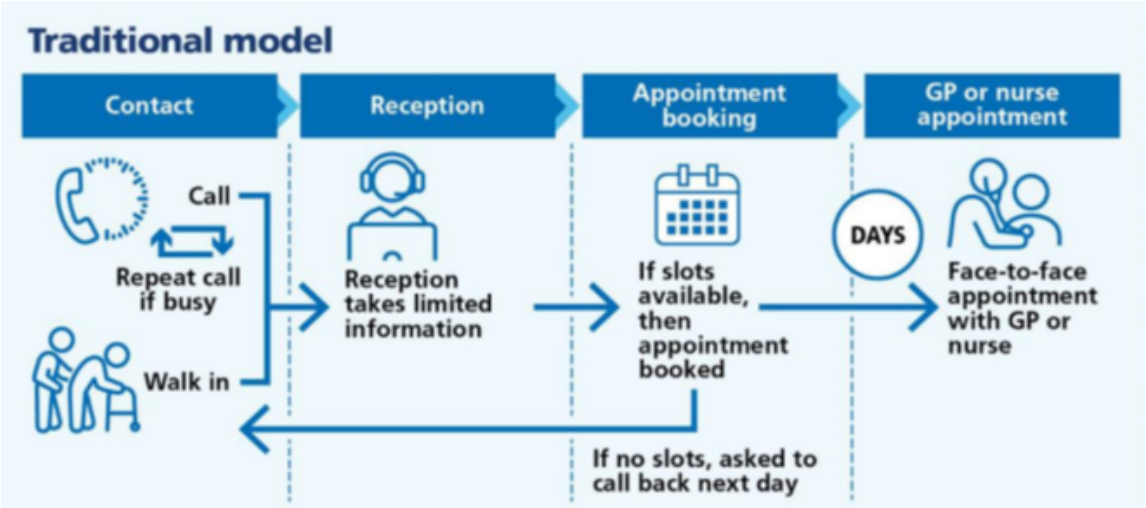


Figure 1 – Traditional model of access to general practice diagram taken from the Delivery plan for recovering access to primary care

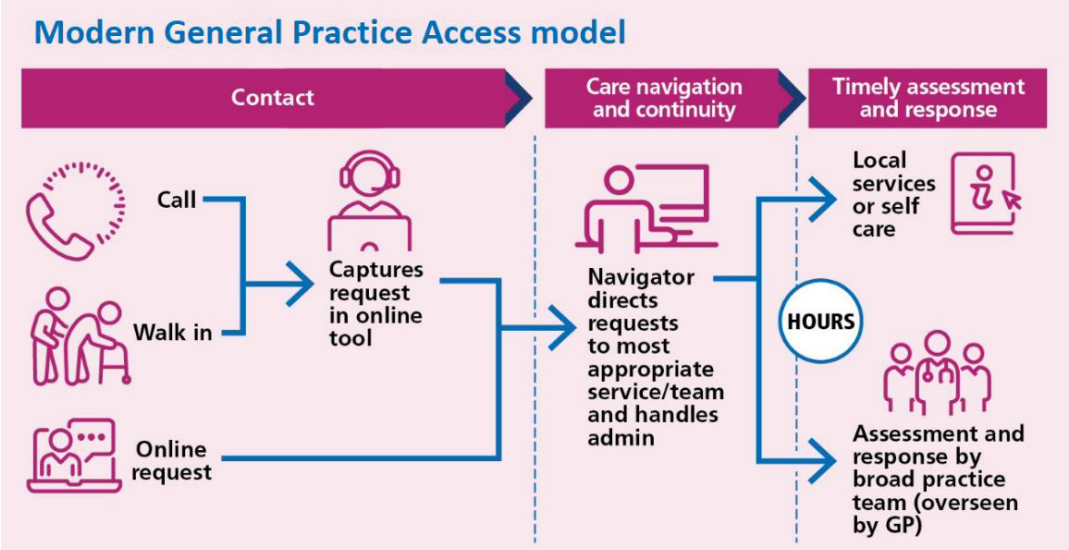


Figure 2 – Modern General Practice Access model diagram taken from the Delivery plan for recovering access to primary care

To support the delivery of this ambition, the plan outlines three key ambitions:

A. Better digital telephony

To support implementation to move to a modern general practice model, the ambition is to move all practices still on analogue systems to move to digital telephony that handles multiple calls and includes call-back functions so patients get a better experience. All analogue phone systems across the country are due to be switched off by December 2025.

B. Simpler online requests

The plan outlines NHS England's intention to make high-quality online consultation, messaging and booking tools available to general practice to support the implementation of the modern general practice access model. Additional funding will be made available to ICBs to support implementation by March 2025.

C. Faster navigation, assessment and response

Care navigation is an essential element of delivering the modern general practice access model. It is estimated that approximately 15% of current GP appointments could be navigated to self-care, community pharmacy, admin teams or other more appropriate local services. With the right protocols it can also mean directing patients to the most appropriate staff member in the wider practice team. Care navigation supports practices to identify patients who would like or benefit from continuity, which is especially important for patients with multiple or complex conditions.

To support this, a national training offer is being provided using the care navigation competency framework developed by NHS England (previously Health Education England). Places are available for staff from every practice and PCNs.

3. Building Capacity

The plan outlines the need to continue to grow practice teams through investment in additional roles, strengthening the foundation for more multi-disciplinary working in the future. There are three key streams of work for ICBs to consider:

A. Larger multidisciplinary teams

The ambition builds on the work of the Additional Roles Reimbursement Scheme that was introduced in 2019 which has supported practices and PCNS to grow their multi-disciplinary workforce through additional roles such as pharmacists, care co-ordinators and social prescribing link workers to help to manage the increasing workload within general practice.
To support delivery, ICBs are being given additional ARRS funding (up to £10m for Norfolk and Waveney) with greater flexibility so PCNs have more choice over who they recruit and how they deploy them.

B. More new doctors

To support the on-going recruitment challenges seen by general practice nationally, the plan outlines the ambition to continue to support new doctors in general practice by training more GPs and supporting other doctors to transition to general practice through GP fellowships.

C. Retention and return of experienced GPs

Through investment in GP retention schemes, that plan outlines the ambition to make it easier for doctors to return to practice. NHS England will run a campaign to encourage GPs to return to general practice or to support NHS 111 in flexible roles where, for example, working from home is possible, as described in the delivery plan for recovering urgent and emergency care service.

4. Cutting Bureaucracy

A major part of the access challenge is the rise in general practice workload, particularly for experienced GPs, which risks them being overloaded and having less time available for patients. Pressure stems from the rising number of patient contacts, which practices report have grown by 20% to 40% since pre-pandemic.

GPs report that over 30% of their time is spent on indirect patient care (including paperwork such as referral letters, fit notes and medical certification, and analysing and responding to test results).

a) Improving the primary-secondary care interface

The ambition is to reduce time spent by practice teams on lower-value administrative work and work generated by issues at the primary-secondary care interface. Practices estimate they spend 10% to 20% of their time on this.

ICBs are asked to establish local mechanisms which will allow both general practice and consultant-led teams from secondary care to raise issues, to jointly prioritise working with LMCs, and to tackle the high-priority issues. ICBs are asked to address these four key areas:

- **Onward referrals:** if a patient has been referred into secondary care and they need another referral, for an immediate or a related need, the secondary care provider should make this for them, rather than sending them back to general practice which causes a further delay before being referred again.

- **Complete care (fit notes and discharge letters):** providers should ensure that on discharge or after an outpatient appointment, patients receive everything they need, rather than leaving patients to return prematurely to their practice, which often does not know what they need.

- **Call and recall:** for patients under their care, providers should establish their own call/recall systems for patients for follow-up tests or appointments. This means that patients will have a clear route to contact secondary care and will no longer have to ask their practice to follow up on their behalf, which can often be frustrating when practices also do not know how to get the information.

- **Clear points of contact:** ICBs should ensure providers establish single routes for general practice and secondary care teams to communicate rapidly: e.g. single outpatient department email for GP practices or primary care liaison officers in secondary care. Currently practices cannot always get prompt answers to issues with requests, such as advice and guidance or referrals, which results in patients receiving delayed care.

The priorities and associated implementation plans are part of the ICBs annual assessment of provider performance that has been a requirement of the NHS Standard Contract since 2021/22.

General Practice and secondary care: Working better together report

In September 2022, NHS England asked the Academy of Medical Royal Colleges (AoMRC) to review how to reduce unnecessary work on the interface between general practice and secondary care. The General practice and secondary care: Working better together report was published alongside the Delivery plan for recovering access to primary care and focuses on reducing barriers between general practice and secondary care. The report includes case studies from across the country of collaborative working to improve communication or clinical processes across organisations.

The authors of the Working better together report recognise that the success of the case studies within the report is driven by many factors including local cultures, leadership and ways of working. To support systems to improve their interface between general practice and secondary care, the report outlines the key drivers for success in implementing more complex change and some relatively simple changes that are believed to be less dependent on local context, included below.

Recommended action	Relevant case study
• Provide easy access to general practice for secondary care clinicians via non-public phone numbers and shared email mailboxes	'Backdoor' GP numbers in secondary care — Gloucestershire
• Provide easy access to individual hospital departments via non-public phone numbers/shared mailboxes to help in the resolution of administrative queries (ideally any correspondence should link directly with the electronic health record)	Email addresses and a shared inbox for all outpatient department secretariats — Mid and South Essex Integrating emails and care records — Yorkshire
• GPs giving trainee doctors regular 'show and tell' sessions on how to fill out discharge summaries in the most informative and accessible way	Primary Care Liaison Officer — North Hampshire
• Establish outpatient helplines where administrative queries about hospital appointments can be directed	Outpatients helpline for hospital appointments — Morecambe Bay
• Make 'fit notes' more accessible on inpatient wards and in outpatient clinics and produce guidance for secondary care clinicians on their use	Writing Fitness to work certificates — Mid and South Essex
• Consider establishing regular 'interface groups' which include balanced representation from general practice and secondary care. The precise specifications should be locally determined (please see the relevant examples for varied configurations)	Integration meetings — North Central London Clinical Interface group (CIG) — North London Joint working — Scotland Medical Council — Gloucestershire Local delivery system — North Hampshire
• Provide clinicians with read-only access to health record systems across the interface	SystmOne access — Leicestershire

• Employ a Primary Care Liaison Officer to help in the resolution of queries between secondary care and general practice	Primary Care Liaison Officer — North Hampshire
• Provide patients with a written update on where they are on the waiting list, asking if they still require or want treatment	Waiting list letter — Leicestershire
• Standardise outpatient clinical letters where possible (placing particular emphasis on concise GP recommendations)	Standardisation of outpatient clinic letters and discharge summaries — Leeds

Appendix 2 – The Norfolk and Waveney System Capacity and Access Improvement Plan

See attached separate PDF document titled The Norfolk and Waveney System Capacity and Access Improvement Plan.

Appendix 3 - Summary of the provider contractual interface requirements gap analyses and action plans

i. Managing DNAs (Did Not Attends)

Providers have the appropriate policies in place to manage DNAs. Where required, providers undertake an annual records audit of a representative sample of patients who DNA to ensure the policy is being followed. Where the audit identifies non-compliance, these issues are raised directly with staff and reminded of the requirements of the policy.

ii. Managing Onward referrals

Providers have the appropriate policy in place to manage consultant to consultant referrals. Where required, providers undertake an annual audit of consultant referral letters to ensure the policy is being followed. Where the audit identifies non-compliance, these issues are raised directly with staff and reminded of the requirements of the policy.

Following an audit undertaken by NNUH, it has been recommended that a review of the consultant to consultant referral policy takes place jointly between the ICB and the providers to ensure the wording is clear and understood by both primary and secondary care colleagues. This is to take place prior to 31 December 2023.

iii. Managing patient care and investigation

An audit of patient case notes is not deemed to be practical by providers due to the numbers involved. Providers review the cases identified through the interface reporting process and respond to any issues that arise. Where non-compliance with the contractual requirement is identified, these issues are raised directly with staff involved in the patients care and reminded of the requirements.

iv. Communicating with patients and responding to their queries

Providers have various routes published for patients to contact them directly with queries; appointment letters have specific telephone numbers for that speciality for patients to use, the provider websites publish details of clinical departments, their consultants and their secretarial contact details. Providers use their website as well as social media channels for communication with the public.

NNUH has a bespoke email for primary care to use if they have specific queries or concerns about individual patient's clinical pathways and the outpatient team also have an email for primary care to use in relation to queries around first appointments.

v. Discharge summaries and clinic letters

Providers have agreed shared care protocols in place overseen by the system Therapeutics Advisory Group. Discharge summaries and clinic letters are sent electronically to general practice. Providers have the appropriate mechanisms in place to communicate any urgent actions required by the patient's GP or if the Consultant needs to urgently communicate significant clinical findings.

Providers have metrics in place to monitor compliance with the discharge letter standards to ensure appropriate completion and timeliness. Any underperforming metrics are discussed at Divisional Performance meetings and reported at Clinical Governance meetings.

Improving lives **together**

Norfolk and Waveney Integrated Care System

Norfolk and Waveney System Capacity and Access Improvement Plan

In response to the Delivery plan for recovering access to primary care

Introduction

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 services.

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 (this means that on average, each person across Norfolk and Waveney attended about six appointments), and 75.6% of people had a positive experience in their GP practice.

General practice is often seen as the bedrock of NHS care, providing 90% of all patient activity across the system so it is not surprising that if general practice struggles, the whole system will feel the impact.

Nationally, all primary care services are facing greater challenges than ever before due to an increasingly complex workload and demand for services exceeding capacity, alongside significant workforce shortages.

Norfolk and Waveney generally has an older population, projected to increase at a greater rate than the England average. As a result, over the next five years the demand for GP appointments is likely to have increased by more than 1,000 per day and the number of people with four or more long term conditions is likely to have increased by about 1,800 per year.

Nationally all ICBs are required to develop a system capacity and access improvement plan for general practice.

For the system to see real change in the issues faced, we need to do more than just expand the current provision of primary care services. Through delivering transformation across our primary care services, as well as wider system programmes of transformational change, we can become a system that supports primary care to be successful, improving experience for both patients and our workforce.

Our Ambition

Our ambition is to ensure all our primary care services are delivered in a way that is sustainable, prioritising transformation of services locally, to provide care that meets the needs of our population.

We aspire to make it easier for people to access our services, addressing variation in access across the system, to enable people to lead happy and healthier lives.

We will use our resources smartly, harnessing digital technology, such as home monitoring solutions for patients, to free up time to care in practices and to streamline access care provision.

We want to support people to understand and manage their health and wellbeing through enabling self-care where appropriate, providing coordinated care and support networks and, as far as possible, we want people to be able to manage their health and wellbeing where they live, in their homes and communities.

We want to make care more personalised; providing individuals with support tailored to their needs, rather than a one-size-fits-all approach which can fail to engage with the people most in need of support, leading to inequalities in access and health outcomes.

Through working at scale and in partnerships with other health and care providers, we will design integrated pathways of care, that focus not only on a patient's health needs, but also their socio-economic needs, to provide more holistic and joined up care across all partners, focussing on patients only having to tell their story once.

Alignment to strategic plans

Our ambition and vision shows strong alignment to a number of key local and national strategic plans:

The Norfolk and Waveney Clinical Strategy 2022-2027 objectives	• Seeing me as a whole person, working together to be once high-quality NHS, tackling waiting times, acting early to improve health, ensuring services are reliable and addressing health inequalities.
Norfolk and Waveney Integrated Care Partnership Strategy objectives	• Driving integration, prioritising prevention, addressing inequalities and enabling resilient communities.
The Norfolk and Waveney Joint Forward Plan 2023-2028 ambitions	• Population health management, reducing inequalities and supporting prevention, primary care resilience and transformation, improving urgent and emergency care and improving productivity and efficiency.
The Norfolk and Waveney Digital Transformation Strategic Plan ambitions	• Improve people's safety and quality of care, give staff more time to care for people, empower people to manage their health and wellbeing better through use of technology.
The Norfolk and Waveney Quality Strategy approach to Quality of Care	• Ensuring care is delivered through a culture of compassionate leadership, focussed on improving quality and outcomes, using population health and inequalities insights to achieve equitable outcomes and ensuring services are safe and sustainable for now and the future.
The delivery plan for recovering access to Urgent & Emergency Care objectives	• Reducing demand for UEC, reducing ED attendances and reducing emergency admissions by taking a population health management approach to development of integrated neighbourhood working and improving same day access in primary care.
The NHS Long Term Workforce Plan 2023 ambitions	• To increase GP training posts by 50% by 2031 with a renewed focus on retention with better opportunities for career development and promoting working differently using technology and delivering training new ways.

Our Approach

Our vision will be supported by a population health management approach to proactively use our data in a joined-up way to put in place targeted support to deliver improvements in health and wellbeing. We will use and analyse our data to support localised decision making and planning.

This proactive approach will be focussed on prevention, reducing inequalities, delivering equitable access, excellent experience and optimal outcomes, improving the quality of care for all people and communities living in Norfolk and Waveney. It will also be driven by our knowledge of local communities, and by partners working together to identify new solutions that can really help to improve health.

Our decision making will be driven by the needs of local communities, and interventions designed to support them, working with our partners from across the ICS to plan new services or models of care in an integrated way.

This approach will be underpinned by enabling digital technologies and a highly engaged workforce.

Norfolk and Waveney Demand and Capacity Modelling

Over the last year, we have been developing primary care demand and capacity modelling to identify the long-term needs for delivering sustainable patient care. The work uses the Johns Hopkins Adjusted Clinical Groups (ACG) population health management dataset to estimate demand.

Aggregated Diagnoses Groups (ADGs):
The Building Block

ADGs classify diagnoses into a limited number of clinically meaningful, but not disease-specific, morbidity groups.

Adjusted Clinical Groups (ACGs):
Patient-Centric Measure of Health Status

Each ACG includes individuals with:

- A similar pattern of morbidity
- Similar expected resource use

Can be collapsed into 6 RUBs to easily assess casemix in different populations

Expanded Diagnosis Clusters (EDCs):
Groups of clinically similar diagnoses

284 groups that can be combined into 27 Major EDC categories of clinical conditions.

Facilitates disease and condition based profiling and sophisticated case finding activities.

Patient Need Groups (PNGs)
An innovative segmentation model

Eleven mutually exclusive population segments, applicable to all age groups, building upon ACG's whole-person approach to health needs across their lifespan.

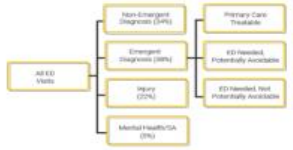
The Johns Hopkins ACG® System

ACG System Predictive Models
Assessing Future Risk

More than a dozen models that predict future resource use (eg total cost, pharmacy cost) and risk of future adverse events (eg hospitalisation).

Additional Mortality Risk Score model assists with identification of patients who may require end-of-life care

Emergency Department Classification



The ACG System's ED classification algorithm categorises people who attend ED based on the condition/diagnosis.

It can be used to identifying people with non-emergent or primary care treatable conditions

Pharmacy-Based Markers
Making Use of Primary Care Prescription Data

A range of markers derived from prescription data including:

- Active ingredient count as a marker of polypharmacy
- Medicine Complexity Score describing each patient's regimen complexity

Additional Markers & Measures

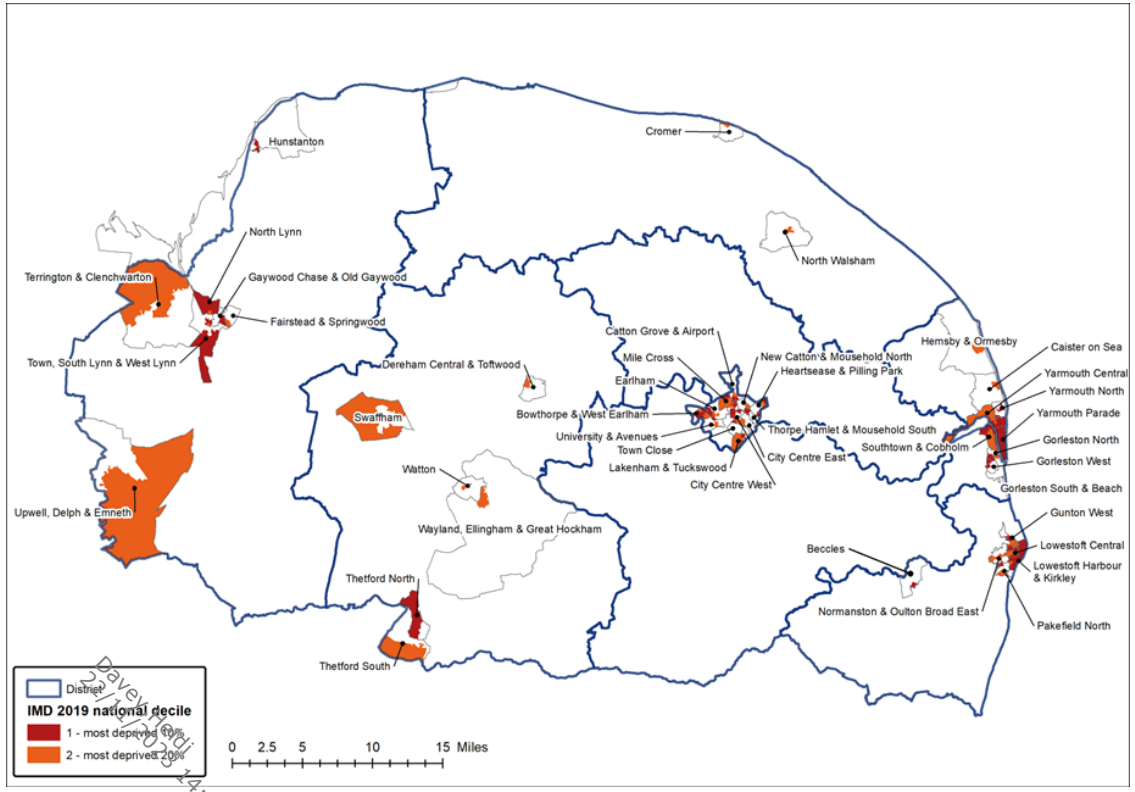
For example:

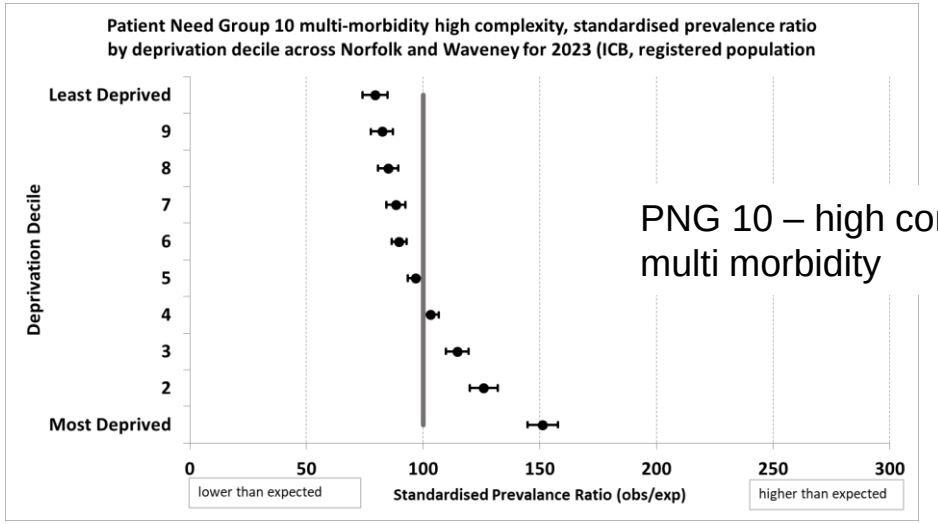
- Flag of conditions likely to require hospitalisation
- A frailty marker
- Flagging patients likely to have care coordination issues
- Laboratory based markers to assess control of LTC like diabetes

Norfolk and Waveney Demand and Capacity

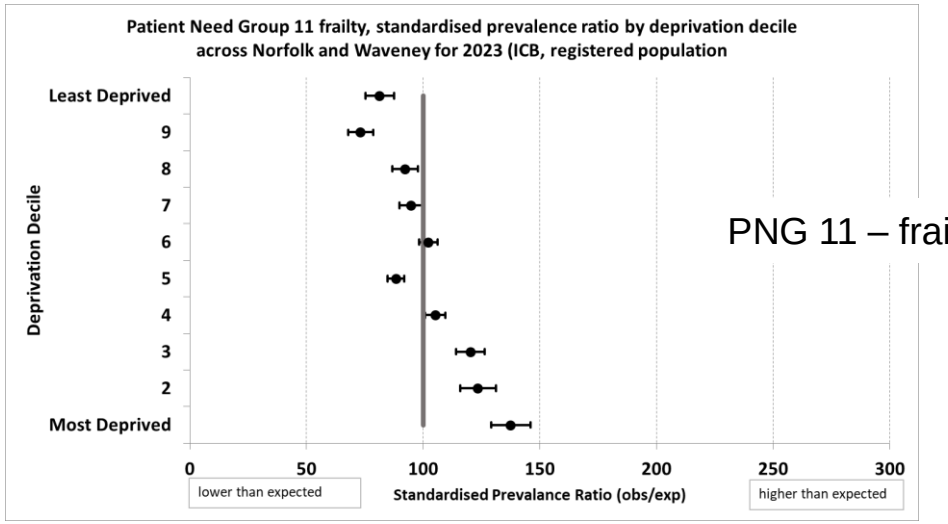
Understanding priority segments and populations at risk

The Johns Hopkins ACG grouper output can be used to estimate various markers of need. For example, relative numbers of those who are frail and of highest complexity are significantly higher in the Core20 most deprived communities than we would expect given the age and gender of the population.





PNG 10 – high complexity, multi morbidity



PNG 11 – frailty

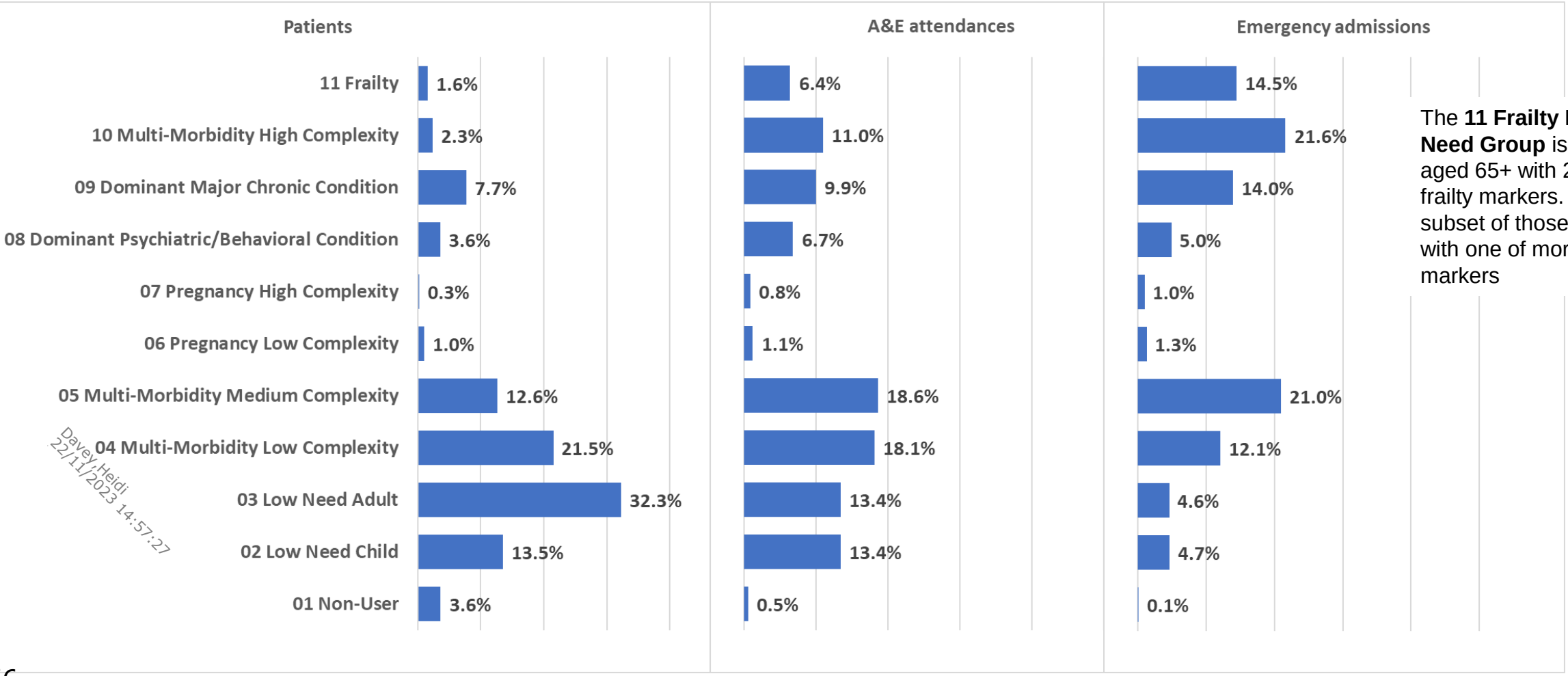
There are 42 communities across Norfolk and Waveney where some or all the population live in the 20% most deprived areas in England.

Approximately 40% of the populations of Great Yarmouth and Norwich live in the most deprived 20% of areas in England compared to 16% for Norfolk and Waveney as a whole.

Norfolk and Waveney Demand and Capacity

Patient Need Group and Activity

Linking activity data to PHM data indicates it is multimorbidity and frailty that is likely to be driving activity. For example, people in PNG 10 (multi-morbidity, high complexity) make up about 2.3% of the population but 11.0% of A&E attendances and 21.6% of emergency admissions.

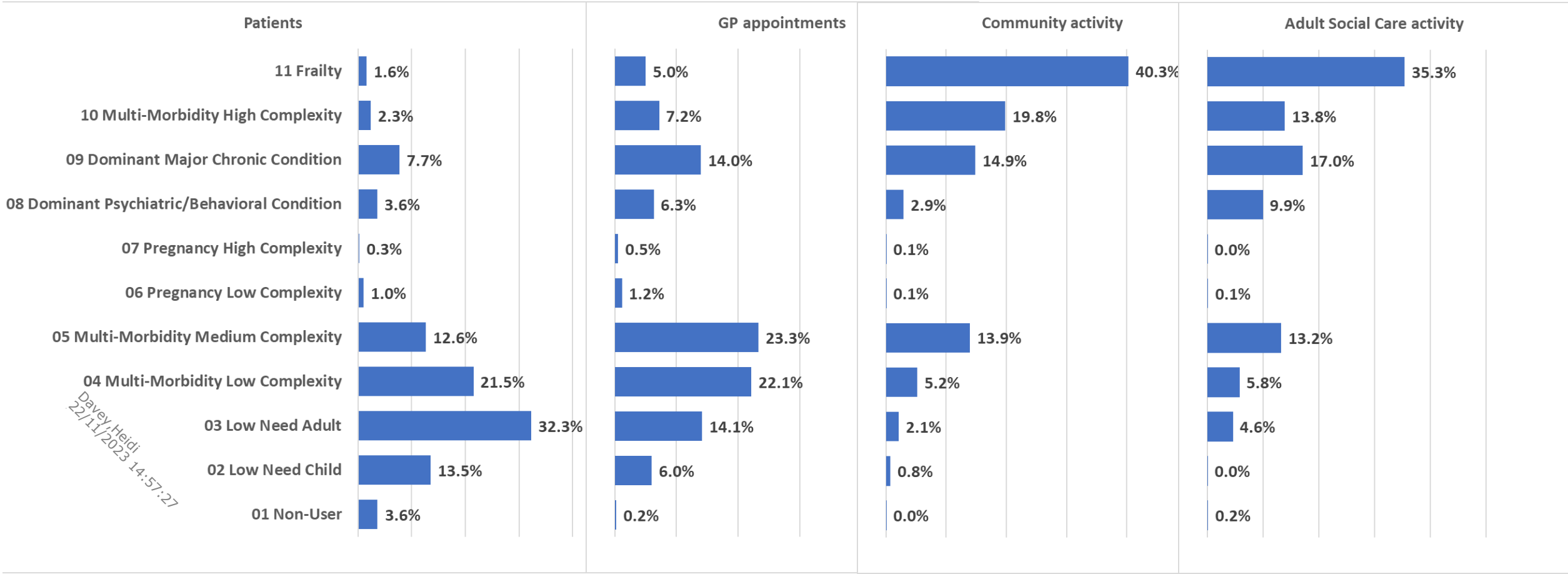


The **11 Frailty Patient Need Group** is those aged 65+ with 2 or more frailty markers. This is a subset of those of all ages with one of more frailty markers

Norfolk and Waveney Demand and Capacity

Patient Need Group and Activity

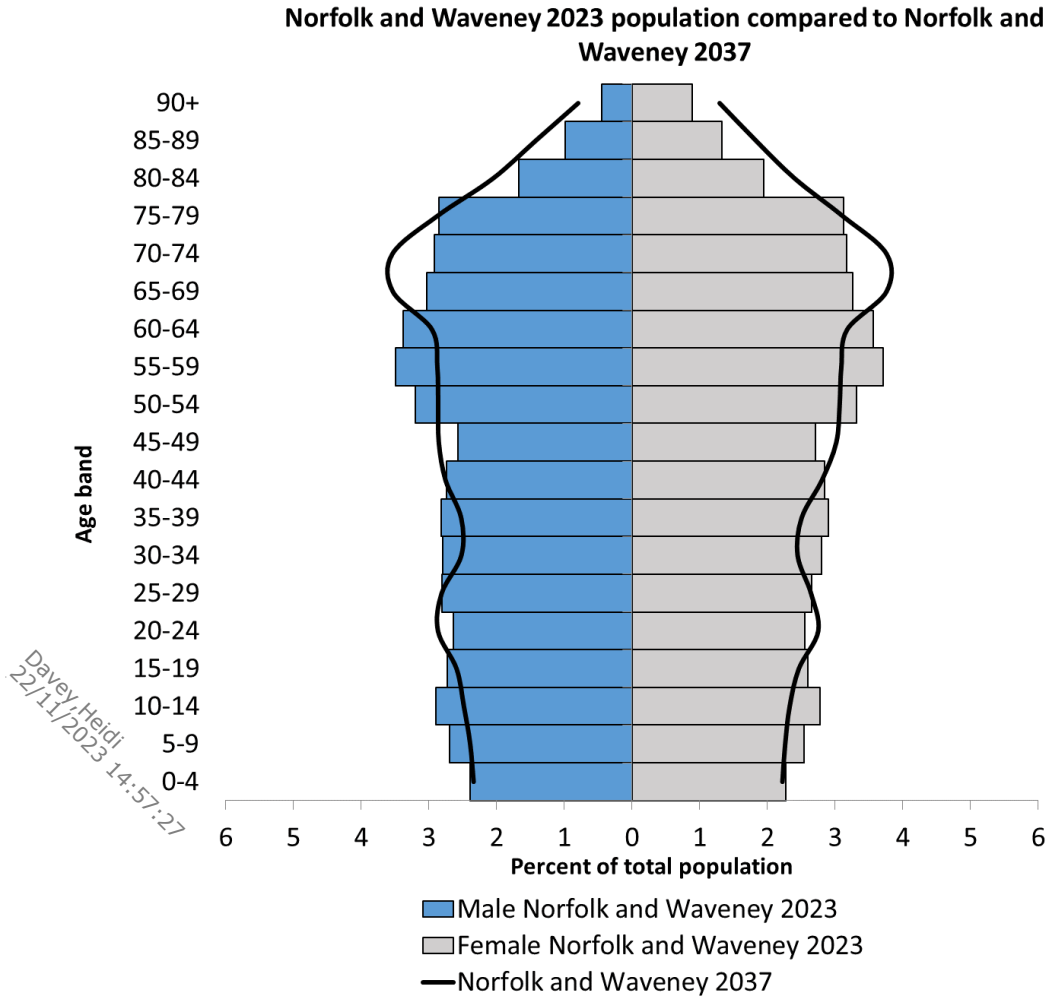
Multi-morbidity and frailty also account for a large part of general practice, community and social care activity: People in PNG 10 (multi-morbidity, high complexity) make up about 2.3% of the population but 7.2% of GP appointments, 19.8% of community activity and 13.8% of adult social care activity.

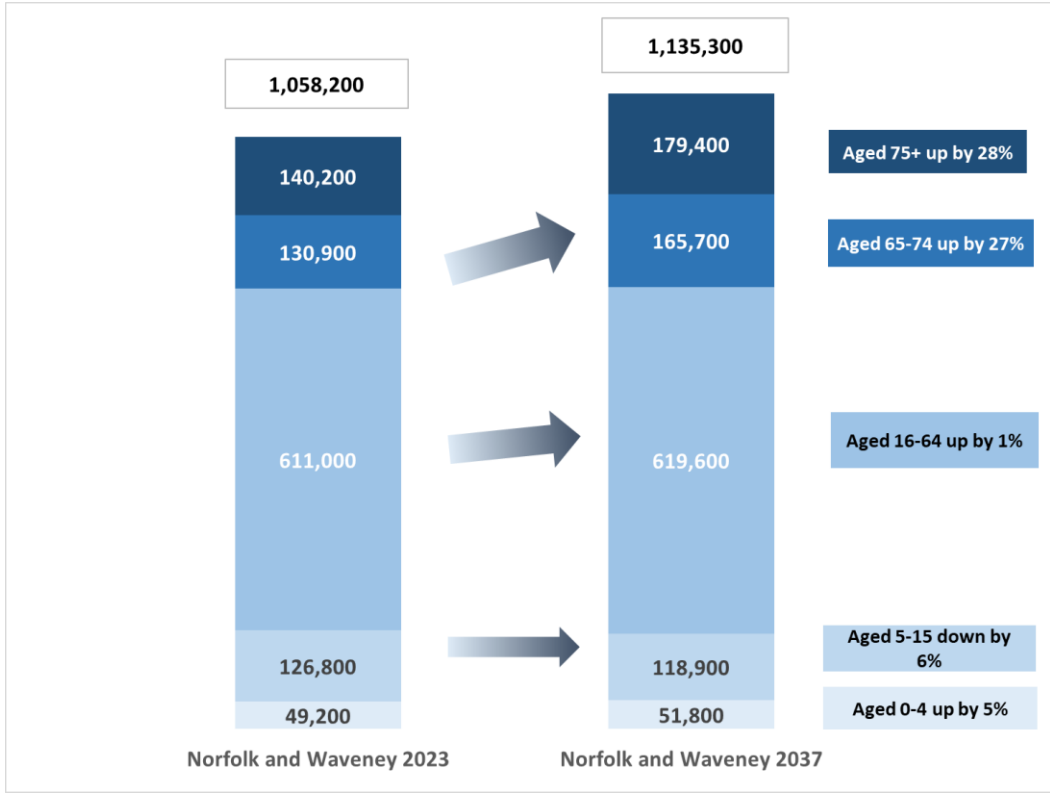


Norfolk and Waveney Demand and Capacity

Estimated Population Growth

The Office of National Statistics (ONS) resident population projections indicate that between 2023 and 2037 we are likely to see an increase of over 77,000 people (about the current size of Lowestoft PCN).



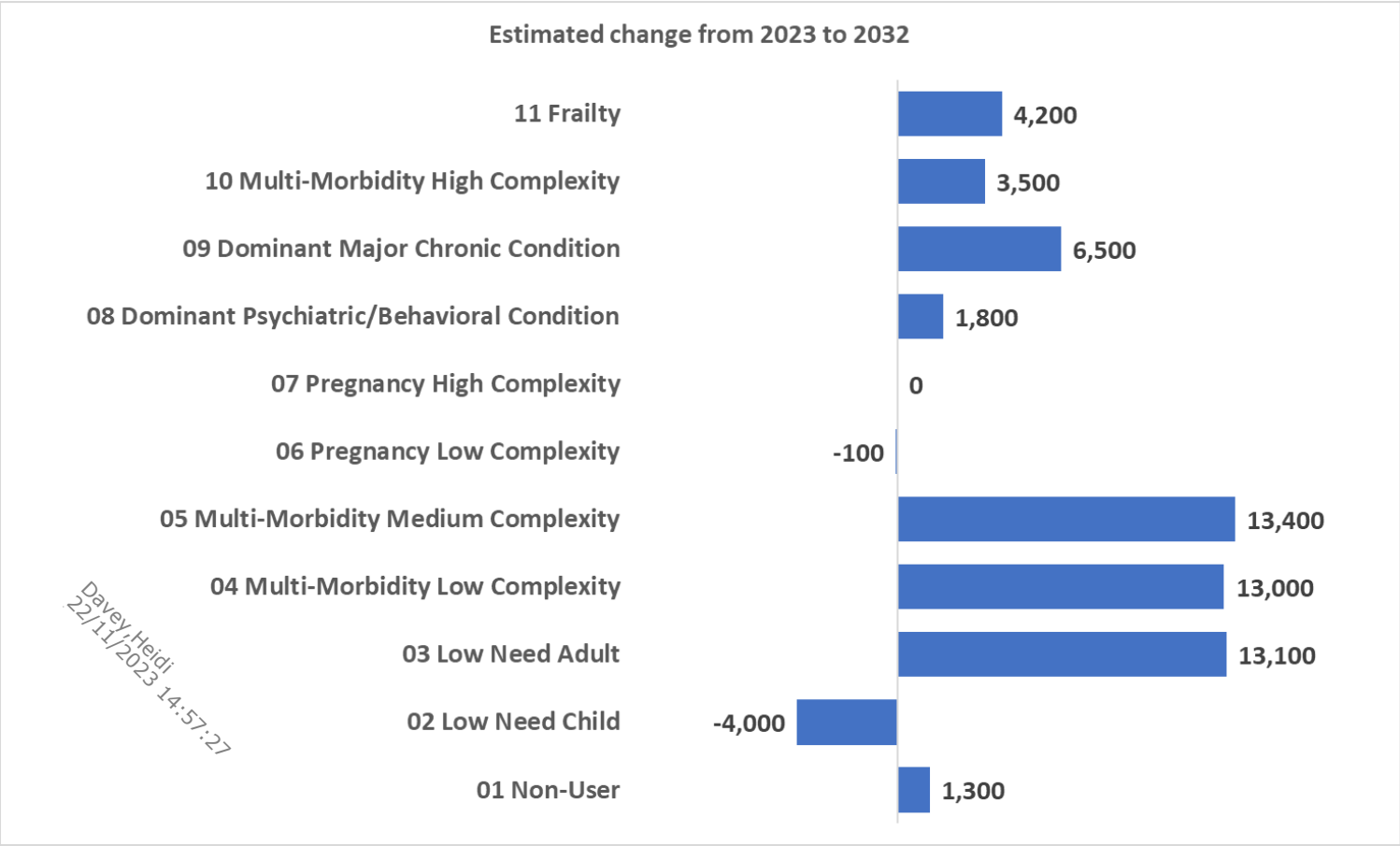


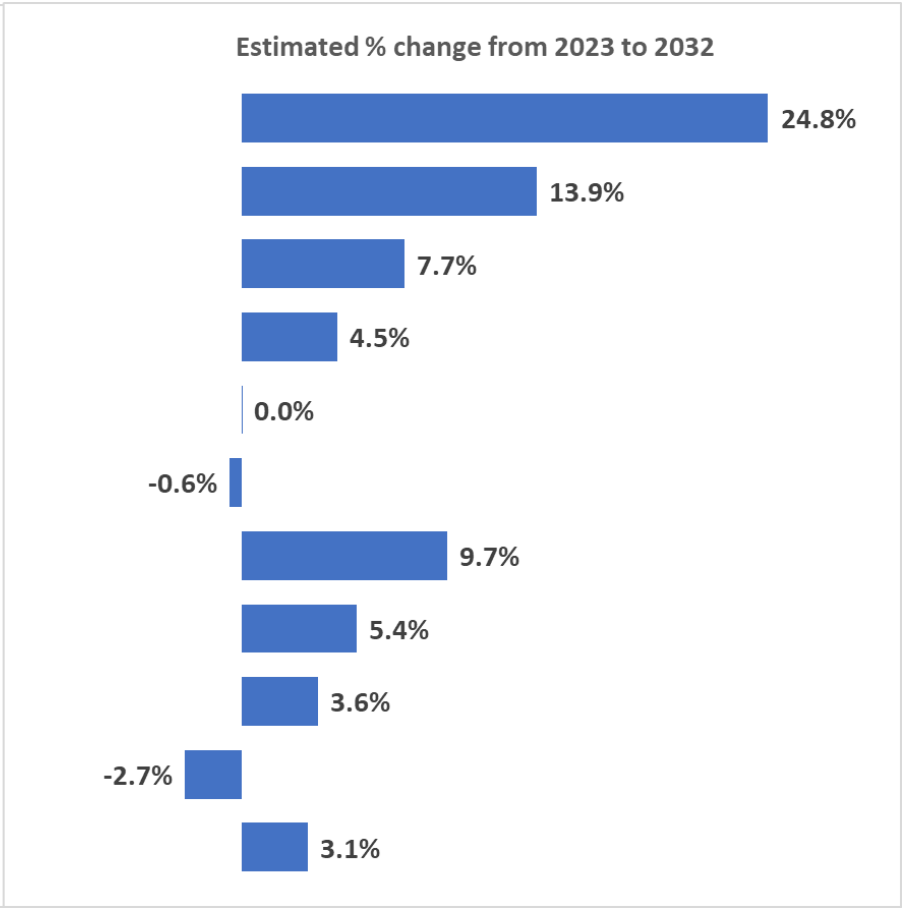
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/subnationalpopulationprojectionsforengland/2018based

Norfolk and Waveney Demand and Capacity

Estimated Population Growth

By applying ONS population projections to the current registered population, assuming nothing else changes, then due to demographic growth we are likely to see the biggest percentage change in those groups with the highest activity. This means as a system we are likely to have to do things differently in the future in addition to preventing multi-morbidity and frailty.





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Norfolk and Waveney Demand and Capacity

The modelling can also be used to understand priority segments and populations at risk for our system, place, PCN and communities.

For example:

- Inequality across Core20 communities, and plus groups where possible
- Individuals and cohorts with a similar pattern of morbidity, similar expected resource use
- Future resource use (e.g. total cost, pharmacy cost) and risk of future adverse events (e.g. hospitalisation) and mortality risk to help identification of patients who may require end-of-life care
- Understanding disease and morbidity distributions within a population
    - Quantifying differences in case mix between different practices and communities
    - Stratifying based on overall morbidity burden, individual diseases and/or future risk
    - Identifying key drivers of cost
    - Segmentation of a population into mutually exclusive groups to aid population health management

Understanding our data in this way allows us to think about how we might design services differently to best meet the needs of our population and the workforce we need to deliver these services.

Fuller Stocktake – Vision for integrating primary care

The Fuller stocktake report published in May 2022 outlines a vision for integrating primary care aiming to improve the access, experience and outcomes for our communities, which centres around three essential offers:

Urgent & Same Day Care

Streamlining access to care and advice for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it

Personalised care for complex patients

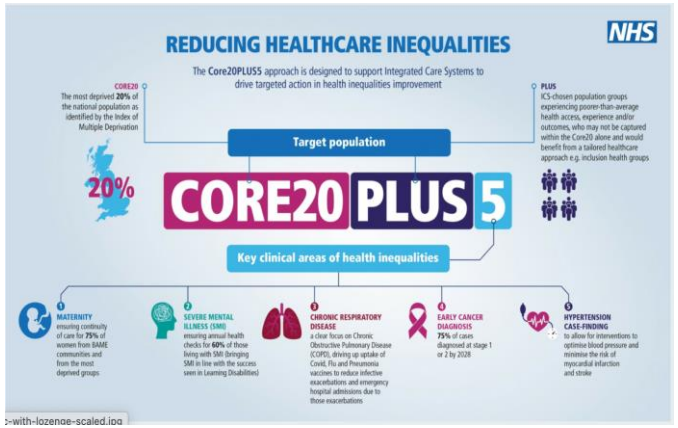
Providing more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions

Preventative Care

Helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention

"This is only achievable if we work in partnership addressing health inequalities through the Core20PLUS5 approach, and taking action to address the wider determinants of health"

– Dr Claire Fuller



Fuller Stocktake Golden Threads

“Despite current challenges, this is a moment of real opportunity”

- Dr Claire Fuller

“Building integrated teams in every neighbourhood - At the heart of the new vision for integrating primary care is bringing together previously siloed teams and professionals to do things differently to improve patient care for whole populations.”

“PCNs that were most effective in improving population health and tackling health inequalities, were those that worked in partnership with their people and communities and local authority colleagues”

“This way of working is only achievable if we work in partnership addressing health inequalities through the Core20PLUS5 approach and taking action to address the wider determinants of health.”

“need to think differently about how we design integrated primary care services that better anticipate the needs of different groups of people.”

What is Integrated Neighbourhood Working?

Dr Claire Fuller described this as where “teams from across PCNs, wider primary care providers, secondary care teams, social care teams, and domiciliary and care staff work together to share resources and information and form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and tackling health inequalities”.

This can be seen as a working model to facilitate the integration of care systems across different organisations to provide holistic health and care services that make sense to the local population.

Moving towards integrated neighbourhood working requires a commitment from all system partners, at all levels, to support a different approach to care delivery.

Integrated neighbourhood working should be supported by a shared vision and purpose with patients and communities at the centre, and underpinned by a set of high-level principles that recognise the contribution of each partner and their commitment to the approach, as well as a shared understanding of roles and responsibilities.

“I can do things you cannot, you can do things I cannot; together we can do great things.”

– Mother Teresa

Delivery plan for recovering access to primary care

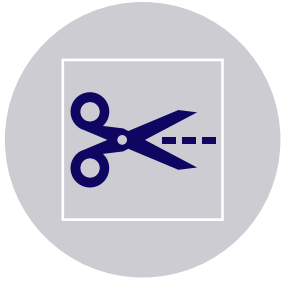
The Delivery plan for recovering access to primary care was published in May 2023 and builds on the GP contract changes announced in March, while reaffirming the commitment to embed the Fuller stocktake vision for integrated primary cares.

The plan seeks to support recovery by focusing on four areas:

Empower patients and where appropriate their carers, to manage their own health. In Norfolk and Waveney this will include supporting patients in using the NHS App and a variety of digital tools, self-referral pathways and through more services offered from community pharmacy through the launch of the pharmacy first programme.

Implement 'Modern General Practice Access' model to tackle the 8am rush, provide rapid assessment and response so patients know on the day how their request will be handled, based on clinical need and continuing to respect their preference for a call, face-to-face appointment, or online consultation.

Build capacity through recruitment to additional roles with increased flexibility for the types of staff recruited and how they are deployed, optimising the use of the full practice team.



Cut bureaucracy by reducing time spent by practice teams on lower-value administrative work and work generated by issues at the primary-secondary care interface.

Drivers for Change

The Delivery plan sets out the national context and drivers for change:

Strained capacity

- **20-40% increase in contacts** since pre-pandemic, exacerbated by care backlogs
- **>30% increase in people >70** since 2010, with more **long-term conditions**
- **12% more appointments** since pre-pandemic
- **Only ~7% increase in doctors** working in general practice since pre-pandemic

Decreasing patient satisfaction

- **Average satisfaction** with general practice fell from **83% to 72%** last year.
- Over **85% of practices** saw their **satisfaction fall**
- **1 in 5 people unable to get through** or get a reply from their practice when last tried
- **Poor contact creates patient dissatisfaction** with practice overall

Norfolk and Waveney GP Patient Survey results

The Norfolk and Waveney GP Patient Survey (GPPS) results benchmark well nationally and regionally:

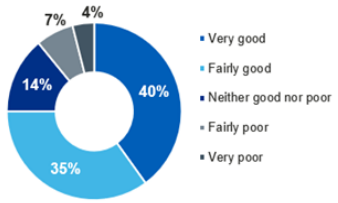
Overall experience of GP practice

GP PATIENT SURVEY

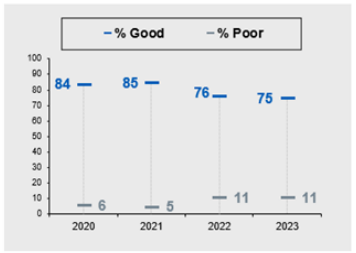
NORFOLK AND WAVENEY ICS

Q32. Overall, how would you describe your experience of your GP practice?

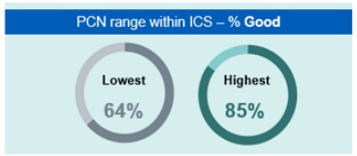
ICS result



ICS result over time



PCN range within ICS – % Good



Comparison of results

ICS		National	
Good	Poor	Good	Poor
75%	11%	71%	14%

Base: Asked of all patients. National (749,020); ICS 2023 (12,632); ICS 2022 (12,084); ICS 2021 (13,779); ICS 2020 (12,225); PCN bases range from 253 to 2,576

%Good = %Very good + %Fairly good
%Poor = %Very poor + %Fairly poor

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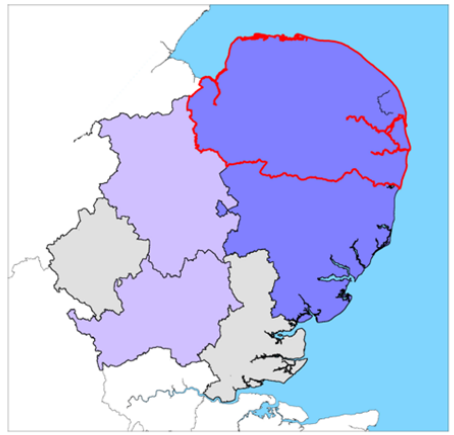
Overall experience: how the ICS results vary within the region

GP PATIENT SURVEY

Q32. Overall, how would you describe your experience of your GP practice?



Overall experience of GP practice
% Good
75.6 to 80.1
73.1 to 75.6
71.2 to 73.1
68.0 to 71.2
62.6 to 68.0

Results range from
63%
to
75%

ICSs across England are divided into five groups (quintiles) based on their results, as shown in the key. The map shows the ICS results within this region based on these groups (the ICS represented by this pack is highlighted in red).

Comparisons are indicative only: differences may not be statistically significant

%Good = %Very good + %Fairly good

Base: Asked of all patients. ICS bases range from 6,116 to 46,211

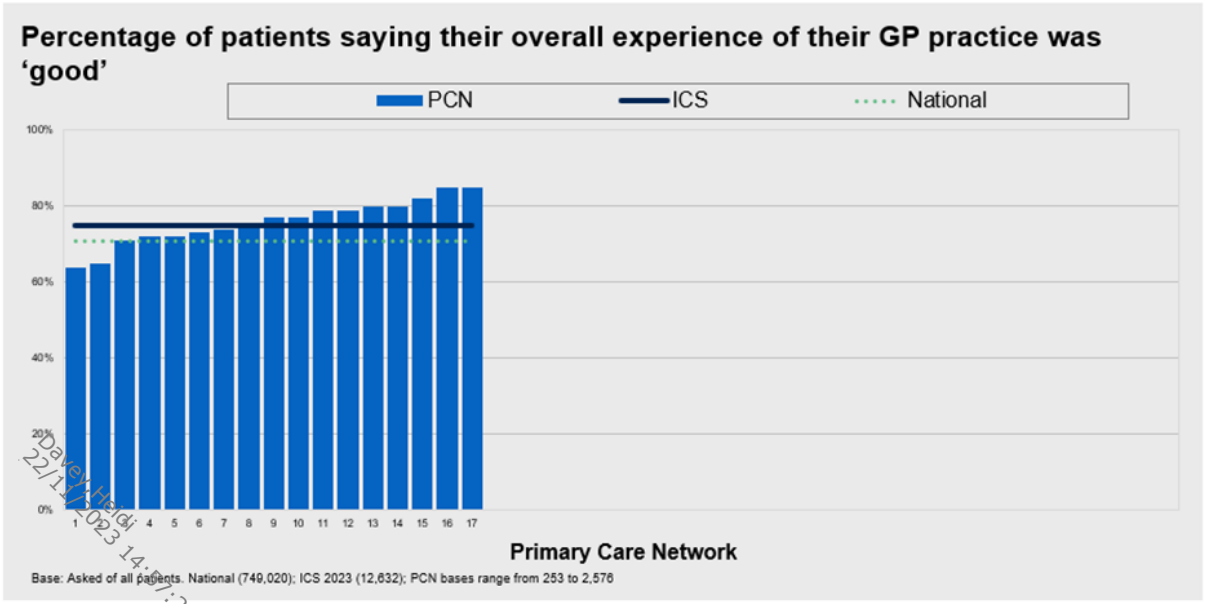
Norfolk and Waveney GP Patient Survey results

Whilst overall as a system, Norfolk and Waveney benchmark well, there is variation across PCNs and practices that we aim to address through the delivery of the actions developed by PCNs included within their Capacity and Access Improvement Plans.

Overall experience: how the results vary by PCN within the ICS

GP PATIENT SURVEY

Q32. Overall, how would you describe your experience of your GP practice?



PCN	Name
1	KINGS LYNN PCN
2	GORLESTON PCN
3	BRECKLAND SURGERIES PCN
4	NORWICH PCN
5	MID NORFOLK PCN
6	KETTS OAK PCN
7	LOWESTOFT PCN
8	SWAFFHAM & DOWNHAM MARKET PCN
9	SOUTH NORFOLK HIP PCN
10	SOUTH WAVENEY PCN
11	NORTH NORFOLK 3 PCN
12	GREAT YARMOUTH & NORTHERN VILLAGES PCN
13	FENS & BRECKS PCN
14	NORTH NORFOLK 1 PCN
15	WEST NORFOLK COASTAL PCN
16	NORTH NORFOLK 4 PCN
17	NORTH NORFOLK 2 PCN

Using the GPPS data at practice and PCN level, as well as our local intelligence, we are developing our local support offers from a wide range of ICB teams (Digital, Workforce, Estates, Locality and Commissioning) to support our most challenged practices to deliver the improvements required to reduce variation in patient experience across the system.

Commitments from PCNs

All PCNs have submitted their capacity and access improvement plans and have shown good commitment to the ambitions outlined within the delivery plan and have included actions to support improvements against the required baseline data.

Key themes of the actions from the PCN plans are:

- Improving PCN communications with patients and communities and supporting patient education
- Improving practice websites with an up-to-date directory of services and to support sign-posting of care to the most appropriate service
- Promotion of the NHS app functionality and making the required changes to support prospective access to records
- Implementation of CBT with call-back functionality enabled in line with the national contract requirements
- Increased use of online consultations and a focus on accuracy of recording this activity
- Review of demand and capacity and provision of available ARRS* staff
- Undertake local patient surveys to monitor improvement

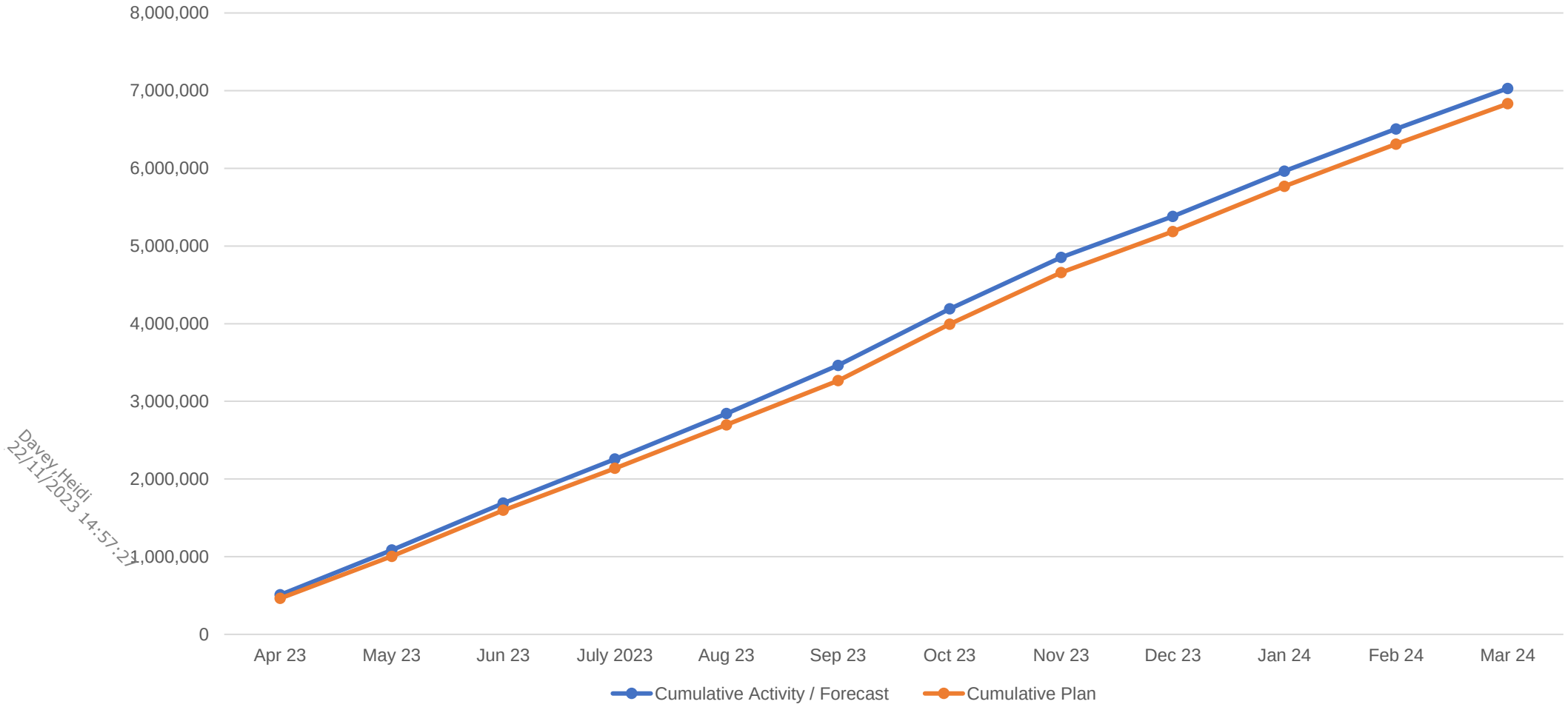
It is important to recognise that the PCN plans will continue to evolve throughout the year and into 2024/25 as the improvement work is undertaken by PCNs and our strategic plans are developed for 2024 and beyond.

* ARRS (additional roles reimbursement scheme) staff, are those employed through PCN funding additional to the practices baseline establishment, and which work in at scale PCN roles

General Practice Appointment Data

Our appointment data shows that our practices are currently delivering more appointments than planned this financial year. Up to September 2023 our practices have delivered total of 3,462,716 appointments compared to a plan of 3,266,614.

If we continue to deliver our plan each month, as a minimum, we will exceed our plan by almost 200,000 appointments at the end of March 2024.



Expected outcomes for 2023/2024

We will continue to develop our interface programme of work and review all opportunities within the General practice and secondary care: Working better together report.

We aspire to increase the number of sign-ups to the NHS app and we will support practices to deliver promotional events for their patients.

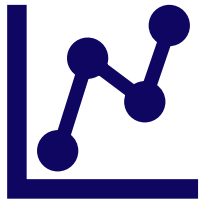
We aim to support 34 practices to update their telephony system to a cloud-based system to help them to better manage their call demand, so patients get a better experience of contacting the practice.

We want to support as many practices as possible to transition to the modern general practice access model by the end of 2024/25 maximising the use of the transition funding provided to ICBs.

We seek to develop a culture of improvement and want to work with practices and PCNs to harness the power of technology and the tools available to support this.

Assuring Delivery

We will be holding quarterly meetings with PCN leaders to review progress against the agreed actions outlined within the PCN Capacity and Access Improvement Plans.



Locally collected PCN / practice data, such as feedback from PPGs and staff experience surveys will be used alongside nationally available data to monitor delivery of improvements.

We will triangulate PCN improvement plans with other local performance data through the development of a primary care dashboard to identify where more specific and targeted support offers may be required.

In addition, the ICB will be assured by NHS England on its progress against the national requirements, as well as being monitored through the Delegation Agreement and Assurance Framework.

Implementing Modern General Practice Access

Modern General Practice Access Model

What is the Modern General Practice Access Model?

Modern General Practice is “a modern approach to general practice that makes it easier for patients to contact their practices by phone or online and supports practices to rapidly assess the nature and urgency of requests by involving the whole practice team.”

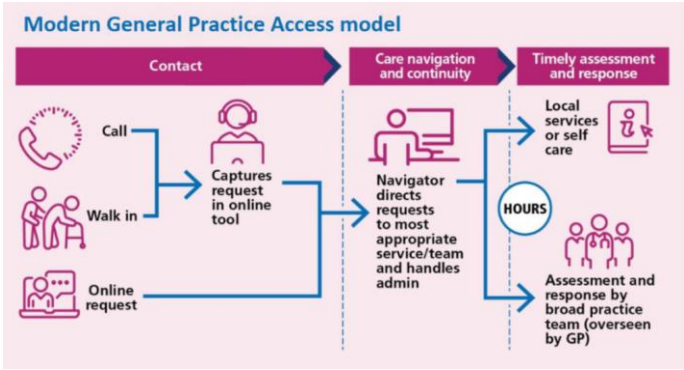
This model is a way of organising work in general practice to help enable practices to provide fair and safe care, while also supporting the sustainability of services and an improved experience for both patients and staff.

The model involves practices:

- having a full **understanding of demand and** available **capacity**
- providing **easy to use access routes** to patients
- **collecting consistent information** from the patient at the point of contact
- using this information to give the **most appropriate help to patients based on need**
- improving **management of non-patient facing workload to** help **release capacity**

Our Digital Team have developed a short video to help explain what the model is for Norfolk and Waveney and support available to support the transformation.

Vision for Modern General Practice in Norfolk and Waveney



Online request

Call the practice

Walk-in

Self-care and self-referral routes

Care Navigation

Access for urgent primary health needs

Improved access for patients that are generally well and require support for a short-term illness from the wider MDT, using digital technology to enable patients to find the right support

Team based continuity for people with more complex needs

Developing multi-professional teams to provide more proactive, personalised support for patients that most benefit from continuity of care (such as those with long term conditions)

Managing health inequalities and supporting prevention

Through working in partnerships with communities and partners including local authorities and the voluntary sector to create healthier communities

Continuity of care – less important

Continuity of care – more important

How will we achieve this?

Access for urgent primary health needs

Improved access for patients that are generally well and require support for a short-term illness from the wider MDT, using digital technology to enable patients to find the right support

- Increase workforce capacity and skill mix including support from non-clinical roles where appropriate for patients' needs
- Utilise digital tools to support people getting the right care for their needs early in their journey and delivery of clinical capacity where most needed
- Increase promotion of self-care and alternatives to General Practice including using Community Pharmacy services

Team based continuity for people with more complex needs

Developing multi-professional teams to provide more proactive, personalised support for patients that most benefit from continuity of care (such as those with long term conditions)

- Develop a person-centred approach to care delivery recognising that there is not a one size fits all approach
- Mature PCN development to increase "at scale" models of care based on local population needs, in line with the ambitions from the Fuller Stocktake, encouraging integrated neighbourhood working in partnership with local health and care providers

Managing health inequalities and supporting prevention

Through working in partnerships with communities and partners including local authorities and the voluntary sector to create healthier communities

- Continue to engage and communicate with our patients and communities at system, Place and Neighbourhood to support co-designing of services locally
- Utilise a population health management approach to deliver proactive care, working in partnership with others to improve health and wellbeing and reduce health inequalities

Cloud Based Telephony

The ICB has received funding for 34 practices to purchase a cloud-based telephony system. This is in addition to 40 practices already funded in a previous pilot phase.

All procurements will be undertaken via the nationally approved framework, to ensure that the chosen system meets the required functionality.

One of the major benefits of Cloud Based Telephony is to support at scale working. Our intention is to work with practices within a PCN to have the same system, where possible, to support this way of working across the system, in line with our future strategic plans.

Online Consultations

Online consultation systems provide patients with an alternative and convenient way to contact the practice via the internet and can free up your phone lines for patients that are unable or choose not to engage with digital services. Some tools already integrate with the NHS App or will in the future, offering a consistent patient facing experience to seek help from the practice online.

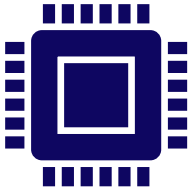
Our Digital Team intranet page (Online Consultations) provides practices information about all the systems currently supported and is host to relevant guidance and resources for each product The Digital Team offer support to practices with reviewing their processes and provide advices for optimising the functionality available through their Online Consultation System, including how to route referrals and enquiries directly to the right person, or to support a total triage model.

The new Digital Services for Integrated Care framework will feature some additional suppliers and our local offers will be reviewed then. This will include looking at systems with AI functionality.

The Digital Team will be holding engagement sessions with PCNs about the new tools available and developing a proposal of options for utilising the funding available.

Additional Digital Offers

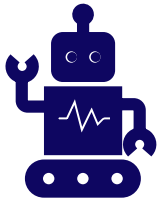
Our Digital Team are also offering various support offers to support practices with managing their workload and implementing the Modern General Practice Access model:



Future Connectivity Investment:
We have been awarded funding by the NHS England Future Connectivity Programme for Fibre connections to all practice premises. These networks will give gigabit connectivity to practices, many of whom will experience speeds 10x faster than current performance. Roll out of the Fibre connections is expected to take a year and be complete by September 2024.

PCN Hub Units:
Promotional materials have been developed for the use of PCN Hub units to support practices to manage PCN activity. The Digital Team can provide support for the implementation of PCN Hub Units for both SystemOne and EMIS practices.

Remote Monitoring in Care Homes:
A pilot group of Care Homes is using remote monitoring technology which is providing benefits to care home residents and to clinical staff in practices and the 111 service, providing more timely care and avoiding hospital admissions.



Robotic Process Automation:
The innovation arm of the Digital Team has been working on a pilot to look at the use of Robotic Process Automation in general practice, focusing on administrative tasks that are low risk as a pilot phase.

Building Capacity

Building and retaining our workforce

As well as supporting our PCNs to develop their plans to utilise their full Additional Roles Reimbursement Scheme budgets, we have many initiatives in place to support recruitment of suitably qualified staff into general practice and PCNs:

General Practice Assistant Programme: The programme offers General Practice Assistants to enhance their skills in care, communication, administration and managing health records supporting the wider practice team to undertake non-medical tasks and become more involved with patient care, reducing pressure on the clinical workforce.

Newly Qualified and First 5 GPs: This scheme provides dedicated coaching and mentoring support in their first 5 years. We are using feedback from our current cohorts to review the local support available for this programme to develop and enhance the support offer further, funded from the GP Retention Budget.

ST3 Incentive Scheme: This is a dedicated package to support our newly qualified GPs to stay and work within the area. This programme is to encourage salaried GP roles within the system, provide up to four clinical sessions per week and a 12 month commitment to the GP practice.

Promotional Events: Events specifically for ST3, newly qualified and First 5 GPs are taking place with the aim of showcasing Norfolk and Waveney as a great place to work and live, also to gather information about the work portfolio new GPs will be looking to achieve to support planning of support offers.

Building and retaining our workforce

General Practice Partnership Model: Our local incentive to support first time partners or returning partners across the system. This is a 2-year commitment to the practice and a minimum of 4 clinical sessions to be provided.

Flexible Staff Pool: We continue to develop our digital flexible staff pool which is providing valuable resources to practices most challenged with high rates of staff absence, with the work improving outcomes in rural areas.

GP Careers Plus: The programme has been built based on engagement with local GPs to develop our offer over the coming year. Feedback from this process of GP engagement was excellent with GPs reporting that they felt listened to, valued and that the ICB was responsive to their needs.

Educator and Learning Organisation: Placement expansion continues to increase with 81% of GP practices across Norfolk and Waveney being approved Learning Organisations. We are creating new placement sites for GP trainees, nurses, paramedics, and pharmacists. We have developed our offers through collaboration with the local Higher Education Institutions by mapping placements and quality assuring through a shared approval process.

Building and retaining our workforce

Schwartz rounds: The aim of our Schwartz Round programme is to support staff to build resilience in managing the increasing challenges faced within our healthcare system. Our programme has been developed on feedback from staff attending the events, reflection and continuous improvement.

Supporting Primary Care Clinicians: We provide online clinical updates, CPD (continued professional development) and confidential support for GPs and clinical staff who have been absent from role, or feel they need additional support.

Apprenticeships (Clinical and Non-clinical): We offer apprenticeships supporting primary care colleagues with their career pathway in both clinical and non-clinical skills. This programme is used to upskill existing staff members and to look to recruit new talent to their organisation.

Looking After You Too: Staff can access coaching with a highly skilled and experienced coach through the NHS Leadership Academy. This programme is to help staff to think about and plan how they work with the people they lead and manage, using approaches centred in compassionate and collaborative team leadership**.** The aim is to encourage resilience in teams while supporting them to continue to deliver projects, services and high-quality care to patients.

Fellowships

The Norfolk and Waveney Fellowship Programme is a two-year programme of support, available to all newly-qualified GPs working substantively in general practice, with an explicit focus on working within and across a PCN.

This is a programme to support GPs to take up substantive roles, understand the context they are working in, become embedded in the PCN, and increase and maintain high levels of participation in primary care workforce development.

We also offer all newly qualified Nurses & AHPs the opportunity to undertake a two-year Fellowship. The Fellowship programme supports Nurses and AHPs to transition and become an embedded part of the primary care team in the PCN.

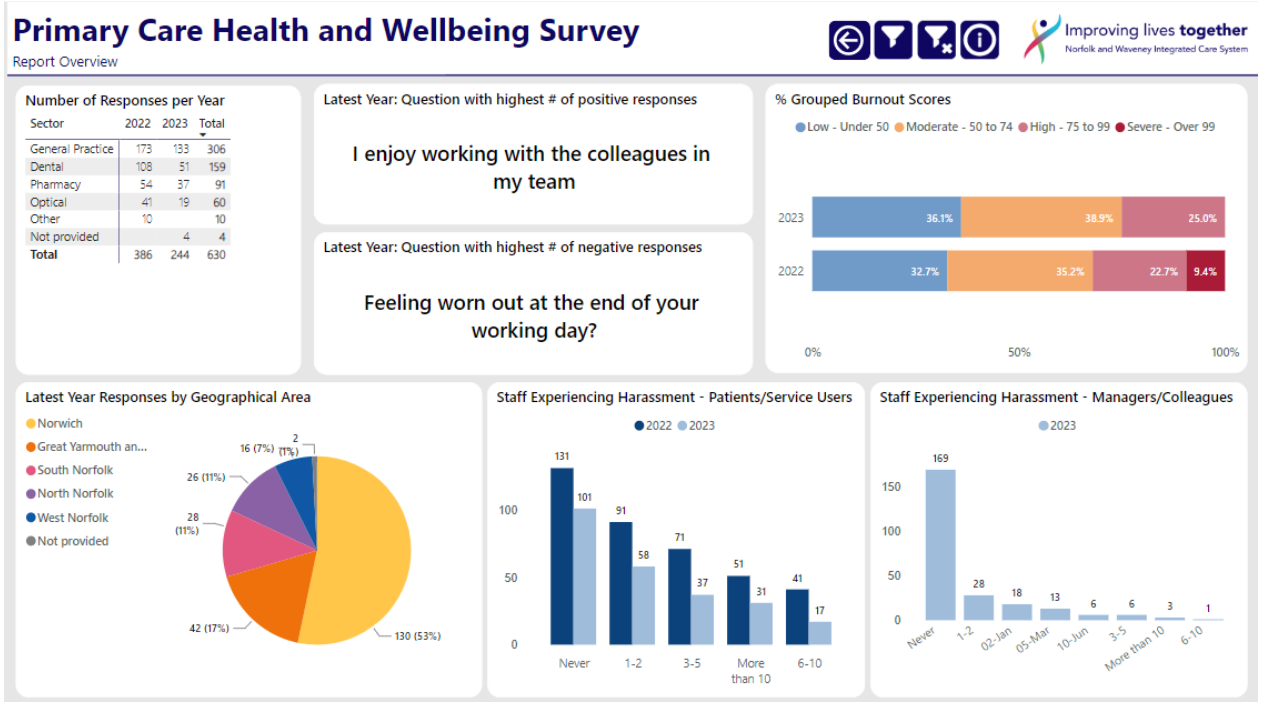
We have developed fellowships for Health Inequalities with a focussing on Learning Disabilities, Severe Mental Illness, Autism and Maternity care.

Further Fellowship opportunities are being developed with focuses on Health & Wellbeing, CaReMe (Cardiac, Renal, Metabolic specialisms), Stroke care, NHSE Integrated Care, Learning Organisation and Student Placement Expansion and Digital.

Health and Wellbeing

Health and Wellbeing offers are being introduced across primary care to support workforce retention and to address the key themes emerging from the Primary Care Health and Wellbeing Survey including burnout, harassment and stress.

25% of primary care colleagues are experiencing “High” levels of burnout, 244 incidents of patient harassment have been recorded in 2023 and 70.8% of primary care staff feel exhausted at the end of the working day.



Developing our workforce

We have developed a Business Intelligence (BI) dashboard using results from the 2021 and 2023 Training Needs Analysis general practice survey to allow us analyse the data with ease and clearly see what our training needs are in at System, Place and individual practice level as required.

The top three topics for clinical training, for all job roles, are:

- Diabetes
- Eating Disorders
- SMI (severe mental illness) Health Checks

The top three topics for non-clinical training, for all job roles are:

- Coding and Read Coding
- Customer Services and Conflict Management
- Medical Terminology

The dashboard also supports analysis of the data in line with our Joint Forward Plan priorities and the Core20PLUS5 framework to see the training needs grouped by these categories helping us to take a more targeted approach to our training offers.

This Primary Care Workforce Team maintain a Training and Workforce Catalogue in line with CPD guidance and local training needs analysis. CPD funding is pooled with system partners to support partnership working across health, local authority, social care and VCSE, provides joined-up solutions to shared challenges and maximises opportunities to have an impact on health inequalities.

Cutting Bureaucracy

Primary-secondary care interface

The ICB has an established Clinical Interface Group, chaired by the ICB Executive Medical Director. This was developed with the purpose of bringing system partners together to discuss interface issues requiring escalation and resolution, which have not been resolved through business-as-usual processes. It also aims to build relationships between clinicians working across primary care and our community, mental health and acute provider Trusts. It provides an opportunity to consider emerging issues and develop shared strategies to address such issues, and to identify opportunities for improved system collaboration. The principle that all system partners are equal underpins discussions along with ensuring the best outcome for patients.

A review of the group effectiveness will be undertaken in line with the recommendations published in the Academy of Medical Royal Collages report, General practice and secondary care: Working better together. This is due to take place after the conclusion of the ICB Change Programme.

Our interface work to date has focused on seeking to address areas raised by our practices, which could improve the way they work as a multi-disciplinary team, or where work has been inappropriately transferred. The key themes to date include:

- Ensuring all appropriate health professionals can order tests and investigations via the ICE systems operated by Trusts
- Enabling private consultants to refer patients directly into Trusts, rather than having GPs forward them on to hospitals
- Trusts offering complete care (e.g. phlebotomy, requests to follow up care, make referrals or prescribe, issuing fit notes for the full duration of absence)
- Improving communication, such as timely discharge letters which appropriately and clearly signal any actions or important information for general practice
- Developing and implementing a process for reviewing and agreeing new pathways of care, to ensure there are no unintended consequences on general practice
- Providing a forum for escalation of individual service issues which have not been agreed through business-as-usual routes

Primary-secondary care interface

Under NHS standard contract provisions for Trusts, action plans are due to be completed by each of the Trusts every year following a self-assessment process in September. The ICB is required to report on the progress of the plan at its public Board meeting in November and March.

The ICB has jointly worked with the Norfolk and Waveney Local Medical Committee (LMC) to develop a route for general practices and providers to raise interface issues directly with providers and also with the ICB and LMC. The aim is to raise the profile of these issues across the system, monitor issues and trends and to work across organisations to find resolutions.

While we know issues are under-reported, the ICB has been using the data collected from this process to support our provider Trusts in their gap analysis and development of the action plans for improving the effectiveness of their interface working arrangements.

These plans are currently in development but do cover the four key priority areas highlighted in the delivery plan;

- Onward referrals
- Complete care (fit notes and discharge letters)
- Call and recall for patients under the care of providers
- Clear points of contact for communication between general practice general practice and secondary care

Primary-secondary care interface

The General practice and secondary care: Working better together report outlines some quick win actions for systems to implement to improve the working across the primary-secondary care interface.

Recommended action	Progress in Norfolk and Waveney
Provide easy access to general practice for secondary care clinicians via non-public phone numbers and shared email mailboxes.	Practices have shared mailboxes that can be used for queries from secondary care.
Provide easy access to individual hospital departments via non-public phone numbers/shared mailboxes to help in the resolution of administrative queries (ideally any correspondence should link directly with the electronic health record).	Providers have shared mailboxes for each department so that queries can be sent to a central point.
GPs giving trainee doctors regular 'show and tell' sessions on how to fill out discharge summaries in the most informative and accessible way.	Providers have suggested they include information about the interface requirements within their junior doctor inductions and teaching sessions. This is currently in progress.
Establish outpatient helplines where administrative queries about hospital appointments can be directed.	All providers have departmental phone numbers published on their websites and included on clinic letters to patients.
Make 'fit notes' more accessible on inpatient wards and in outpatient clinics and produce guidance for secondary care clinicians on their use.	Providers have actioned this and we have seen a sustained improvement in reported issues with fit note compliance over the last six months
Consider establishing regular 'interface groups' which include balanced representation from general practice and secondary care. The precise specifications should be locally determined	Our monthly interface group has been established for the last two years and includes representation from the ICB, primary care and secondary care.
Provide clinicians with read-only access to health record systems across the interface.	The Norfolk and Waveney Shared Care Record is currently being rolled out across the system, supporting this action.
Employ a Primary Care Liaison Officer to help in the resolution of queries between secondary care and general practice	NNUH is currently in the process of recruiting a GP to be their Associate Medical Director supporting Primary Care Liaison. Other providers are developing local interface forums to resolution of queries between secondary care and general practice.
Provide patients with a written update on where they are on the waiting list, asking if they still require or want treatment	Providers already contact patients, either by phone or letter, when they have been waiting for extended periods to confirm they wish to remain on the waiting list. Practices receive updates on waiting times per specialty and provider so that this information can be shared with patients at the time of referral.
Standardise outpatient clinical letters where possible (placing particular emphasis on concise GP recommendations)	There is work ongoing currently led by the ICB to review the content of clinic letters, including the requirement for clinic letters to be addressed directly to patients rather than referrers.

Empowering Patients

What this means in Norfolk and Waveney

NHS App

Patients can interface with practices via various routes such as apps, telephones, websites and face to face. The NHS App is now viewed as the future gateway to all NHS services.

The NHS App can be used by patients to request repeat prescriptions, book, and manage appointments, view their GP health record to see information like allergies and medicines as standard and if notifications are switched on, to receive messages from your GP practice.

The NHS App will provide access to prospective records when this is enabled by each GP practice and all practices have committed to make the required changes by 31 October 2023, in line with the national contract.

The Digital Team have created a promotional information on how digital tools can help with Primary Care Access Recovery, including information the revamped toolkit that helps practices to encourage their patients to use the NHS App.

The Digital Team are working with our GP practices to promote the use of the NHS App and have attended practices to support with practice events. This has not just centred around the functionality of the NHS App but also to increase digital inclusion.

Website Optimisation

Support is available to all practices for website optimisation, whether that is for their current website or in the transition to a new website provider. Our Digital Team will ensure that the website is enhanced and accessible to the practice's patients and their carers.

Support is also available where practices wish to transition from one provider to another, through use of a digital solution where possible.

The ICB Digital Team have developed a standardised website template for Norfolk and Waveney giving practices framework to add in practice specific content.

The template is designed to make it as easy as possible for patients to get the right help, from the right place, first time, as well as promoting self-help and the NHS App.

Social Media Managed Service

Social Media plays a vital role in communicating effectively to our patient population and when used properly, is a key part of the digital front door. It is not only great for sharing important messages to patients and increasing good demand through practice doors, but also in combatting misinformation and helping to educate patients to access the correct service for their needs.

We have partnered with Redmoor Health to offer all Practices in Norfolk and Waveney a social media managed service. This service will support practices by; creating, managing, and developing their social media pages, providing patient communication training to practice teams, and posting regular relevant content to local communities using a mixture of national campaigns and bespoke posts. These are co-created with the practice and Redmoor Creative. Redmoor also manages all patient comments on posts and raises anything important with the practice.

The Digital Team are on hand to support practices in the implementation of the social media managed service as well as supporting the creation of local campaigns and monitoring the success of engagement.

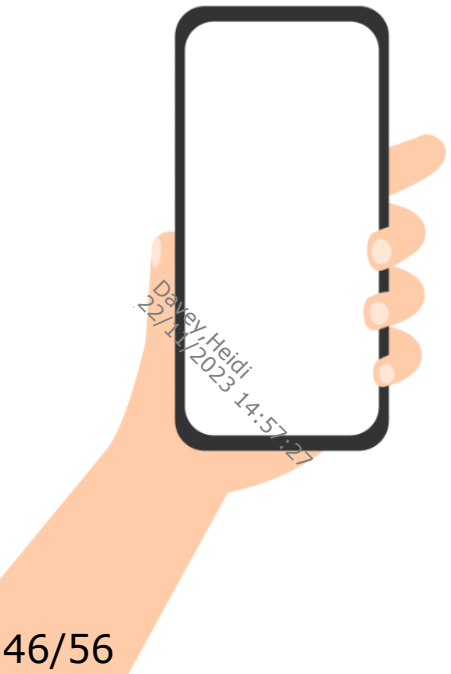
Our intranet page provides more information about the Social Media Managed Service Redmoor Health Provide.

Citizen Access to Records

The updated GP Contract requires all practices to provide their patients with online access to new (prospective) health information in their GP records (unless exceptions apply) from 31 October 2023.

The only exceptions are people who have asked to opt out or individuals identified as at risk. This means the application of SNOMED CT exclusion (104) code should only be applied to those individuals.

Nationally, more than 1 in 4 practices have now switched on for prospective access safely and effectively, enabling more than 8 million patients to benefit from having access to their health information.



As part of the local Digital support offer, the ICB Digital Team have developed robust information to support practices with implementing this change both within EMIS and SystemOne.

The information includes sign-posting to national support materials and provides contact details for practices that require additional support.

Proxy Access to Medication Ordering

Having aligned Care Homes enabled to order medications online for their residents can save time for both GP practice staff and Care Homes and will ensure better accuracy, making the overall process more efficient.

The Digital Team has robust processes, guides and resources in place for GP practices and Care Homes and also can provide training to GP staff if they do not know how to set up staff members as proxy users.

Some of the feedback we've received after implementing proxy access:

> *"Dispensary are well chuffed, had the first lot of online requests on Friday, really simple and easier than a load of phone calls!"*
> **Wayne Catchpole**
> **Practice Manager**

> *"This is so much easier to use, especially for PRNs outside of the monthly cycle. It's easy to see what's been ordered and there'll be no need to chase any more. It's going to save so much time as we won't need to take the orders to two different GP surgeries. We can even order in the evenings when we are less busy in the homes."*
> **Nanette Causton – Registered Manager**

Self-referral pathways

Across Norfolk and Waveney, there are a number of self-referral pathways already in place to support patients to directly manage their care without the need to see a GP to make the necessary onward referral.

Self-referral routes are in place for:

- Community Musculo-skeletal (MSK) services
- Community Weight Management services
- Community Falls Response services
- Community Audiology services – currently only community services commissioned in Central Norfolk
- Community Podiatry services – currently only for patients known to the service
- Community Wheelchair services – currently only for patients known to the service

There are plans in development to increase self-referral pathways for:

- Community Podiatry services – to include self-referral for all patients, by April 2024
- Community Wheelchair services – to include self-referral for all patients, by April 2024
- Community Falls Prevention services, by the end of Q1 2024

Community Pharmacy Integration

Across Norfolk and Waveney, we have 175 community pharmacy sites, more than any other provider within our system, and pharmacy can reach more of our population than anyone else. 80% of the UK population live within a 20-minute walk of their local pharmacy. Most of the population visit a pharmacy at least once every 28 days.

By seeking to fully integrate pharmacy into PCNs and our overall approach to tackling health inequalities, community pharmacies have the potential to unlock capacity released from other primary care contractors and provide essential services to support the health of the communities of which they are within.

Alongside the national funding received for ICBs to appoint and develop Community Pharmacy PCN Leads, the ICB Training Hub has provided retention funding allowing us to recruit five posts, one allocated to each Place. We have successfully recruited to three posts, with recruitment to the other posts under way.

Independent prescribing will be at the heart of many of the future services community pharmacist will provide and independent prescribing will be integral to the development of community pharmacy services, it's integration into PCNs and ensuring the clinical skills are maximised to benefit the health of the Norfolk and Waveney population.

In readiness for this, we are working to support Independent Prescribing training for our existing workforce of Community Pharmacists (including locum pharmacists and Pharmacists employed in General Practice or PCN ARRS roles. We are also mapping where our Primary Care Designated Prescribing Practitioner (DPP) are located across Norfolk and Waveney.

We have started to work with our other primary care stakeholders about the Pharmacy First service and how this can support them going forward. As well as general practice, this service has the potential to release capacity from our GP Out of Hours and NHS 111 services, therefore we are currently working on strengthening our signposting through existing pathways such as the NHS 111 Community pharmacy Consultation service (CPCS).

Transformation Support Offers

Transformation Support Offers

National GP Improvement Programme:

There are many nationally funded and delivered support offers available to practices and PCNs to support with designing and implementing improvement initiatives. We want to support as many practices as possible to take up these offers would encourage any practice or PCN interested in undertaking an offer, but have reservations, to contact us to discuss how we may be able to support. All information is available on the NHS futures platform **General Practice Development offers 23/24**

Local Training offers:

The Primary Care Workforce team keep a live catalogue of all training and development offers available to primary care staff **Primary Care Workforce Training & Development Resource Catalogue**

Local Health Coaching and Care Navigation Training:

As part of the ICS Educational and Development plan for Clinical Professional Development, a local programme is being established to be delivered as soon as possible. Further details will be provided by the Primary Care Workforce Team in due course.

Cloud Based Telephony:

We have employed a dedicated project manager to support practices to implement Cloud Based Telephony. Support is available at all stages of the process from our Digital Team.

Transformation Support Offers

Transition Funding:

The ICB have received a funding allocation from NHS England which is designated to provide support to practices for making the transition to the Modern General Practice Access model. The funding is available for practices to draw on when approaching the point of adopting the new model.

The funding can be used flexibly to support the transition, for example, to pay for sessional GPs, support from experienced peers or for additional sessions from current practice staff (clinical or non-clinical).

We want to support as many practices as possible to move to this model over the course of the next year and practices are encouraged to work with their PCN managers to discuss their plans for transitioning to the Modern General Practice Access model and how any support funding will be used, linking in with the actions in the PCN capacity and access improvement plans.

Support Level Framework (SLF):

Where practices want to dive deeper into areas for improvement, the SLF is a more comprehensive tool that can be used to understand wider development needs.

The SLF is undertaken through a facilitated conversation with the outputs used to develop a brief action plan with areas of focus.

The SLF is not a performance management tool and is not mandatory, but it can help practices to better understand their support needs and improvement priorities. It will also help us to ensure there is the right support available to practices.

Where practices would like support in completing the SLF, they can be supported by our primary care commissioning team.

Communications and Engagement

Support Primary Care Campaign

NHS Norfolk and Waveney has launched the Support Primary Care campaign to help raise the profile of Primary Care services and support patients to understand how they can get the best from these services.

Like other areas across the country, many people in Norfolk and Waveney may find themselves turning to their General Practice because they don't always know where to go for help.

Sometimes this is because of a lack of awareness of what services exist, which health and care professionals form part of the multi-disciplinary practice team and what services can help them with their needs. The campaign aims to improve that.

The aim of this campaign is to make it easier and quicker for patients to understand what services are available to help them based on their health needs, and to help patients to understand how they can get the best from these services.

The campaign is for all primary care contractors, starting with General Practice, and will be expanded to provide more information about Pharmacy, Optometry and Dentistry in due course.

Support Primary Care - Norfolk & Waveney Integrated Care System (ICS (improvinglivesnw.org.uk)

Support Primary Care Campaign

The campaign for Supporting General Practice currently focuses on five key areas, with more work planned for later in the year:

Choosing the right service
Providing patients information on the different services available to them and signposting to the types of illness that each service can provide treatment or advice

Meet the General Practice team
Supporting patient education around the different roles working within general practice, how they work together as one practice team, and the types of conditions each member of staff can help to manage

Self-care
Supporting patient education around the types of illnesses that do not normally need medical care or prescribed treatment or how to access further advice from the community pharmacy team and further information on preventing ill health in the longer term

Accessing Primary Care services
Providing patients information on how they can access each of the primary care services and for general practice, promoting the use of the NHS app and use of online consultations to manage routine requests to the practice

Let's work together
Asking patients for their support in working together so that both patients and staff can have positive experiences within general practice

Support Primary Care Campaign

The campaign is promoted on the following channels:

- Norfolk and Waveney ICS social media channels (Facebook, Instagram, LinkedIn, including paid-for ads and regularly scheduled posts)
- Bespoke GIFs developed for different general practice team members highlighting the illnesses they can support patients with
- Norfolk and Waveney ICS website – home page banner and dedicated campaign pages
- Printed advertisements in local newspapers
- Digital campaign materials shared with 105 GP practices in Norfolk and Waveney and PCN colleagues, and regular reminders provided in the ICB's weekly GP newsletter
- Laminated A3 posters promoting zero tolerance to abuse, and A5 Self Care leaflets distributed to all GP practices
- Laminated A3 posters distributed to all pharmacies, promoting zero tolerance to abuse

The campaign uses bespoke local materials whilst also making use of national campaign materials such as the NHS General Practice Team Campaign and General Practice Access Routes which support the aims of this campaign and provides extra flexibility in delivering core campaign messages.

A campaign hashtag **#SupportPrimaryCareNW** is used on digital materials to bring all the different materials together and signposts to more information on the Support Primary Care campaign webpages.

Improving lives **together**

Norfolk and Waveney Integrated Care System

Integrated Care Board Finance Report

October 2023

(Month 07, 2023-24)

ICB Board – Part One: 28th November 2023

Contents

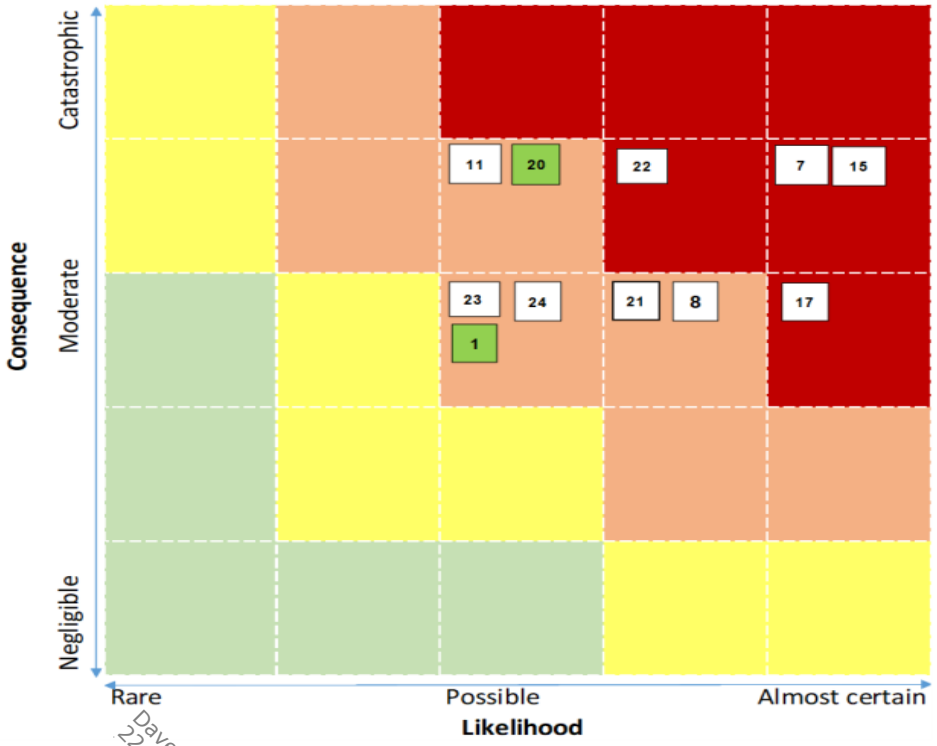
1. Executive Highlights

- This report represents the October 2023 year-to-date position of the ICB as part of the 2023/24 Financial Year.
- The ICB has reported a **Year-to-Date break-even position**, which is in line with the plan submission
- The **Forecast out-turn position is break-even**, in line with plan, but includes some offsetting variances, the major items being:
  - Full delivery of 17m of Pipeline Efficiencies. As part of the closing the gap exercise, £17.0 of pipeline efficiencies were identified of which £13.5m have been progressed to delivery stage – leaving £3.5m still being finalised (this balance is forecast to be delivered but with a commensurate risk included). The £17m achievement is spread across all directorates (albeit it on different spread than the original unidentified efficiency targets)
  - £(11.7)m Continuing HealthCare (CHC) pressures as result of increases in High Costs Learning Disability packages and Fast Track packages (excludes unidentified efficiency)
  - £(3.3)m Prescribing Pressure due to the Edoxaban Prescribing Rebate loss, national stock pressures, diabetes prescribing and increase in Oxygen Costs
  - £12.3m of combined smaller favourable benefits to include Prior Year, contract negotiations and other planning benefits.
- **The Underlying position at M06 is £(89.8)m deficit**, a deterioration of £(32.5)m against the £(57.4)m financial plan for 2023/24. £(17.5)m relates to delivery of efficiencies in a Non-Recurrent Way, and a further £(21.1)m due to Operational Pressures in CHC, Acute Independent Sector, Prescribing and Mental Health Packages. This is a further deterioration of £(3.1)m against M06 underlying deficit of £(86.6)m.
- The **2023/24 Financial Plan included £75m of unmitigated risks** in-line with NHSEI guidance relating to efficiency delivery, investment slippage, service demand, inflationary pressures beyond funding, and corporate pay costs for the Re-Organisation.
- As at **M07 the £75m planning risk is reassessed as being £26.3m** net risk on a probability basis, which is excluded from the forecast. This risk has decreased from M06 (£27.6m). Remaining risks include the continued operational pressures in CHC, Prescribing and Acute spend, along with risk to delivery of the efficiency schemes now identified.

2. 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.

Kev: ■ = Worsening Risk □ = Stable risk ■ = Improving risk



Financial Strategic Risks	Ref.	Details	Tolerated Risk appetite	Aug-23	Sep-23	Oct-23
Achievement of Plan	1	Achieve the 2023/24 financial plan **(BAF 11)**	12	16	16	12
	15	Underlying deficit position **(BAF 11A)**	12	20	20	20
	17	Inflationary pressures	9	15	15	15
	20	Impact of new prescribing guidance	8	16	16	12
	21	Impact of Direct Commissioning transfer	9	12	12	12
	22	Re-Organisation: Running Costs Reduction, Increased Pay Costs and Cost of Delivery	9	12	16	16
	23	Debt and Working Capital Management (NCC)	6	9	9	9
Demand and Capacity	7	Continuing Health Care demand growth	9	20	20	20
	11	ERF: RTT backlog and Acute demand management	9	12	12	12
	24	Patient Choice (Learning Disabilities & Autism)	9	9	9	9
Efficiency	8	Efficiency, transformation development/delivery	8	12	12	12

Extreme	5	6	4
High	6	5	7
Moderate	0	0	0
Low	0	0	0
Total Risks	11	11	11

As at M07 (October) 11 Key Financial Risks remain open. Against M06(September) two risks have deescalated from Extreme to High.

- Risk 1 Delivery of 2023/24 Financial Plan recognises the non-recurrent benefit of retaining Dental Underspends as part of the wider Industrial Action (£800m national) funding arrangement and conditions.
- Risk 20 Impact of Prescribing Guidance recognises the availability issues of the recommended drugs which has non-recurrently lessened the impact for 2023/24.

All other risks remain consistent to those reported last month.

Whilst risk FinCOM 15 'Underlying Deficit' risk-scoring remains consistent, the actual reported underlying position has deteriorated further which is a cause for concern. The ICB will commence a financial strategy and recovery plan when the Medium-Term Financial Plan (MTFP) has concluded.

3 Statement of Financial Position (SOFP)

The Statement of Financial Position presents the aggregate closing position of the ICB as at 31st October 2023.

Non Current assets:
IFRS16 was implemented in April 2022. The non-current assets balance includes the right of use assets for the lease of the premises at King's Lynn and Norfolk County Council. Corresponding entries are also included in both current and non-current Lease Liabilities. The lease for Castle Quarter (£0.1m) is no longer recognised as it has been taken over by another NHS body.

Current assets:
Total current assets have increased since year end, driven principally by aged debtors and prepayments. The £12.2m balance is made up of aged debtors of £4.9m (including NHSE £2.1m and NCC £1.7m), net of a provision against this balance of £1.6m and prepayments and accrued income of £8.9m.

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 decreased by £56m since year end, driven principally by ICB and system invoice accrual timing. The £170m balance is made up of trade creditors of £4m, Prescription Pricing Authority accruals of £18m, dental accruals of £5m, payroll costs including GP pensions of £3m, deferred income of £11m, prior year accruals of £48m and ICB and system invoice accruals of £81m.

Provisions include legal, staffing and estates costs.

As part of the improvement in working capital with Norfolk County Council, outstanding non-PO transactions stand at £8.3m. Of this £3.2m relating to BCF was settled on 2nd November 2023.

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 month's 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 month's commitment at a time.

NHS NORFOLK & WAVENEY ICB STATEMENT OF FINANCIAL POSITION	Position as at 31/03/23	Position as at 30/09/23	Position as at 31/10/23
ASSETS EMPLOYED			
Non-Current assets			
Right-of-use Assets	1,152	1,005	1,005
Accumulated Depreciation	(147)	(236)	(252)
Total non-current assets	1,005	769	753
Current assets			
Trade and Other Receivables	8,676	10,628	12,163
Cash and Cash Equivalents	1,649	1,890	518
Total current assets	10,325	12,518	12,681
Current liabilities			
Trade and Other Payables	(225,918)	(168,980)	(169,671)
Lease Liabilities	(219)	(191)	(191)
Provisions for liabilities and charges (including non-current)	(4,732)	(4,732)	(4,732)
Total current liabilities	(230,869)	(173,903)	(174,594)
Long Term liabilities			
Non-Current Payables	(686)	(686)	(686)
Non-Current Lease Liabilities	(775)	(568)	(559)
Total non-current liabilities	(1,461)	(1,254)	(1,245)
Net assets employed	(221,000)	(161,870)	(162,405)
FINANCED BY TAXPAYERS EQUITY			
General fund	(221,000)	(161,870)	(162,405)
Total taxpayers equity	(221,000)	(161,870)	(162,405)

4. ICS Financial Summary

Revenue position:

The ICS reported position for M7 is,
- £25.6m Year to Date deficit, adverse to plan by £13m.
- Full year Forecast Breakeven, on plan.

The most significant variances are as follows:
- NNUH is £4.9m adverse to plan, mainly due to the impact of Industrial Action on pay costs, lost activity and additional independent sector capacity support to deliver lost activity.
- QEH is £5.5m adverse to plan due to slippage in delivery of the CIP programme; lost income and additional costs due to Industrial Action; pay pressures due to sickness, and additional capacity costs as a result of RAAC issues.
- JPUH is £2.7m adverse to plan due to the impact of Industrial Action on pay, impact of lost activity on income and impact on transformational saving schemes..

Revenue surplus/(deficit) £m	Month 7 YTD			Forecast Outturn		
Organisation	Plan	Actual	Variance	Plan	Actual	Variance
JPUH	(1.1)	(3.8)	(2.7)	0.0	0.0	0.0
NNUH	(3.1)	(8.0)	(4.9)	0.0	0.0	0.0
QEH	(3.7)	(9.2)	(5.5)	0.0	0.0	0.0
NSFT	(4.8)	(4.8)	0.0	0.0	0.0	0.0
NCH&C	0.2	0.2	0.0	0.0	0.0	0.0
Provider Subtotal	**(12.6)**	**(25.6)**	(13.0)	**0.0**	**0.0**	0.0
ICB	(0.0)	0.0	0.0	0.0	0.0	0.0
N&W System Total	**(12.6)**	**(25.6)**	(13.0)	**0.0**	**0.0**	0.0

Capital position (System Capital Delegated Expenditure Limit – System CDEL):

The ICS reported position for M7 is,
- £34.2m spend against a plan of £41m, an underspend of £6.8m.
- Full year Forecast broadly to plan.
- Nearly all providers have a YTD underspend against plan, this is mainly due to slippage/delays in project roll out and RAAC schemes.
- NSFT forecast a £3.8m underspend which has nearly all been redistributed amongst system partners, this redistribution is showing as overspend forecasts at the other providers. Alongside this, some extra RAAC allocated is not yet included in provider plans. When considering both of these, forecast outturn is expected to be broadly to plan.

System CDEL	Month 7 YTD			Forecast Outturn		
Organisation	Plan	Actual	Variance (Under)/Over	Plan	Actual	Variance (Under)/Over
	£m	£m	£m	£m	£m	£m
JPUH	8.8	5.3	(3.5)	14.8	15.2	0.4
NNUH	7.2	6.0	(1.2)	14.6	15.5	0.9
QEH	18.3	17.8	(0.5)	31.7	40.1	8.4
NSFT	4.5	2.8	(1.7)	12.6	9.4	(3.2)
NCH&C	2.1	2.3	0.2	4.8	7.3	2.6
Provider Subtotal	**41.0**	**34.2**	**(6.8)**	**78.5**	**87.6**	**9.0**
From NSFT - To be distributed	0.0	0.0	0.0	0.0	0.2	0.2
QEH RAAC - Plan not in PFR	0.0	0.0	0.0	7.0	0.0	(7.0)
NCHC RAAC - Plan not in PFR	0.0	0.0	0.0	2.3	0.0	(2.3)
Total Adjustments	**0.0**	**0.0**	**0.0**	**9.4**	**0.2**	**(9.1)**
N&W System Total	**41.0**	**34.2**	**(6.8)**	**87.9**	**87.8**	**(0.0)**

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: 10

Subject:	**Norfolk Local Health Resilience Partnership (LHRP) NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR) annual assurance process for 2023/24**
Presented by:	**Steven Course, Director of Finance, Accountable Emergency Officer (AEO) NHS Norfolk and Waveney ICB**
Prepared by:	**Grant Rundle, EPRR Lead NHS Norfolk and Waveney ICB**
Submitted to:	**NHS Norfolk and Waveney ICB Board**
Date:	**28 November 2023**

Purpose of paper:

To present the Board with the Norfolk Local Health Resilience Partnership (LHRP) NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR) annual assurance process for 2023/24 for approval.

Executive Summary

EPRR annual assurance process 2023/24

As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of NHS-funded services must show they can effectively respond to major, critical and business continuity incidents while maintaining services to patients.

NHS England has an annual statutory requirement to formally assure its own and the NHS in England's readiness to respond to emergencies. To do this, NHS England asks commissioners and providers of NHS-funded care to complete an EPRR annual assurance process.

This report provides a summary of the core standards annual assurance process for Norfolk Local Health Resilience Partnership (LHRP).

Report

Recommendation to the Board:

The Board is asked to approve the contents of this paper.

Key Risks	
Clinical and Quality:	Risk to the safety of patients and public if statutory civil protection duties are not fulfilled. Failure to fulfil duties could have an impact on the quality of clinical services.
Finance and Performance:	Risk of failure to comply with ICB statutory duties, with the Civil Contingencies Act 2004 and with NHS England's EPRR requirements.
Impact Assessment (environmental and equalities):	None
Reputation:	Risk to organisational reputation resulting from failure to respond in an emergency and to recover business as usual functions.
Legal:	As a ICB we must comply with relevant legislation and guidance. (see reference documents)
Information Governance:	Failure to ensure all actions are taken with regards to IG during an incident could result in legal challenge.
Resource Required:	EPRR Lead and EPRR Support Officer
Reference document(s):	Civil Contingencies Act 2004 (legislation.gov.uk) NHSE Emergency preparedness resilience and response EPRR annual assurance process for 2023-24 letter May 2023.
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Governing Body Assurance Framework	N/A

GOVERNANCE

Process/Committee approval with date(s) *(as appropriate)*	N/A

1. **NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR) annual assurance process for 2023/24.**

1.1 Purpose

This report provides a statement of assurance for Norfolk Local Health Resilience Partnership of the requirements of the NHS Core Standards for EPRR Annual Assurance process for 2023/24.

1.2 Process

Norfolk LHRP organisations were asked to undertake a self-assessment against individual core standards relevant to their organisation type and rate their compliance for each. This was then used to inform the organisation's overall EPRR annual assurance rating.

A peer review session was conducted to capture best practice and any challenges encountered. This was an open and honest forum for all attendees.

Organisations were required to submit their completed self-assessment to NHS Norfolk and Waveney ICB and to take part in a confirm and challenge session to gain confidence with the assurance ratings. Additionally, NHS England regional EPRR conducted a similar confirm and challenge session with NHS Norfolk and Waveney ICB's self-assessment.

A collated Norfolk LHRP assurance return was submitted to the NHS England regional EPRR team on 10 November 2023.

1.3 NHS Core Standards for EPRR

The NHS Core Standards for EPRR are the requirements commissioners and providers of NHS-funded services must meet. These core standards are the basis of the EPRR annual assurance process. Commissioners and providers of NHS-funded services must assure themselves against the core standards.

The applicability of each core standard is dependent on the organisation's function and statutory requirements. Each organisation type has a different number of core standards to assure itself against. The NHS core standards for EPRR cover 10 core domains:

1. governance
2. duty to risk assess
3. duty to maintain plans
4. command and control
5. training and exercising
6. response
7. warning and informing
8. co-operation
9. business continuity
10. chemical biological radiological nuclear (CBRN) and hazardous material (HAZMAT

1.4 EPRR Core Standards 2023/24

The compliance level for each standard is defined as:

Compliance Level	Compliance definition
Fully Compliant	Fully compliant with core standard.
Partially Compliant	Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan is in place to achieve full compliance within the next 12 months
Non-compliant	Not compliant with the core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months

An overall assurance rating is assigned based on the percentage of NHS Core Standards for EPRR which the organisation is assessed as being 'Fully Compliant' with. The thresholds for each assurance rating are:

Overall EPRR assurance rating	Criteria
Fully Compliant	The organisation if fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial Compliance	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial Compliance	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards.
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards.

1.5 Assurance levels summary

The outcomes of the Norfolk LHRP overall assurance ratings for EPRR Core Standards 2023/24 are:

Organisation	2023/24
NHS Norfolk & Waveney ICB	Substantial Compliance
JPUH NHS Foundation Trust	Substantial Compliance
NNUH NHS Foundation Trust	Substantial Compliance
QEHKL NHS Foundation Trust	Partial Compliance
Norfolk Community Health and Care NHS Trust	Substantial Compliance
Norfolk and Suffolk NHS Foundation Trust	Substantial Compliance
East Coast Community Healthcare CIC	Substantial Compliance
ERS Medical	Non Compliance

All Norfolk LHRP providers recognise where there are core standards for which they are not fully compliant with. Actions have been identified with the aim of achieving a fully compliant status. The LHRP working group will continue to provide a collective and safe environment whereby organisations are supported in undertaking and completing these actions.

Note - As a regional service, the East of England Ambulance Service Trust submit their annual assurance return through the Suffolk LHRP. Additionally, IC24 submit their return through Essex LHRP, and Cambridgeshire Community Services NHS Trust through Cambridgeshire LHRP. Similarly, these organisations have action plans for those core standards which are not fully compliant.

East of England Ambulance Service Trust	Substantial Compliance
Integrated Care 24	Substantial Compliance
Cambridgeshire Community Services NHS Trust	Partial Compliance

1.6 Deep Dive

The 2023/24 EPRR annual deep dive focused on responder training.

The outcome of the deep dive will be used to identify areas of good practice and further development whilst seeking additional assurance in this area of the core standards and guide organisations in the development of local arrangements.

The deep dive process does not contribute to the overall assurance ratings for organisations. However, each organisation was assessed as either Fully Compliant or Partially Compliant with each of the deep dive standards.

1.7 Areas of EPRR good practice

The annual core standards assurance documentation was cascaded by NHSE early for 2023. This was welcomed to extend the period for organisations to action, collate the self-assessments and conduct confirm and challenge sessions where necessary. This should continue for future assurance returns.

An LHRP EPRR peer review session was a positive addition to the process to explore how colleagues support each other with the core standards assurance requirements, along with capturing best practice and any challenges encountered. This was an open and honest forum for all attendees. It was noted that time was not sufficient, despite a full afternoon scheduled, and the intent would be to review this for next year.

1.8 Common challenges/issues

All organisations reflected that the continued response to Industrial Action (IA) during 2023 had a detrimental impact on EPRR related workstreams. This has directly impacted on core standard compliance levels. Examples of comments from organisations included:

– The continued response to Industrial Action (IA) during 2023, and increasing EPRR workstreams, has been a challenge while looking to prioritise the need of the core standards process. IA during the planned period of core standard confirm and challenge sessions for the LHRP necessitated the delay of this process being undertaken.

- With more and more information coming through the EPRR route with limited resource, and coupled with IA, it became an even a bigger challenge to keep everything up to date and meet deadlines.

- The core standards process was required during exceptional operational pressures which has include the concurrent incident response to multiple Industrial Action periods. There seems to have been no allowances for the fact we are not BAU and have not been for some time. The training for all Trusts has had to take a back seat and the ability to conduct regular exercising has been impacted.

- The main bulk of the core standards work is also undertaken during the summer period of leave, and in the current climate the need to ensure staff are taking time off is important due to wellbeing and morale of the protracted IA response. This compresses the core standard timeline even more for the staff who are ultimately conducting the front-end work of assurance, i.e. EPRR resources.

- Recognise this is not only limited to EPRR as most areas under pressure, but core standards plus IA + actual change-making work such as exercises and BCP support has been a serious challenge to balance with limited EPRR resource.

EPRR resourcing within organisations continues to be a factor and there are different interpretations of what is acceptable to fulfil requirements. This links into a wider piece of work required to benchmark and map fully the range of workstreams necessary to adhere to and contribute to organisational, ICS, LRF, NHSE Regional & National needs.

The availability of trained loggist support in terms of numbers of staff, as well as access 24/7 to comply with core standards, is of concern. All organisations have had difficulty in maintaining a sufficient pool of appropriately trained individuals.

1.9 Norfolk LHRP considerations for EPRR improvement/development

An LHRP training needs analysis session to be scheduled to review the extent of training requirements for providers. This will allow for a joint understanding of needs to allow for a system approach in delivering focussed EPRR training locally.

A recommendation from last year's core standards process was to work collaboratively in reviewing plans/documents such as policy statements, EPRR/Business Continuity Plans, EPRR committee ToR etc. The intent was to provide commonality across all organisations and develop shared understanding of EPRR core standards. Unfortunately, due to the protracted response required from all organisations to Industrial Action during 2023, it has not been possible to undertake this activity. Therefore, the objective is for this to be undertaken during 2023/24. This will also contribute to the aspiration of core standards assurance being a continued process throughout the year, instead of an undertaking during a fixed period.

A common approach for the recruitment and availability of loggist support should be taken through the LHRP Executive to establish an agreed process that can be instigated across the ICS

1.10 Next Steps

Norfolk LHRP organisations will build upon the close working relationships of the EPRR leads in supporting organisations in attaining a Fully Compliant status. A review of the organisational core standard actions will be conducted within the regular LHRP working group meetings. A summary report will be provided to the quarterly Norfolk LHRP Executive meetings. This process will enable the LHRP to continue to share good practice and maintain a consistent approach across the system.

To:
- NHS Accountable Emergency Officers
- ICB Accountable Emergency Officers
- NHS England:
  - Regional Directors
  - Regional Directors of Performance and Improvement
  - Regional Directors of Performance
  - Regional Heads of EPRR
- LHRP co-chairs

cc.
- Mike Prentice, National Director for Emergency Planning and Incident Response
- NHS England Business Continuity Team
- CSU managing directors
- Clara Swinson, Director General for Global and Public Health, Department of Health and Social Care
- Emma Reed, Director of Emergency Preparedness and Health Protection Policy Global and Public Health Group, DHSC

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

23 May 2023

Dear colleagues,

Emergency preparedness, resilience and response (EPRR) annual assurance process for 2023/24

Many thanks to you and your teams for your continued leadership and focus on the delivery of patient care during what has been another challenging year. Amongst the backdrop of a number of concurrent issues, not least the ongoing industrial action, whilst delivering a major recovery plan for urgent and emergency care service, the ability of the NHS to remain resilient and responsive over a sustained period is due to our collective commitment to emergency preparedness, resilience and response (EPRR).

NHS England is responsible for gaining assurance on the preparedness of the NHS to respond to incidents and emergencies, while maintaining the ability to remain resilient and continue to deliver critical services. This is achieved through the EPRR annual assurance process.

The process last year returned us to many of the previous mechanisms following a reduced process in the previous years, due to demands on the NHS. It was also the first time since the introduction of the Health and Care Act 2022 which established Integrated Care Boards as Category 1 responder organisations in the CCA (2004) and as local health system leaders. It is hoped that this year's process will build on these experiences by developing robust local processes for undertaking organisational self-assessments against the core standards and agree the processes to gain confidence with organisational ratings.

This letter notifies you of the start of the 2023/24 EPRR assurance process and the initial actions for organisations to take.

Core standards

The NHS core standards for EPRR are the basis of the assurance process. This year Domain 10 (CBRN) of the core standards have been reviewed and will also incorporate updated interoperable capabilities standards. The refreshed core standards can be found in the NHS core standards for EPRR self-assessment tool.

You are asked to undertake a self-assessment against the individual core standards relevant to your organisation type and rate your compliance for each.

The compliance level for each standard is defined as:

Compliance level	Definition
Fully compliant	Fully compliant with the core standard.
Partially compliant	Not compliant with the core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan is in place to achieve full compliance within the next 12 months.
Non-compliant	Not compliant with the core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.

Deep dive

Following key themes and common health risks raised as part of last year's annual assurance process, the 2023/24 EPRR annual deep dive will focus on EPRR responder

training. Training is a fundamental element of embedding resilience within organisations as part of the cycle of emergency planning.

The deep dive questions are applicable to those organisations indicated in the NHS core standards for EPRR self assessment tool.

The outcome of the deep dive will be used to identify areas of good practice and further development whilst seeking additional assurance in this area of the core standards and guide organisations in the development of local arrangements.

Organisational assurance rating

The number of core standards applicable to each organisation type is different. The overall EPRR assurance rating is based on the percentage of core standards the organisations assess itself as being 'fully compliant' with. This is explained in more detail below:

Organisational rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

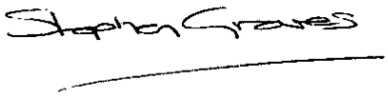
Action to take/next steps:

- All NHS organisations should undertake a self-assessment against the 2023 updated core standards (attached) relevant to their organisation. The outcome from this should then be taken and discussed at a public board or, for organisations that do not hold public boards, be published in their annual report.
- ICBs are required to work with their commissioned organisations and LHRP partners to agree a process to gain confidence with organisational ratings and provide an environment that promotes the sharing of learning and good practice. This process should be agreed with the NHS England regional head of EPRR.
- NHS England regional heads of EPRR and their teams are to work with ICBs to agree a process to obtain organisation-level assurance ratings and provide an environment that promotes the sharing of learning and good practice across their region.

- NHS England regional heads of EPRR are to submit the assurance ratings for each of their organisations and a description of their regional process to myself before Friday 29 December 2023.

If you have any queries, please contact your ICB EPRR Lead or regional head of EPRR in the first instance.

Yours sincerely,



Stephen Groves
Director of NHS Resilience (National)
NHS England

Norfolk and Waveney
Integrated Care Board

Agenda item: 11

Subject:	**Review of the Governance Handbook**
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:	**28 November 2023**

Purpose of paper:

To propose amendments to Governance Handbook for Board approval.

Executive Summary:

Introduction
The ICB's Governance Handbook has been reviewed and the following changes are proposed:

Sections 1 to 4
No changes apart from minor correction of typos.

Section 5 - Scheme of Reservation and Delegation
Added line to section on decisions and functions delegated by the Board to individual Board Members and employees that the Deputy Chair is Hein van den Wildenberg.

Sections 6 to 12
No changes apart from minor correction of typos.

Changes to Committee's Terms of Reference
Changes have been made to the following committees as indicated below.

Appendix A - Integrated Care Partnership
This is a statutory committee of the ICB and Norfolk County Council and Suffolk County Council. There have been changes to the Cabinet in Norfolk County Council with a Cabinet Member for Adult Social Care and a Cabinet Member for Public Health and Wellbeing. It was therefore necessary to make amendments to the membership and titles of the Cabinet Members contained within the Terms of Reference. As a result, these changes were agreed at the last Integrated Care

Partnership Board meeting on the 27 September 2023 and are attached at **Appendix 1.**

Appendix B - Audit and Risk Committee
It is proposed that the Committee's terms of reference are updated to provide for broader membership of the Committee with the Board member for VCSE becoming a member. Amended wording for the membership section of the Terms of Reference are therefore:
Members of the Committee will be:

- Non-Executive member with a lead for Audit and Risk (Chair)
- A minimum of one further ICB Board Non-Executive member in addition to the Chair
- Any further members of the Committee need not be ICB Board members

If approved, these changes will be included in Version 5 of the Governance Handbook which will be published on the ICB's website.

Recommendation to the Board:

To not and approve the changes to the Governance Handbook.

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 1

Norfolk and Waveney Integrated Care Partnership (ICP)

Terms of Reference and Procedure Rules

1. Context and Role of the Integrated Care Partnership

The role of the Integrated Care Partnership (ICP) in Norfolk and Waveney is to promote the close collaboration of the health and care system, building on the existing Norfolk Health and Wellbeing Board and other partnerships with the expanded geography that includes Waveney, to ensure better health and care outcomes for all our residents.

It provides a forum for stakeholders to come together as equal partners to discuss and resolve crosscutting issues. The ICP is a statutory committee of both the Integrated Care Board and Norfolk and Suffolk County Council's under the Health and Care Act 2022, it plays a central role in the planning and improvement of health and care in Norfolk and Waveney and will support place-based partnerships**.**
It drives and enhances integrated approaches and collaborative behaviours at every level and promotes an ethos of working in partnership with people and communities, and between organisations to address challenges that the health and care system cannot address alone.

Together, the ICP will generate an Integrated Care Strategy to improve health and care outcomes and experiences for our residents, for which all partners will be accountable.

2. Principles

The Norfolk and Waveney ICP will operate under these guiding principles:

1. Partnership of equals – to find consensus and make decisions including working though difficult issues, where appropriate.
2. Collective model of accountability – partners hold each other mutually accountable for shared and individual organisational contributions to objectives.
3. Improving outcomes for communities – including improving health and wellbeing, supporting people to live more independent lives, reducing health inequalities, and tackling the underlying social determinants.
4. Collaboration and integration – a culture of broad collaborations and integration at every level of the system to improve outcomes and reduce duplication and inefficiency.
5. Co-production and inclusivity – create a learning system which makes decisions based on evidence and insight.

3. Membership

The Membership of the ICP mirrors the existing Norfolk Health and Wellbeing Board, with additional membership to consider Waveney and place partnerships. Whilst it is important for the ICP to engage with a wide range of stakeholders and understand the differing viewpoints across the system and communities, membership will be kept to a productive level.

The membership for the Norfolk and Waveney ICP is attached at appendix A.

4. Appointment of Chair

The Chair of the ICP will be selected from among the members of the ICP and agreed jointly by the ICB, and Norfolk and Suffolk Local Authorities.

This appointment process will take place at the start of the meeting with an officer informing members of the need to elect a chair. Nominations will then be called and then seconded. If more than one nomination is received this will be dealt with by way of a majority vote of those present. If only one nomination is forthcoming the officer will then ask for any objections. If objections are received, a vote will take place which will be carried by a majority vote by those present. Once this process takes place and the nomination is passed, the Chair then commences the meeting. If the nomination is rejected, the whole process will commence again until agreement by majority of those present is reached.

The Chair will be appointed at the first meeting of the ICP and annually at a meeting of the ICP thereafter.

The Chair will be expected to:

- be able to build and foster strong relationships in the system
- have a collaborative leadership style
- be committed to innovation and transformation
- have expertise in delivery of health and care outcomes
- be able to influence and drive delivery and change

The ICP will appoint three Vice Chairs drawn from its membership. These will also be appointed at the first meeting of the ICP and annually thereafter.

5. Duties and Responsibilities

The ICP is a core part of the Norfolk and Waveney Integrated Care System, driving their direction and priorities.

The ICP will be rooted in the needs of people, communities, and places.
The ICP will help to develop and oversee population health strategies to improve health outcomes and experiences.

The ICP will support integrated approaches and subsidiarity.

The ICP will take an open and inclusive approach to strategy development and leadership, involving communities and partners to utilise local data and insights.

The ICP will work to embed safeguarding as everyday business across the Norfolk and Waveney Integrated Care System.

The ICP will develop an Integrated Care Strategy which the ICB, Norfolk and Suffolk County Council's will be required by law to have regard to when making decisions, commissioning, and delivering services.

The ICP is expected to highlight where coordination is needed on health and care issues and challenge partners to deliver the action required. These include, but are not limited to, helping

people live more independent, healthier lives and safer lives for longer, free from abuse and harm, taking a holistic view of people's interactions with services across the system and the different pathways within it, addressing inequalities in health and wellbeing outcomes; experiences and access to health services; improving the wider social determinants that drive these inequalities, including employment, housing, education environment, safeguarding, and reducing offending; improving the life chances and health outcomes of babies, children and young people, and improving people's overall wellbeing and preventing ill-health.
The ICP will provide a forum for agreeing collective objectives, enable place-based partnerships and delivery to thrive alongside opportunities for connected scaled activity to address population health challenges.

The ICP will set the strategic directions and workplans for organisational, financial, clinical, and informational integration, as well as other types.

6. Authority, Accountability, Reporting and Voting Arrangements

The ICP is tasked with developing a strategy to address the Health, Social Care and Public Health needs of their system, and of being a forum to support partnership working. The ICB and Local Authorities will have regard to ICP Strategies when making decisions. The ICP has no executive powers, other than those specifically delegated in these terms of reference. Individual members will be able to act with the level of authority and the powers granted to them by way of their constituent bodies' policies and make decisions on that basis. The ICP is able to discuss and agree recommendations for approval by the constituent members' statutory bodies. Its role is primarily one of oversight and collective co-ordination.

The aim will be for decisions of the ICP to be achieved by consensus decision making. Voting will not be used, except as a tool to measure support, or otherwise, for a proposal. In such a case, a vote in favour would be non-binding. The Chair will work to establish unanimity as the basis for all decisions.

Meetings of the ICP will be open to the public unless the matter falls within one of the categories of information, outlined in Appendix B. In this instance, the ICP may determine public participation will be withdrawn for that item.

Meetings will be live streamed and recorded, to be made available to the public afterwards.

Minutes of the meeting will be taken and approved at the next meeting of the ICP.
Final minutes will be made available on the websites of the ICB, Norfolk and Suffolk County Councils.

7. Attendance

Members are expected to attend 75% of meetings held each year. It is expected that members will prioritise these meetings.
Where it is not possible for a member to attend, they may nominate a named deputy to attend meetings in their absence and must notify the Secretariat, at norfolkandwaveneyicp@norfolk.gov.uk, who that person will be.
Members and those presenting must attend meetings in person.
The quorum, as described at section 8, must be adhered to for all meetings, including urgent meetings.

Attendance will be recorded within the minutes of each meeting and monitored annually.

8. Quorum

A quorum will be reached when at least the Chair and four members from different partnership organisations are present.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no recommendations for decision by the constituent member bodies may be taken.

In the unlikely event that a member has been disqualified from participating in the discussion of an item on the agenda, for example by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

Nominated deputies attending a meeting on behalf of a member may count towards the quorum.

9. Notice and Frequency of Meeting

Generally, meetings will be held four times a year but more frequently if required for specific matters.

As a matter of routine, an annual schedule of meetings will be prepared and distributed to all members. In other specific instances, or in cases where the date or time of a meeting needs to be changed, notice shall be sent electronically to members at least five working days before the meeting. Exceptions to this would be in the case of emergencies or the need to conduct urgent business.

An agenda and any supporting papers specifying the business proposed to be transacted shall be delivered to each member and made available to the public five working days before the meeting, potential exception being in the case of emergencies or the need to conduct urgent business. Supporting papers, shall accompany the agenda.

Secretariat support to the ICP will be provided by Norfolk County Council.

10. Public Questions

The public are entitled to ask questions at meetings of the ICP and questions should be put in writing and sent by email at least three working days before the meeting. If the question relates to urgent matters, and it has the consent of the Chair to whom the question is to be put, this should be sent by 4pm on the day before the meeting.

Questions should be sent to the Chair, at norfolkandwaveneyicp@norfolk.gov.uk, and will be answered as appropriate, either at the meeting or in writing.

The Chair on behalf of the ICP may reject a question if it:

a) is not about a matter for which the ICP has collective responsibility or particularly affects the ICP, or

b) is defamatory, frivolous, or offensive or has been the subject of a similar question in the last six months or the same as one already submitted under this provision.

Who may ask a question and about what

A person resident in Norfolk and Waveney, or who is a non-domestic ratepayer in Norfolk and Waveney, or who pays Council Tax in Norfolk and Waveney, may ask at a public meeting of the ICP through the Chair any question within the terms of reference of the ICP about a matter for which the ICP has collective responsibility or particularly affects the ICP. This does not include questions for individual ICP members where responsibility for the matter sits with the individual organisation.

Rules about questions:

Number of questions – At any public ICP meeting, the number of questions which can be asked will be limited to one question per person plus a supplementary. No more than one question plus a supplementary may be asked on behalf of any one organisation. No person shall be entitled to ask in total under this provision more than one question, and a supplementary, to the ICP in any six-month period.

Other restrictions – Questions are subject to a maximum word limit of 110 words. Questions that are in excess of 110 words will be disqualified. The total time for public questions will be limited to 15 minutes. Questions will be put in the order in which they are received.

Supplementary questions – One supplementary question may be asked without notice and should be brief (fewer than 75 words and take less than 20 seconds to put). It should relate directly to the original question or the reply. The Chair may reject any supplementary question which s/he does not consider compliant with this requirement.

Rules about responses:
The Chair shall exercise his/her discretion as to the response given to the question and any supplementary.

Not attending – If the person asking the question indicates they will not be attending the ICP meeting, a written response will be sent to the questioner.
Attending – If the person asking the question has indicated they will attend, response to the questions will be made available at the start of the meeting and copies of the questions and answers will be available to all in attendance. The responses to questions will not be read out at the meeting.

Supplementary questions – The Chair may give an oral response to a supplementary question or may require another Member of the ICP or Officer in attendance to answer it. If an oral answer cannot be conveniently given, a written response will be sent to the questioner within seven working days of the meeting.

Written response – If the person who has given notice of the question is not present at the meeting, or if any questions remain unanswered within the 15 minutes allowed for questions, a written response will be sent within seven working days of the meeting.

Rejection of a question

A question may be rejected if it:

a) is not about a matter for which the ICP has collective responsibility or particularly affects the ICP; or
b) is defamatory, frivolous, or offensive or has been the subject of a similar question in the last six months or the same as one already submitted under this provision; or
c) requires the disclosure of confidential or exempt information, as defined in the Access to Information Procedure Rules.

11. Managing Conflicts of Interest

A conflict of interest may be defined as “a set of circumstances by which a reasonable person would consider that an individual’s ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold”.

The ICP specifically recognises and acknowledges that its members have legal responsibilities to the organisations which they represent and that this may give rise to conflicts of interest being present. However, discussions at the meetings are to be focussed on the needs of the Norfolk and Waveney population and health and care. Therefore, members will not be excluded from engaging in discussions that will benefit the system as a whole.

Members of the ICP shall adopt the following approach for managing any actual or potential material conflicts of interest:

- To operate in line with their organisational governance framework for managing conflicts of interest/probity and decision making.
- For the Chair to take overall responsibility for managing conflicts of interest within meetings as they arise.
- To work in line with the ICS system objectives, principles, and behaviours.
- Members are to ensure they advise of instances where the register of members interest for the Norfolk and Waveney system requires updating in relation to any interests that they have.

In advance of every ICP meeting consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This action will be led by the Chair with support from their governance advisor.

At the beginning of each meeting of the ICP, members and attendees will be required to declare any interests that relate specifically to a particular item under consideration. If the existence of an interest becomes apparent during a meeting, this must be declared at the point at which it arises. Any such declaration will be formally recorded in the minutes for the meeting.

Elected members will be bound by their own codes of conduct and provisions for declaration of interests.

12. Working groups

To assist with performing its role and responsibilities, the ICP is authorised to establish working groups and to determine the membership, role, and remit for each working group. Any working group established by the ICP will report directly to it.

13. Other Boards

As a key part of the health and care system the ICP will seek active engagement and collaboration with the Norfolk and Waveney ICB, Norfolk and Suffolk Health and Wellbeing Boards, Place Boards, Health and Wellbeing Partnerships, Safeguarding Adults Boards, Safeguarding Childrens Partnerships, County Community Safety Partnerships, Autism Partnership Boards, and the Learning Disabilities Partnership Boards.

14. Review

The ICP will review these terms of reference at least annually or more regularly if needed, considering policy changes in respect of the Integrated Care System.

Appendix A

Membership of the Integrated Care Partnership

1. Borough Council of King's Lynn & West Norfolk
2. Breckland District Council
3. Broadland District Council
4. Cambridgeshire Community Services NHS Trust
5. Chair of the Voluntary Sector Assembly
6. East Coast Community Healthcare CIC
7. East of England Ambulance Trust
8. East Suffolk Council
9. Great Yarmouth Borough Council
10. Healthwatch
11. James Paget University Hospital NHS Trust
12. Norfolk Care Association
13. Norfolk Community Health & Care NHS Trust
14. Norfolk Constabulary
15. Norfolk County Council, Cabinet member for Adult Social Care
16. Norfolk County Council, Cabinet Member for Public Health and Wellbeing
17. Norfolk County Council, Cabinet member for Childrens Services and Education
18. Norfolk County Council, Director of Public Health
19. Norfolk County Council, Executive Director Adult Social Services
20. Norfolk County Council, Executive Director Children’s Services
21. Norfolk County Council, Leader (nominee)
22. Norfolk & Norwich University Hospital NHS Trust
23. Norfolk & Suffolk NHS Foundation Trust
24. Norfolk & Waveney ICB, Chair
25. Norfolk & Waveney ICB, Chief Executive Officer
26. North Norfolk District Council
27. Norwich City Council
28. Police and Crime Commissioner
29. Place Board Chairs for each Place Board area
30. Primary Care representatives (1)
31. Primary Care representatives (2)

32. Primary Care representatives (3)
33. Primary Care representatives (4)
34. Primary Care representatives (5)
35. Queen Elizabeth Hospital NHS Trust
36. South Norfolk District Council
37. Suffolk County Council, Cabinet Member for Adult Care
38. Suffolk County Council, Executive Director of People Services
39. Voluntary sector representatives (1)
40. Voluntary sector representatives (2)

Appendix B

Categories of Information

Information relating to any individual.
Information which is likely to reveal the identity of an individual.
Information relating to financial or business affairs of any particular person (including the authority holding that information).
Information relating to any consultations or negotiations, or contemplated consultations or negotiations, in connection with any labour relations matter arising.
Information relating to any action taken or to be taken in connection with the prevention, investigation, or prosecution of crime.

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:	**28 November 2023**

Purpose of paper:

To present the Board with a copy of the ICB's Board Assurance Framework (BAF) to assist the facilitation of discussions around risks impacting the ICB's ability to deliver its strategic objectives.

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:

- 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

The BAF has undergone significant review since the last board meeting in July this year 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 26 September 2023:

- **BAF08 Elective Recovery –** The mitigated risk score has decreased to 4x4=16. The risk actions, controls and mitigations detail the support for the proposed change

- **BAF10 EEAST Response Time and Patient Harms –** The mitigated risk score has increased to 5x4=20. The risk actions, controls and mitigations detail the support for the proposed change.

- **BAF11 Achieve the 2022/23 Financial Plan.** The mitigated risk score has increased to 3x4=12. The risk actions, controls and mitigations detail the support for the proposed change.

- **BAF13 Personal Data** – The mitigated risk score has decreased to 2x3=6. The risk actions, controls and mitigations detail the support for the proposed change.

- **BAF15 Staff Burnout** – The mitigated risk score has increased to 4x4=16. The risk actions, controls and mitigations detail the support for the proposed change.

- **BAF19 Discharge from inpatient settings** – The mitigated risk score has increased to 5x3=15. The risk actions, controls and mitigations detail the support for the proposed change.

- **BAF20 Industrial Action**. The mitigated risk score has increased to 4x4=16. The risk actions, controls and mitigations detail the support for the proposed change.

- **BAF21 Mortality Review** – The mitigated risk score has decreased to 4x4=16. The risk actions, controls and mitigations detail the support for the proposed change.

- **BAF22 Specialised Commissioning.** This is a new risk relating to the transfer of Delegated Specialised Services to N&W ICB from NHS England on 1 April 2024. The risk was approved by EMT for transfer to the BAF.

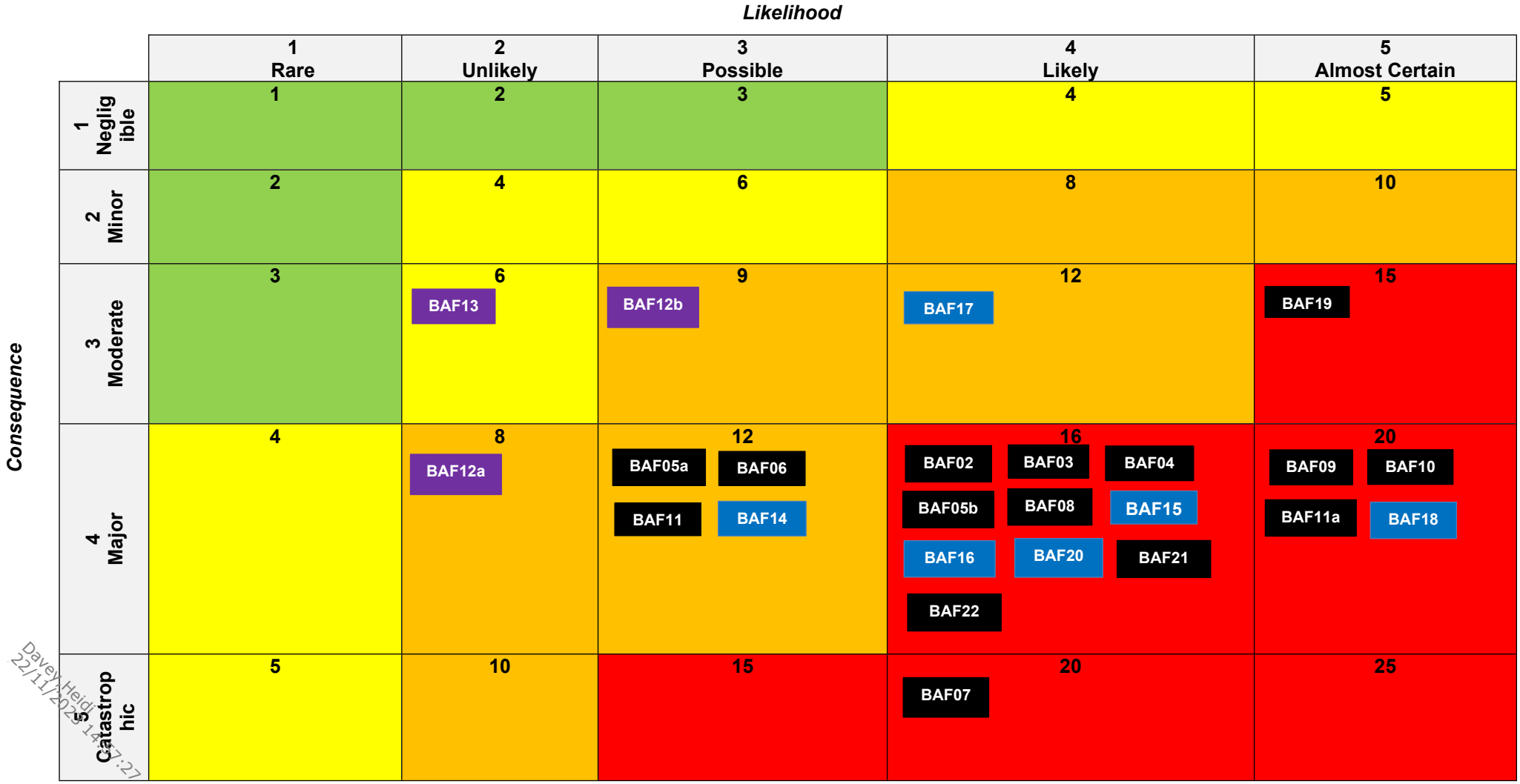
Recommendation to Board:

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



Norfolk and Waveney
Integrated Care Board

NHS Norfolk and Waveney ICB – Board Assurance Framework (BAF)

Version:	5	Date:	16 November 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	Date risk identified	Target delivery date	Score at target delivery	2023-2024 Monthly Risk Rating											
						1	2	3	4	5	6	7	8	9	10	11	12
BAF02	System Urgent & Emergency Care (UEC) Pressures	Mark Burgis	01/07/22	31/03/24	12	16	16	16	16	16	16	16					
BAF03	Providers in CQC Special Measures (NSFT)	Tricia D'Orsi	01/07/22	31/12/24	8	12	12	12	16	16	16	16					
BAF04	Timely cancer diagnosis and treatment	Dr Frankie Swords	01/07/22	31/03/24	8	9	16	16	16	16	16	16					
BAF05a	Barriers to Full Delivery of the Mental Health Transformation Programme (Adult)	Jocelyn Pike	01/07/22	31/03/24	8	12	12	12	12	12	12	12					
BAF05b	Barriers to Full Delivery of the Mental Health Transformation Programme (CYP)	Patricia D'Orsi	01/07/22	31/03/24	8	16	16	16	16	16	16	16					
BAF06	Health Inequalities and Population Management	Dr Frankie Swords / Mark Burgis	01/07/22	31/03/24	4	12	12	12	12	12	12	12					

BAF07	RAAC Planks	Steven Course	01/07/22	31/03/24	15	20	20	20	20	20	20	20					
BAF08	Elective Recovery	Dr Frankie Swords	01/07/23	31/03/24	12	16	16	16	16	20	20	16					
BAF09	NHS Continuing Healthcare	Tricia D'Orsi	01/07/23	31/03/24	9	16	16	16	16	20	20	20					
BAF10	EEAST Response Time and Patient Harms	Tricia D'Orsi / Mark Burgis	01/07/22	31/03/24	9	16	16	16	16	16	16	20					
BAF11	Achieve the 2023/24 Financial Plan	Steven Course	01/07/22	31/03/24	12	16	16	16	16	16	16	12					
BAF11a	Underlying Deficit Position	Steven Course	01/07/22	31/03/24	12	20	20	20	20	20	20	20					
BAF19	Discharge from inpatient settings	Tricia D'Orsi	25/10/22	31/03/24	6	15	15	12	12	12	15	15					
BAF21	Grant Thornton Mortality Review	Dr Frankie Swords	18/07/23	31/03/24	4				20	20	20	16					
BAF22	Delegation of 59 Specialised Services to N&W ICB from NHS England on 1 April 2024	Andrew Palmer	3/10/23	31/03/24	9							16					

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. This could lead to 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. In turn, this 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	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 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:

- **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

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

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: ○ **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. ○ **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. ○ **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. ○ **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. ○ **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 ○ **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:** ○ **Cohorting:** A range of cohorting measures are available at acutes to provide ED surge capacity and reduce waiting to handover at hospital. ○ **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. 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 to 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). • Position continues to improve with a reduction in escalation beds at the Acute hospitals and improvement in C1 and C2 ambulance response times. Ambulance handover into ED is showing early signs of improvement, however this needs to embed and sustain before further risk reduction.	

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
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 population (368 beds). This initiative will support Admissions Avoidance and Early Supported Discharge to meet the 76% A&E 4 hour target	A	31/03/24

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16	16	16	16	16	16	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**	**4**	**4**	**16**	**2**	**4**	**8**

Controls	**Assurances on controls**
• The report published on 28/04/22 gave an overall reduced rating of inadequate. The Trust was able to provide adequate assurance to mitigate the need for a Section 31 enforcement notice during the inspection. • The Trust's Improvement Plan is over seen by an Improvement Board with a focus on the areas set out in the section 29a letter and Must Do's issued in April 2022. Stakeholder engagement has been strengthened. Evidence Assurance Panel established with attendance by ICB MD and DoN. • Regular NHSE/I Oversight, and Assurance Group in place. Dedicated senior NHSE/I and ICB support has been taken up. • Staff engagement events have taken place across Trust sites and staff groups, with support from the Norfolk & Waveney and Suffolk ICBs. • Weekly internal Performance Board is driving progress. NHSE and ICB are working collaboratively to support the Trust. • Transformation plans continue to progress alongside Quality Improvement. • Strengthened leadership to support key clinical areas. • The ICB MH Strategic Commissioning Team are attending 'pillar' meetings around Culture, Leadership & Governance, Safety, Demand & Capacity and Service Offer. Each pillar is led by an NSFT Executive SRO, supported by an external consultant supporting delivery of the overarching improvement plan. ICB staff are participating in working groups. • ICB supporting Trust with data validation, completion of dashboard and South Norfolk community capacity pilot. • ICB attending Trust Quality and Safety Reviews (QSR) with frontline teams and working closely with NHSE on a governance review. • Evidence Assurance Panel is in place, chaired and supported by ICB Medical Director.	**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.

• 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. • High-level oversight of Grant Thornton actions in place. Bereaved families, Healthwatch and ICBs included. Norfolk HOSC has external oversight.	

Gaps in controls or assurances

- High levels of patient acuity are being reported. Capacity is not currently able to meet demand; particularly in the community.
- 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. This is improving but needs to embed.
- 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.
- Long term sustainability of improvements, which is required to move out of NOF4 status.
- Recent publication of the Grant Thornton Review of mortality reporting (see BAF 21). High-level oversight is in place, however there is still work required to ensure that the evidence of progress is shared and monitored consistently.
- The Trust has commenced a restructure of Care Groups and has had significant changes in senior leadership.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
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
21/08/23	First commissioners meeting held regarding oversight, governance and reporting arrangements against the Grant Thornton Mortality Action Plan. The Trust did not attend; this will be followed up.	B	30/09/23
14/08/23	NWICB is setting up a new contract, commissioning and quality meeting with the Trust. This will provide oversight of the sustainability of improvements.	A	30/11/23

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12	12	12	16	16	16	16					
Change	↓	→	→	↑	→	→	→					

BAF04

Risk Title	**Timely cancer diagnosis and treatment**
Risk Description	There is a risk that patients with cancer will not be diagnosed and treated as early as possible due to the multiple impacts of the pandemic. Delayed diagnosis and treatment can lead to poorer long-term outcomes for cancer patients as well as significant psychological distress to those waiting for treatment. There is clinical risk to patients on 62-day cancer pathway and other elective waiting lists with last minute cancellations to their surgery. Recent industrial action has also impacted negatively on current backlogs. Recent SIs have shown impact on patient outcomes. There is an ongoing perception of difficulty accessing healthcare which may also be impacting on patients help seeking behaviours

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
4	**4**	**16**	**4**	**4**	**16**	**2**	**4**	**8**

Controls	Assurances on controls
Controls: The Cancer Programme Board works in close partnership with regional cancer screening and North EOE Cancer Alliance, to: Optimise uptake and coverage of screening, provide fixed term transformation resource and support system transformation projects which expand diagnostic and treatment capacity and transform how care is delivered to improve timeliness and efficiency. This work feeds into the **Elective Recovery and Diagnostics Boards**. There is a unified prioritisation and harm review process of reviewing patients on waiting lists for possible harm, to ensure that elective capacity is used to deliver care to patients in order of clinical priority at all acute trusts. Also a quarterly presentation of anonymised key themes from cancer significant incidents at Cancer Programme Board to share learning. Implementation of C the Signs in Nov 23 will support patients being referred onto the most appropriate pathway	A local communication plan is in place to educate patients on worrying symptoms and encourage presentation to Primary Care. **Internal:** Quarterly reports re cancer screening backlogs and bi-monthly updates re transformation progress and operational cancer services restoration into Cancer Programme Board. Monthly update on Cancer Tiering to Elective Recovery Board. Escalation of performance issues to Performance Committee. Escalation of issues/challenges to Transformation Board. Monthly regional support meetings for Cancer Tier 1 trust which are also attended by the EOE North Cancer Alliance. **External**: PHE, NHSE Cancer Alliance.

Gaps in controls or assurances

- Changed help seeking behaviour for worrying symptoms led to a fall in the number of people coming forward and led to an increase in delayed presentations (EOE Cancer Alliances estimate of approx 600 missed cancer diagnoses). Challenge of workforce resilience/capacity to continue to meet the backlog demand, including administrative capacity/processes to safely manage backlogs and waiting lists, exacerbated by industrial action. Continued surges in 2ww demand with variable performance across providers and pathways. Little spare capacity to support mutual aid and complex surgery is provided by the NNUH as Cancer Centre.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
01/11/23	Cancer risk reviewed with system Medical Director. Propose to close this risk this month and replace with an updated risk: system failure to meet cancer waiting times standards	G	Replace with updated risk next month

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	9	16	16	16	16	16	16					
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	Emma Willey	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 in situ • Acting Director of Mental Health Transformation appointed to lead development of system collaborative, acts as MH SRO • 22/23 N&W Planning submission agreed by NHS England & Improvement • Finance & Planning working group meet monthly to drive robust financial arrangements and deliver planned MHIS investment • System commitment to increase knowledge skills and expertise and develop additional capacity through use of digital • MH Workforce 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 • Working in partnership with Norfolk and Suffolk Constabularies to implement a system wide collaborative approach to Right Care Right Person	**Internal:** SMT, EMT, Board **External**: N&W MH Strategic Oversight 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
- 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 talking therapies model – National NHSEI and HEE guidance is restrictive and does not allow local flexibility

- The ICB is going into restructure July 2023, Capacity and impact may be noted as the process progresses

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
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 Clinical Reference Group is central to initiating and sustaining positive change. Recent governance refresh to include Adult MH System collaborative established from April 2023.	G	31/03/24
29/04/22	MH Workforce Programme Manager in conjunction with AD Workforce Transformation and AD MH Transformation driving development of workforce dashboard, and transformation programme. Working with system partners to deliver the N&W MH workforce strategy.	G	31/03/24
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 to reflect difficulties reducing use of OAP beds and eradicating 12-hour breaches during a time of extraordinary demand and pathway pressures. Work is continuing across all areas.	A	31/03/24
20/10/22	Community Transformation: Working with Locality leads and GP Practices to implement the 'MH Integrated Care Interface'. The MHICI is a primary care-based MH Multi-disciplinary team, including professionals from different organisations (NSFT, NCC, VCSE and primary care) that work together to assess and direct people to the most beneficial service according to their need.	G	31/03/24
29/08/23	ICB Leads working in partnership with Norfolk and Suffolk Constabularies and delivered a Right Care, Right Person workshop on 29/06/23 from which a cross organisational working group has formed to implement RCRP transformation in Norfolk. Also working with Suffolk Constabulary and SNEE ICS to support Suffolk arrangements in Waveney and align where possible. National Partnership Agreement incorporating RCRP principles and operating model drafted aiming to embed learning and mitigate risks following rollout in Humberside.	G	31/01/25

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12	12	12	12	12	12	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
- All age Eating Disorder Strategy
- Established Children and Young Peoples System Collaboratives in Norfolk and Suffolk
- Working in partnership with Norfolk and Suffolk Constabularies to implement a system wide collaborative approach to Right Care Right Person

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, Children and Young People's System Collaborative

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.
- Lack of clarity regarding workforce capacity to deliver support at required levels.

- 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

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**
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	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	31/10/23
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 talking therapies offer for 16-25 to improve access, engagement and outcomes.	A	30/09/23
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	31/10/23
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	G	31/10/23
10/01/23	Collaborative working with Suffolk and Norfolk systems to introduce short breaks provision. Capital funding in use to develop estates	G	31/10/23
10/01/23	System planning to ensure alignment of provision in Waveney with Suffolk system colleagues. Task and finish group established	G	31/10/23
10/01/23	Engagement exercise commenced to revisit ambitions and transformation plan with Norfolk and Waveney stakeholders	G	31/10/23
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	31/10/23
11/07/23	Integrated Front Door established and taking referrals for mild to moderate need. Early data shows 27% of CYP have their needs met on first contact. Work continues to expand to all referrals in September. Stakeholder workshop planned for 11/07/23	A	01/10/23
11/07/23	Main provider supported to complete demand, capacity and process review of CYP waiting lists. Update 25/08/23 - review completed	G	01/9/23
11/07/23	Successful bid for NHSE regional funding to create mental health care navigator team – recruitment commenced. Potential delay due to organisational restructure Update 25/08/23 - delays in recruitment as awaiting sign off on Trac.	A	01/10/23
11/07/23	Collaborative working with local authorities to establish an integrated short stay facility using NHSE capital funding and joint funding from LA. Next steps to confirm revenue funding.	A	01/10/23
25/08/23	Integrated Front Door workshop completed. Recent staff changes within main provider place September implementation of full IFD at risk as advised no capacity to support. Further work planned to escalate to NSFT Executive	R	01/10/23
25/08/23	Waiting list size within main provider continues to increase. Staff vacancies within central youth team critical. Proposal from provider to declare business continuity. Trust undergoing organisational restructure so delays to replacing key leadership roles. Plan to escalate to NSFT Executive.	R	
25/08/23	Procurement of gender identity support completed, and contract awarded	G	

25/08/23	Procurement of eating disorder parent support completed, and contract awarded	G	
08/11/23	Procurement of youth pathway complete, and award of contract imminent	G	
08/11/23	Castle Green Integrated Intensive Day Support/Short Breaks Unit paper prepared and prioritisation matrix complete. Risks identified regarding financial implications.	R	31/12/23
08/11/23	CYP Collaborative continues to develop. System workshop scheduled for 15/12/23 to progress system working and opportunities for stakeholders to align resource	A	

Visual Risk Score Tracker – 2023/24												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	16	16	16	16	16	**16**	**16**					
Change	→	→	→	→	→	→	→					

BAF06

Risk Title	**Health inequalities and Population Health Management**
Risk Description	Health inequalities (HI) are avoidable, unfair and systematic differences in health between different groups of people, which impact on longer term health outcomes and a person's ability to access healthcare. Core20Plus5 is the NHS Health Improvement framework for tackling HI. Population health management PHM is a system that uses data to segment the population and identify groups of people at risk of poor outcomes or inequalities, and then to proactively address these with the aim of improving population health outcomes, reduce unwarranted variation and health and care inequalities. There is a risk that the ICB will not use PHM techniques to their full potential and not meet its statutory requirements to reduce health inequalities, and deliver the Core20Plus5 commitments. If this happens, specific groups of people will experience poor outcomes which could have been prevented.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Mark Burgis / Dr Frankie Swords	Patients and Communities	S Meredith	01/07/2022	31/03/2024

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

- Specialty advisors leading on CORE20PLUS5, HI, PHM and on HI in CVD.
- The NCC deputy DPH is now leading the ICB team to coordinate and lead this.
- PHM and addressing HI has been identified as a priority in our JFP.
- Plus groups now defined for N&W.
- 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 reports 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
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

- Duplication of effort, energy and resources at Place and system level – lack of coordination of all mechanisms to address inequalities, further alignment required with review underway
- Capacity and lack of data – 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.
- NHSE HI funding not ring-fenced to support emerging work programmes and respond to system priorities.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
31/10/23	Additional 2 days per week management support identified for HI (temporary pending re-structure)	B	Complete
31/10/23	Established assurance reporting to PH&I Board	B	Complete
31/10/23	Engagement events have commenced to support the development of the PHM strategy and ICS HI Framework for action (including wider determinants of health).	G	March 2024

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4		5	6	7	8	9	10	11	12
Score	12	12	12	12	12	12	12	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	**Assurances on controls**
• Trusts have robust plans in place to manage a possible incident; however these only cover immediate evacuation and not reprovision • Regional RAAC response plan is established • Regular surveys and assessments are being carried out to determine the severity of the issue and to identify and address signs of deterioration. • Region-wide scoping piece commissioned to look at ongoing service transition and recovery. • Current work ongoing to address issues found on inspection as issues identified. Each issue is separately risk assessed using NHSE led guidelines for 'Best Buy' hospitals and a RAACter Scale used to assess level of issue. • Legal position and recommendations provided by Browne Jacobson on ICB responsibilities should there be a catastrophic failure at either acute.	**Internal:** SMT, EMT, ICB Board **External:** ICS Boards, Estates, NHSE/I, Individual trust boards RAAC related exercises have been undertaken to provide assurance of plans and procedures in responding to an evacuation of a RAAC impacted trust. • Feb 22 - Exercise Farthing • Jun 22 – Exercise Walker • Nov 22 – Exercise Fox EPRR Core Standards incorporated a Deep Dive on health providers Evacuation and Shelter arrangements specifically due to the RAAC risk Funding has been secured to support the mitigation of RAAC within the two acute hospitals by implementing programmes of interim works to mitigate risk, and planned replacement of each hospital under the NHS new hospitals programme. Funding has been secured to demolish the storage facility within the community site by the end of 23/24. Storage has been displaced to other sites.

Gaps in controls or assurances

- Lack of approval of region-wide scoping piece prevents full evaluation and plan of service transition and recovery

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
05/06/23	QEH approved for New hospital	G	ongoing

Visual Risk Score Tracker – 2023/24												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	20	20	20	20	20	20	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 harm for individual patients resulting from prolonged waits for treatment.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Dr Frankie Swords	Quality & Safety	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

- The Elective Recovery Board meets bi-weekly to oversee all workstreams to improve performance and reduce harm.
- Each Provider has completed waiting list validation, all patients clinically prioritised.
- Unified process of clinical harm review and prioritisation in line with national guidance.
- Workstreams in place to expand capacity, share learning, maximise efficiency and reduce variation in waiting times, including through mutual aid, and to transform care pathways to accelerate elective recovery, each led by a chief operating officer or medical director.
- 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
- EMT agreement to commission elective capacity through independent sector providers.

Assurances on controls

The initial focus to clear all patients waiting 104 weeks or more across our system by 1 July 2022 was met with data confirmed by NHSEI.
Trusts are expected to ensure zero 65+ week waits for non-admitted patients by end Nov in order to ensure delivery of admitted March 2024 target. 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.
JPUH escalated to Tier 2 in June.
NNUH remains on Tier 1
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 and administrative resources to support validation and booking
- Critical incidents declared at trusts due to intense pressure on emergency
- Staffing challenges at the Trusts with consultant sickness and vacancies.
- JPUH reporting 4 x104wk waits for end of Oct: Gen Surg x2, Gynae & Ophthalmology corneal graft plus 157x 78-weeks breaches with Urology Gynae, ENT and T&O remaining the challenged specialties.
- NNUH projecting 397 78-week breaches for end of Oct with x344 due to capacity.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
18/10/23	Trusts expected to date all 65-week outpatients by end of Nov. PIDMAS process to launch 31.10.23. Providers are required to submit details of volumes of patients needing to be contacted to offer choice of provider by 20th Oct. ICB required to manage the requests if internal capacity not identified. Trusts working with ICB to transfer appropriate long wait patients to ISPs. Hip, Knee and Foot & Ankle patients being transferred. Mitigated risk reduced to 16 due to PIDMAS implementation, drive by hospital teams to date patients within an 8-week window and maximise ISP capacity.		

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16	16	16	16	20	20	16					
Change	→	→	→	→	↑	→	↓					

BAF09

Risk Title	**NHS Continuing Healthcare**
Risk Description	There is a risk that not all NHS Continuing Healthcare (CHC) funded packages will 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	Paul Benton	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**	**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.
- 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.
- Interim staff on secondment have been asked to extend the period of their secondment.

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 11/10/23, there are in excess of

200 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.

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.	**B**	21/06/23 Complete.
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.	**B**	21/06/23 Complete.
21/06/23	The ICB is working very closely with NCC to establish models of joint commissioning and agreed funding streams to apply stability into the care market. We are currently working with a consultancy firm to identify the next steps for this process. **11/10/23** ICB restructure consultation period extended so unable to recruit to posts.	**G**	31/12/23

Visual Risk Score Tracker – 2023/24												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	16	16	16	16	20	20	20					
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**	**5**	**4**	**20**	**3**	**3**	**9**

Controls	Assurances on controls
• Daily sit-rep ensures ICB is sighted on real-time demand and resource. • HALO role across all Acute sites to support Emergency Departments (ED). • 999 / 111 multi-disciplinary approach via CAS at IC24 to manage some ambulance calls and dispositions • Pre-alert and rapid release processes in place with safety netting for patients waiting to be seen. Ambulance and ED 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. • In August 2023 the ICB launched the Unscheduled Care Coordination Hub (UCCH) with the aim of reducing conveyances, this replaces and builds on the work of the previous 'Virtual Open Room' which triaged people waiting for an ambulance and re-routed appropriate calls directly into other community services. Seasonal planning is underway, to coordinate additional interventions to support resilience.	**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. 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, however this has reduced in recent months. Incidents have also previously occurred where inter-facility transfers e.g., from local acute hospitals to tertiary centres for specialist care have been delayed, however mitigations across organisations have been successful in closing this as a specific risk.
- Discharge pressures, with high numbers of patients with no criteria to reside, are improving but still impacting on patient flow through the acute hospitals.
- Significant challenge remains 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 moral injury.

- Sustained periods of industrial action have an impact on flow, which also impacts ambulance handover times. This can be positive or negative depending on how the action effects the capacity of senior decision makers in ED, and the movement of patients through the wider hospital.
- The system is now in OPEL 4; due to fluctuating pressures leading to offload delays and ambulance response times. This prompts a increase of risk at M7 (2023-24).

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**
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
29/08/23	System plans to mitigate industrial action are in place and working well. However, the resilience of staff and the pressure of prolonged action on interprofessional relationships is emerging as a risk. The system IA EPRR response continues to manage and mitigate risk.	**G**	31/03/24
01/11/23	Partners have been asked to ensure frontline staff are able to access support, including management oversight and access to wellbeing resources and interventions.	**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	16	16	16	16	16	20					
Change	↓	→	→	→	→	→	↑					

BAF11

Risk Title	**Achieve the 2023/24 financial plan**
Risk Description	If the ICB does not deliver the 2023/24 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	10/05/2022	31/03/2024

Risk Scores

Unmitigated			Mitigated			Tolerated (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	3	4	12	3	4	12

Controls

- Monthly monitoring of risks and mitigations, reported to NHSE/I.
- Detailed plan for 2023/24 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.

Assurances on controls

Internal: Board Reports and Minutes, Audit Committee reports and Internal Audit work plan, Finance Committee reports, Executive Management Dashboards, Delegated Budget manager review, Internal monthly review of Risks & Mitigations.

External: ICB assurance process, early flagging of risk with NHSE/I and Protocol conditions.

Gaps in controls or assurances

- No contingency reserve in plan;
- £75m of unmitigated risks against the plan at the point of final submission, of which £52.2m (70%) assumed credits embedded within the plan relating to Efficiencies and project slippage.
- As at M07 (October 2023) the £75.0m planning risks have been re-assessed to £20.1m on a probability basis. This significant improvement arises from developing 5% efficiency plans through Closing-the-gap works and project management deferral. The remaining planning risks relates to unfunded Restructuring Costs, Prescribing, CHC and Identified Efficiency delivery.
- In addition to the remaining £20.1m Planning Assumption Risks a further £6.2m of Net Risks have been noted at the end of M07 (October 2023) resulting in a Total net risk of £26.3m (M06 £27.6m). The increase in new risks arises from continued significant CHC growth pressures likely to continue beyond those forecasted.
- Current discussion around national funding and conditions may de-risk the ICB further when finalised.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
13/06/23	Review of M02 year to date performance and assess forecast out-turn evaluated risks and mitigations.	G	Monthly to 31/03/24

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16	16	16	16	16	16	12					
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	10/05/2021	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

- Analysis and understanding of underlying recurrent position, including drivers of the deficit on a monthly basis.
- ICS Medium Term Financial Model has been developed on consistent assumptions.
- An ICB Detailed Medium Term Financial Model is being updated for the closing 2022-23 financial outturn. This will highlight the key drivers of the deteriorating underlying deficit.
- Key lines of Inquiries (KLOEs) have been reviewed and provide assurances as to strong financial governance and best practice adoption.

Assurances on controls

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. ICS CFOs.

Gaps in controls or assurances

- ICB has an underlying deficit position of £(65.1)m at the end of March 2023, and a planned 2023/24 underlying deficit of £(57.3)m. There are no plan at present to bring to a break-even position in the short term. A Financial Strategy and Recovery Plan will be developed once the MTFP commencing in 2024/25 has concluded for the ICB.
- The ICB detailed Medium-Term Financial Plan remains in draft until final submission (date tbc). The ICB has received feedback on its first submission from September 2023 which notes both the highest rates of inflation anticipated and planned efficiencies targeted.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
13/06/23	Continue to monitor and report the financial position via the Finance Committee reporting		30/09/2024
13/06/23	Identify mitigations to risk in plan to include unidentified efficiencies. Ensure new schemes deliver on a recurrent basis.		31/12/2023
13/11/23	The M06 Forecast Outturn underlying position is £(89.8)m deficit (M06 £(86.6)m), which against the plan of £(57.3)m is a worsening position of £(32.5)m. Principle drivers are Non-Recurrent efficiencies, and operational pressures through CHC & IPP packages.		31/03/2024

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	20	20	20	20	20	20	20					
Change	→	→	→	→	→	→	→					

BAF19

Risk Title	**Discharge from inpatient settings**
Risk Description	There is an increased risk to patients no longer meeting the 'Criteria to Reside' in both acute and community hospitals; numbers of which continue to fluctuate. The cause is insufficient pathway 2 & 3 beds for people needing onward care, particularly for people with complex needs, as the local care market is not designed to meet current acuity and care requirements.

Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Tricia D'Orsi	Quality and Patient Safety Committee	Danny Edmonds	25/10/22	31/03/24

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 of all system discharge delays. • Escalation process for problems. • Deconditioning and reconditioning programmes have had good buy in from staff across sites and we have commissioned Exercise Trainers across multiple sites as a result of the regional Deconditioning Games. • Single agreed system dashboard established and continuously developing to strengthen oversight. • New Transfer of Care form and processes approved for use across system. • The system has committed to commissioning of the Optica system, planned implementation starting in October 2023; this has the potential to reduce length of inpatient stay and streamline system data. • Length of stay is improving across community and ICB commissioned beds. • More positive outcomes have been recorded for patients returning home, as opposed to long term care placement. • Key vacancies across the system are filled following successful recruitment. • 7-day discharge is embedded in East and Central localities.	**Internal:** ICB Executive Management Team; UEC Board; Discharge Programme Board; Discharge Steering Group; ICB Quality and Safety Committee; Bi-weekly Discharge Touchpoint Meeting. Daily Integrated Discharge Team Meetings; Strategic Operational Delivery Group; system Clinical Oversight Meeting. **External:** Trust Boards; 3 x Acute System Operations, Resilience and Transformation Boards; NHSE oversight.

Gaps in controls or assurances

- Insufficient capacity within existing care market as local provision is not designed to meet current acuity and complex care requirements.
- Workforce pressures. Staff sickness and absence continue to impact on performance.
- Underutilisation of criteria led discharge. This continues to be a system priority.
- 7-day working needs to embed fully across the whole Norfolk and Waveney footprint. This is improving but is still a risk.
- Local authority funding allocation for discharge support is split across SCC and NCC. There is as yet no central breakdown for the system, that can be accessed by Discharge Programme Board.
- Breakdown and oversight of current ICB funding; what is recurrent and what is non-recurrent is unclear to Discharge Programme Board.
- Modular build is due for completion by 01/04/24. Recruitment is in progress. This will provide an additional 48 beds from 01/04/24. However, funding for the current 47 ICB commissioned beds runs out on 31/01/24, which reduces the impact of the modular build capacity. This potentially means a deficit of circa 47 beds between 01/01/24 to 31/03/24. This could potentially be longer if the modular build is delayed. A decision is required on the longer term commitment for additional ICB funded beds.

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**
09/11/22	Roll out of criteria lead discharge to all wards has commenced.	**A**	31/10/23
22/06/23	System awarded capital investment for modular build at NCH&C, with a potential of 48 beds. Planned to mobilise in January 2024.	**G**	28/02/24
29/08/23	Roll-out of Optica system, this has the potential to reduce length of inpatient stay and streamline system data.	**G**	31/10/23
19/10/23	SCC are pulling together the local authority funding allocation plan on behalf of both areas.	**G**	31/10/23
19/10/23	ICB is pulling together an outline plan for ICB funds, detailing what is recurrent and non-recurrent, for Discharge Programme Board. This will outline funding gaps for 24/25.	**G**	31/10/23
01/11/23	A paper has been received by ICB EMT, to explore future funding streams to support discharge.	**G**	30/11/23

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

BAF21

Risk Title	Grant Thornton Mortality Review
Risk Description	Grant Thornton was commissioned by Norfolk and Waveney and Suffolk and North East Essex Integrated Care Boards to review the collection, processing and reporting of data. This found the processes to be unclear and rely on multiple systems to record and produce the data, with inconsistencies in the categorising and grouping of expected and unexpected deaths and unclear and inconsistent decision making and reporting of community deaths. There is a risk that the ICS fails to learn from the tragic events reported in the review. This could potentially lead to missed opportunities for prevention of future deaths which could lead to further distress of bereaved families, friends and carers who lose trust and confidence in the service. There is a significant risk of reputational damage and national media interest.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Dr Frankie Swords	Quality and Safety Committee	Karen Watts	18/07/2023	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**	**1**	**4**	**4**

Controls

- NSFT have formulated an Action Plan for both Grant Thornton and Seagry recommendations with senior NSFT SROs aligned to specific actions.
- Trust developing a Standard Operating Procedure (SOP) to manage data recording and validation with auditable trail.
- Standardised reporting structure for mortality will be presented through the Trust Committee structure and agreed by the Board.
- Data sharing agreements in place and functional across ICS areas.
- Data quality Dashboard is in place and shared with the ICB, trust mortality dashboard under development.
- Work with HM Coroner's to enable sharing of cause of death data.

High-level oversight of Action Plan by mortality review group, including ICBs, Healthwatch and bereaved families.

Assurances on controls

Internal: ICB EMT, Quality and Safety Committee, Board, System Quality Group, system Learning from Deaths Forum, ICB Serious Incident Oversight, LeDeR and Child Death Review.

External: Regional Quality Group, NHS England Oversight and Assurance of NSFT, NSFT Board, NSFT Quality Committee, NSFT Mortality Improvement Board, NSFT Co-production Groups, Norfolk HOSC and CQC.

Gaps in controls or assurances

- There is currently a lack of national guidance regarding recording of mental health mortality data with a gap concerning the oversight of deaths occurring in the community .
- The Trust needs to apply rigour to improve the processes around the reporting of all mortality, including consistent categorisation and grouping of unexpected v expected deaths, and improve the understanding of all deaths for patients on its caseload, or within six months of discharge.
- The Trust's Learning from Deaths quarterly Board report will include thematic analysis of key metrics such as age, diagnosis, cause of death and deprivation indices.
- Lack of clarity within public facing documents and reduced clinical insight into the mortality information reported resulting in a lack of confidence from external stakeholders, including regulators and the public, in the data, and in the Trust's understanding of it.
- NSFT is reliant on other NHS providers for cause of death information for community patients. The Trust will need to take responsibility for the actions they are able to complete, and to be clear on the requirements of partner organisations around the additional information they need and which organisation holds it.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion

09/11/23	Weekly meetings of mortality review group (MRG) held with representation from Healthwatch Norfolk, Healthwatch Suffolk, the authors of the Forever Gone report, Medical director and chief nurses from NSFT and both ICBs in place. Ways of working and terms of coproduction agreed	B	30/10/23
09/11/23	MRG members agreed to support NSFT internal action plan to address specific reporting issues raised in GT report. MRG prepared a joint action plan to address wider concerns as requested by Norfolk HOSC. Plan currently under review by CEO and Chairs of NSFT, SNEE and N&W ICBs with a view to finalising and presenting at HOSC January 2024	A	30/01/24

Visual Risk Score Tracker – 2022/23												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score				20	20	20	16					
Change				New	→	→	↓					

BAF22				
Risk Title	Delegation of 59 Specialised Services to N&W ICB from NHS England on 1 April 2024			
Risk Description	This risk is written in the context of the timing of what we need to do to transition safely between now and 31 March 2024, and how that aligns with the ICB re-structure. The is a risk that the lack of current capacity / bandwidth to undertake detailed due diligence and engagement during the pre-transfer lead in, specifically within the areas of Finance, BI, Quality, Contracting, Complaints, Comms & Engagement, Workforce and Commissioning. Commissioning is the greatest risk area as there is currently no commissioning team to do this engagement. This may lead to emergent finance / quality issues post transfer.			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Andrew Palmer	Transformation Board	Liz Joyce	3/10/23	31/03/24

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**4**	**4**	**16**	**3**	**3**	**9**

Controls	Assurances on controls
• Fortnightly N&W ICB internal T&F group in place • Working with the other five ICB's and NHSE to complete the Safe Delegation Checklist • Part of the regional Finance Sub-Committee to discuss / agree the proposed risk-share model • Simon Griffith, NHSE lead for Spec Comm in N&W is part of the System Contracting Development Group and is working with us • Caveats that must be met before N&W ICB could accept delegation were fully supported by the ICB Board (Sept 2023) • BLMK ICB confirmed as the host for the eastern region • NHSE staff are not TUPE transferring to BLMK ICB until 1 April 2025 so they have some stability and a confirmed employer, but their line management will be via BLMK ICB and the ICB's • BLMK ICB have recruited ex NHSE Commissioning Director Catherine O'Connell as Managing Director to lead the Multi-ICB workstream on behalf of all ICB's, and Andy Leary as Finance Director • An initial Integrated Performance Report has been shared with ICB's for comment but it is high level • ICB's are being invited to review draft documentation as it is produced e.g. Delegation Agreement, Multi ICB Agreement, Commissioning Hub Agreement • Arden & GEM CSU manage the BI functionality and this contract will remain with NHSE	**Internal**: Monitoring reports to Quality & Safety Committee, Finance Committee, Transformation Board **External**: Monitoring meetings: Specialised Services Joint Commissioning Committee (SSJCC) which reports to the national Delegated Commissioning Group (DSG) by exception, Safe Delegation Checklist meetings hosted by NHSE and the Joint Endeavour Huddle hosted by BLMK.

Gaps in controls or assurances
• Timing is an issue. When will we know exactly what our teams will need to do i.e. what the NHSE/BLMK hosted team will do, and what does N&W ICB need to do? This is across Finance, BI, Quality, Contracting, Complaints, Comms & Engagement, Workforce and Commissioning. • The six ICB's have not yet got into a meeting rhythm to discuss the multi-ICB functions they will work together on • Linked to the resourcing point above, there is no visibility yet of what outward facing liaison resource the ICB will need for working with the other five ICB's and NHSE, and what will be needed for working with the providers, for both new issues and routine monitoring. • There is no established relationship yet with the acute Specialised Commissioning Provider Collaborative • Unconfirmed risk-share or delegated budget for 2024/25 yet, based on our population • Budget for HCD's and Devices is staying with NHSE for 2024/25. The drugs spend is volatile and activity & HCD are inextricably linked - we will be in control of one element but not both • The HCD budget for Spec Comm is part block for the known drugs/activity i.e those drugs that have been embedded for a while, and PbR for all new drugs agreed in-year. (This is a different model to acute HCD contacting which is all block). There will be some other unknowns for HCD activity e.g. for those patients who choose out of area providers, we'll get pass through invoices and other add-ons. The mitigation is that in an ideal scenario the initial (transferring) provider would seek prior approval but this is not always the case, or possible. • The available BI reports are not yet understood, and we do not have identified commissioner leadership to review this with Simon Griffith • No commissioning team leadership in post yet to resolve issues and promote a positive culture to develop Spec Comm services, within the ICB and with partners • Commissioning team leadership will be required for local end to end pathway transformation, to integrate with other ICB commissioned services • The operational working relationship with hospitals in Cambridgeshire and London will need to be developed / improved • Linked to the point above, Data Quality in the eastern region is deemed by NHSE to be good, that is not the case outside our region • There is a 30% vacancy rate within the TUPE list of NHSE staff – we do not know which teams/posts are vacant. • N&W ICB is not yet well sighted on local Performance issues (e.g. RTT or Quality) • N&W ICB Comms & Engagement resource to engage with the local population in pathway changes will not be available if the proposed re-organisation structure is implemented • Clinical leadership and the role of Providers within the new arrangements has not yet been discussed with them as the ask is unclear • Final versions of the Multi-ICB Agreement, Delegation Agreement and Commissioning Hub Agreement are not yet available – all are out to consultation

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**
	Risk and actions being scoped – full update to next Board		

Visual Risk Score Tracker – 2023/24												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score							16					
Change							New					

Norfolk and Waveney ICB aim: To make sure that you only have to tell your story once

Principal risk: That people in Norfolk will have their time wasted due to lack of integration and poor data sharing between different providers of health and care. This could lead to frustration for patients and staff, and introduce errors due to multiple handovers of information

Summary of risks

Ref.	Risk Title	Risk Owner / Operational Lead	Date risk identified	Target delivery date	Score at target delivery	2023-2024 Monthly Risk Rating											
						1	2	3	4	5	6	7	8	9	10	11	12
BAF12a	Impact on Business Continuity in the event of a large-scale Cyber Attack on N365 National Tenant	Ian Riley	01/03/2023	31/03/2024	6	8	8	8	8	8	8	8					
BAF12b	Impact on Business Continuity in the event of a Cyber Attack on the ICB	Ian Riley	01/03/2023	31/03/2024	6	9	9	9	9	9	9	9					
BAF13	Personal data	Ian Riley	01/07/2022	31/03/2023	6	12	9	9	9	9	6	6					

BAF12a				
Risk Title	**Impact on Business Continuity in the event of a large-scale Cyber Attack on N365 National Tenant**			
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.			
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
• NCHC 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 • Leaver processes for NHS mail accounts are now standardised for the ICB so all leavers have their NHS Mail accounts disabled • MFA mandatory for non ICB Staff provided with an ICB NHS Mail address • NHSE have confirmed (August 2023) that they monitor and provide technical resource to support business continuity, data recovery and cyber breach remediation.	**Internal:** Cyber Security Assurance Manager, Head of Digital, IG Working Group, NWICB N365 Technical Workstream Delivery Group **External**: National Cyber Security Operations Centre, NHSE, NCHC, MTI Technology Limited (technical partner to NHSE)

Gaps in controls or assurances

- Making MFA mandatory for ICB staff provided with an NHS Mail address
- 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 NHSE providing this function to other organisations as needed.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
01/03/23	Work with NCHC as part of their ICB IT Service Delivery to roll out MFA to all ICB staff before 31/03/24 deadline. As of 31/10 the Digital Team led project has 429 out of 810 staff in the ICB self-enabled for MFA. Enforced enablement via NCHC IT service		31/03/24

	starts Dec 2023											
Visual Risk Score Tracker – 2023/24												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	8	8	8	8	8	8	8					
change	➔	➔	➔	➔	➔	➔	➔					

BAF12b				
Risk Title	**Impact on Business Continuity in the event of a Cyber Attack on the ICB**			
Risk Description	Risk via a Phishing attack on the ICB which could result in a data breach of patient/personal information and/or financial extortion. This could happen through one of the following top three risks identified by the IG Working Group: - 1. Ransomware attack 2. Lack of user awareness Phishing/social engineering			
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** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**3**	**3**	**9**	**2**	**3**	**6**

Controls	**Assurances on controls**
• From March 2024 MFA on NHS Mail will deploy as part of national policy from NHSE (MFA pilot for Digital IG Data and Finance staff being delivered) • NCHC 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 devices • Secure boundary protection is in place • Since November 2022, NHSMail is protected by Microsoft Safe Links & Attachments • InTune with mobile device management rolled out to staff using ICB issued and personal devices to access NHS Mail and MS Teams. • MFA mandatory for non ICB Staff provided with an ICB NHS Mail address. • Cyber security behaviour change support and awareness package with clear guidance 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 • NHSE have confirmed (August 2023) that they monitor and provide technical resource to support business continuity, data recovery and cyber breach remediation	**Internal:** Cyber Security Assurance Manager, Head of Digital, IG Working Group, NWICB Technical Workstream Delivery Group **External**: National Cyber Security Operations Centre, NHS Digital, NCHC, MTI Technology Limited (technical partner to NHSE)

Gaps in controls or assurances

- MFA mandatory for ICB provided with an NHS Mail address
- 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 NHSE providing this function to other organisations that needed.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion

01/02/23	Phishing test was completed previously in 2022. 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. The target date has been moved given the sensitivities of the staff consultation		15/01/24
01/03/23	Work with NCHC as part of their ICB IT Service Delivery to roll out MFA to all ICB staff before 31/03/24 deadline. As of 31/10 Digital Team led project has 429 out of 810 staff in the ICB self-enabled for MFA. Enforced enablement starts December 2023 via NCHC IT Service		31/03/24

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	9	9	9	9	9	9	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, since the protection of the current COPI Notice ceased 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. There is a subsequent risk of health inequalities due to surgeries not signing up to data sharing and sub licensing

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	2	3	6	1	3	3

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
11/01/23	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.		31/03/2023
01/1123	The IG and PHM team are working with the practices data who have signed data processing agreements, (95 of the 105). A documented use case process for any processing of the data is completed as and when data is required to support PHM initiatives. This requires sign off from ICB DPO and Practices DPO. The section 251 for risk stratification which has been submitted and approved till September 2024 covers the use of our risk stratification supplier identifying patients who meet a criteria identified and verified by a clinical lead to offer interventions to improve health outcomes. The ICB has signed new assurance statements and as such the ICB can continue to process data for invoice validation in line with the S251 for invoice validation, which has been extended for a further year to Sept 2024 The development of the Data hub and its information sharing agreement and DPIA is being implemented with updated agreements and DPIA. the use of the data will be approved by a joint controller group made up of all contributors to the Data Hub and ICS who will consider each use case to process data, to determine if it is lawful, fair and transparent and compliant.		01/09/24

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12	9	9	9	9	6	6					
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 Title	Risk Owner / Operational Lead	Date risk identified	Target delivery date	Score at target delivery	2023-2024 Monthly Risk Rating											
						1	2	3	4	5	6	7	8	9	10	11	12
BAF14	#WeCareTogether People Plan	Ema Ojiako	01/07/22	01/04/24	3	12	12	12	12	12	12	12					
BAF15	Staff Burnout	Ema Ojiako	01/07/22	31/03/23	4	12	12	12	12	12	12	16					
BAF16	The resilience of general practice	Mark Burgis	01/07/22	31/03/23	12	16	16	16	16	16	16	16					
BAF17	Financial Wellbeing	Ema Ojiako	01/08/22	Ongoing	12	12	12	12	12	12	12	12					
BAF18	Resilience of NHS General Dental Services in Norfolk and Waveney	Mark Burgis	01/04/23	31/03/23	6	12	12	20	20	20	20	20					
BAF20	Industrial action	Ema Ojiako	14/11/22	31/03/23	6	16	16	12	12	12	12	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
#WeCareTogether system wide People Plan has been in place since August 2020 – this requires a refresh in line with the publication of NHS Long term Plan for Workforce released in June 2023 People Board in place with an operating model of Networks, Groups, and Stakeholders contributing to and leading delivery of the strategy Good linkages with both NHS and Social Care Providers Alignment to local workforce strategies within NHS Provider organisations and the NCC Adult Social Care Workforce Strategy. N&W ICB Change Programme will see a change in form and function for Workforce and the People Directorate, moving to a greater collaborative and convening style of leadership to work more closely with system partners to delegate and take shared responsibility for transformation across the ICS. N&W ICB Senior Team will review portfolios and ensure the right skills are in place to deliver against our agenda.	**External:** Norfolk and Waveney people Board and associated stakeholder Networks and Groups including HRDs, DoNs, Education, OD and Culture & Inclusion Leads **Internal:** N&W ICB Remuneration and Culture Committee

Gaps in controls or assurances

- ICB Change Programme will result in a change of form and function for the People Directorate. The change programme is led by the ICB Executive Director of People and some of the Senior Team which is causing a delay in external transformation activities.
- 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
- Ongoing system pressures exacerbate the risk of poor wellbeing and resilience for our workforce, increasing our collective challenge to retain and recruit workforce

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	A	31/3/23

	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		
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 1/4/23	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 Refresh of People Plan postponed in recognition of the pending publication of the NHS Long Term Plan for Workforce and the commencement of the N&W ICB Change Programme	**R**	~~March 2023~~ 2024 - TBC
30/6/23 Sep 2023	Publication of the NHS Long Term Plan for Workforce – sets the intention for transformation over the next 5 years, awaiting further information from Region regarding objectives and deliver timeframes NHSE launched delivery plan and objectives for the LTP, this is now being socialised with N&W stakeholder groups to ensure alignment to local NHS Provider Workforce Plans, integration with Social Care, and N&W ICS JFP.	**G**	Dec 2023 Summer 2024

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12	12	12	12	12	12	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 pre pandemic, and now the ICB Change Programme which launched at the start of this year, presents a high risk of staff feeling unsettled and anxious in line with a change process which will require focussed support to lead people from our Executive and Senior Leaders. Consequences from burnout 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.

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	4	4	16	1	4	4

Controls	Assurances on controls
• We are seeing an increase in ICB staff requesting support from the People Team – in particular line management culture change, new ways of working, developing teams. • The Staff Involvement Group and Senior Management Team flag issues regarding economic and cost of living rises – agreement in 2022 to add as a new risk to ICB corporate risk register as the impact of lifestyle pressures will impact on people's resilience and increase likelihood of burnout. This risk will be reviewed in Nov 2023 given the current macro context and mitigations implemented for financial wellbeing under risk BAF17. • Staff wellbeing is a key consideration of the ICB Change Programme, with the Org Change Working Group regularly reviewing and factoring in updates from our staff, Change Buddies and Staff Involvement Group into the planning, response, and actions for the Change programme • Additional HR expertise has been enabled to support the pace and scale of the Change programme, and to maintain BAU for our staff from a HR perspective. • ICB is participating in this years staff survey which was open in Sep/October. Outcomes from the survey will be released in the new year by NHS England.	**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 remain
- 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
- ICB Change Programme is a highly emotive process for our staff. Increased effort required by our Executive, Senior leaders, HR and Finance colleagues, and our wellbeing leads to minimise the impact of a change cycle on individuals. We must ensure that support is in place for operational and exec leads aligned to the process to ensure people do not burn out.

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 Summit postponed; however regular Extended Senior leadership meetings are taking place (most recently on 6/11). Awaiting EMT agreement on resource to lead the Phase 3 of the Org Change Programme – ICB Readiness and Implementation of new operational model	A	April 2024

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12	12	12	12	12	12	16					
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 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	01/09/2020	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. All practices have previously been supported to review business continuity plans • PCN ARRS (additional roles reimbursement scheme) funding has increased again in 2023/24 • Primary care workforce and training team working closely with locality teams to ensure training available to support practices and PCNs in setting up and maintaining services • 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:** Executive Management Team, workforce steering group, primary care strategic planning meetings, establishment of new medical operational delivery group **External**: Primary Care Commissioning Committee, NHS England via delegation agreement and assurance framework, 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
- Vacancies within primary care, workforce, quality and locality teams impacts the level of support which can be provided to practices. Potential for organisational change to also impact on support available going forward as vacancy controls restrict recruitment and add pressure to others in the teams
- Continued reports of poor patient behaviour across practices, decrease in patient satisfaction nationally with general practice through GP patient survey, consistent with national position
- Progress on interface action planning process across Trusts impacted by ongoing pressures
- Reporting process for inappropriate transfers of workload from community and secondary care providers to general practice under-utilised by practices, leading to potential under-reporting of issues
- 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
- Lack of additional funding for primary care budgets leading to delays (or potential ceasing) of work to support resilience and transformation in general practice

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
13/06/23	• Support from internal ICB teams for practices rated inadequate or RI continues. Bite size training sessions to share learning are ongoing		30/09/23

	• 67 practices benefitted from the quality, stability and support payment with a total investment from the ICB of £788,020 • Interface reporting was encouraged intensively for 2 weeks in May to maximise understanding of issues facing practices. Significant increase in reporting with themes reported to the working group. Pace of developing Trust action plans is slow • Ongoing support being provided by locality teams to support development of PCN access recovery plans in line with national contract requirements. System plan under development with regional assurance meetings underway • Attended Norfolk Health Overview and Scrutiny Committee to discuss the issues and ICB plans to support patient access • Comms campaign launched with focus on the additional roles forming part of modern general practice • Agreement of final primary care budgets still awaited, causing delay to some areas of work • Publication of national guidance to support investment of primary care system development funding to enable delivery of system and PCN access recovery plans, however budget availability may impact on this		
10.08.23	• Quality, stability and support payments calculated for primary care networks – provisionally 11 PCNs will benefit with £680k due to be paid in August, which is a significant investment from the ICB. When added to the QOF QSSP, this totals nearly £1.3m. • Winter resilience letter published which confirms no additional funding for primary care over and above access recovery funding. • Interface group continues to make slow progress, the medical director has written to the Trusts to encourage them to address and progress the outstanding issues in private consultant referrals and ICE requesting for health care professionals. There will be a report to the November ICB Board meeting • All 17 PCNs have submitted access recovery plans, however there has been limited interest from practices in the national GP improvement programmes. Feedback suggests this is due to the intensity of the programmes and lack of backfill support available. The national funding for transition support has now been made available for this year, the ICB is developing its communications to practices.		30.11.23
Sept 2023	• Covid and Flu vaccination programme start date has been brought forward to early Sept, accelerating rollout of vaccinations, starting with care home residents and eligible vulnerable patients. Aim is to vaccinate as many people by end Oct.		
Oct 2023 Davey Heidi 22/11/2023 14:57:27	• System Primary Care Access Improvement Plan will be on the November Board agenda for discussion, including an update on the progress we are making in addressing interface issues. We are in contact with all providers to progress their action plans. • ICB teams providing support to a small number of practices experiencing significant resilience issues to ensure continuity of services. • Current and impending vacancies in ICB teams working with practices are causing capacity issues, leading to re-prioritisation of workload and possible delays to key pieces of work including the workstreams		31.03.24

	supporting improvements across the primary-secondary care interface and the development of the strategic plan for general practice • No clear picture on any winter funding for general practice, meaning any plans that can be enacted if funding is confirmed will be mobilising during the winter period.		
Nov 23	• Support being provided to the Norwich locality as we work on the safe transition of services for patients affected by the One Norwich Practices decision to close. • Funding decision made on £715k to provide additional capacity to general practice for winter resilience. Aiming to mobilise in early December. • Further vacancy in the team from 1 December will impact on capacity for system planning and interface work.		31.12.23

Visual Risk Score Tracker – 2023/24												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	16	16	16	16	16	16	16					
Change	→	→	→	→	→	→	→					

<table>
<tr><th colspan="9">BAF17</th></tr>
<tr><td>Risk Title</td><td colspan="8">Financial wellbeing</td></tr>
<tr><td>Risk Description</td><td colspan="8">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).</td></tr>
<tr><th>Risk Owner</th><th colspan="3">Responsible Committee</th><th colspan="2">Operational Lead</th><th>Date Risk Identified</th><th colspan="2">Target Delivery Date</th></tr>
<tr><td>Ema Ojiako</td><td colspan="3">People and Culture</td><td colspan="2">Emma Wakelin</td><td>01/08/2022</td><td colspan="2">ongoing</td></tr>
<tr><th colspan="9">Risk Scores</th></tr>
<tr><th colspan="3">Unmitigated</th><th colspan="3">Mitigated</th><th colspan="3">Tolerated (Target in 12 months)</th></tr>
<tr><td>Likelihood</td><td>Consequence</td><td>Total</td><td>Likelihood</td><td>Consequence</td><td>Total</td><td>Likelihood</td><td>Consequence</td><td>Total</td></tr>
<tr><td>4</td><td>4</td><td>16</td><td>4</td><td>3</td><td>12</td><td>4</td><td>3</td><td>12</td></tr>
<tr><th colspan="4">Controls</th><th colspan="5">Assurances on controls</th></tr>
<tr><td colspan="4">External
• Flexible working policies in place which supports staff to manage their wellbeing through a mix of home working and office – impact on reduction in travel time, fuel consumption and parking fees.
• Local initiatives for staff to manage their financial wellbeing are in place and localised to ICS Employing organisations
• Utilisation of Apprenticeship Levy provides funded support for staff increase their skills, competencies, and enhance career progression
• Employee Reward and Benefit Programme. plus Employee Assistance Programme (EAP) to support wellbeing and advice on financial management are in place
• 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.
• EoE Regional Teams (HEE/NHSEI) also provide support, resources and regular updates on national responses.

Internal ICB – additional enhancements
• 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</td><td colspan="5">Internal: SMT, EMT, ICB Board, Staff Involvement Group, Remuneration People & Culture Chair

External: HRDs, N&W People Board</td></tr>
</table>

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 • Employee Assistance Programme (EAP) to support wellbeing and advice on financial management implemented in 2023 with regular communications, links, and information shared with staff to encourage utilisation of the platform via Vivup.	

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
- Financial constraints in the N&W system prevent large scale additional enhancements for staff for prolonged periods of time

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
13/11/23	Recommendation that this risk is now closed give the broader macro context of cost of living in the UK. Satisfaction that adequate controls are in place to monitor financial wellbeing through existing ICS and ICB networks and groups – including People Board, HRDs, and the ICS Health and Wellbeing Leads Network Close working with HRDs and staff networks will allow our system to consider rising issues, and promotion of resources and support for our staff include Employee Assistance Programmes	C	28/11/23

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12	12	12	12	12	12	12					
Change	→	→	→	→	→	→	→					

BAF18

Risk Title	**Resilience of NHS General Dental Services in Norfolk and Waveney**
Risk Description	Primary Care Services became the responsibility of the Integrated Care Board from 1st April 2023, the risk is the unknown resilience, stability and quality of dental services, and critical challenges relating to the recruitment and retention of dentists and dental care professionals and the limitations of the national dental contract, leading to a poor patient experience for our local population with a lack of access to NHS general dental services and Level 2 dental services.

Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Mark Burgis	Primary Care	Sadie Parker	01/04/2023	31/03/2025

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**	**2**	**6**

Controls

- ICB primary care team recruited and in place working alongside newly recruited Quality Dental Nurse in Quality team and Finance colleagues, and Planned Care Team (for secondary care dental services)
- Ring fenced dental budget for investment
- Active engagement with dental contractors, LDC and Local Professional Network (and Managed Clinical Networks), regular dental newsletter in place
- Dental Development Group established to engage with key stakeholders to agree short term plan by Sept 2023
- Dental Services Delivery Group established reporting to PCCC
- Dental Strategy and local workforce plan to be in place by March 2024
- NHS England Long Term Workforce plan published June 2023
- NHS Business Services Authority performance/quality management reporting and quality framework in place with regular meetings established with the ICB. Access to eDen dental data management reports and dashboard for ICB staff.
- Clinical expertise provided by NHSE through the LPN and Dental Advisor roles for 2023/2024
- Oral Health Needs Assessment in final development to inform commissioning plans

Assurances on controls

Internal: EMT, Primary Care Commissioning Committee, Dental Services Delivery Group

External: NHS England, Norfolk and Waveney LDC, regional Local Professional Network and Managed Clinical Networks, Healthwatch Norfolk/Suffolk, NHS Business Services Authority

Gaps in controls or assurances

- The level of the unmet need for general dental services and the associated financial consequence of this once addressed (if possible) given the transfer for funds was based on 2022-23 current expenditure which are below budget required to meet population need
- 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 access to NHS dentistry services is an area of quality concern. This impacts on some of our most vulnerable patient groups.
- Significant workforce shortfalls across general dental services, Level 2 services and secondary care dental services and a lack of comprehensive workforce data to support planning

• Lack of knowledge about the resilience and stability of existing dental services			
Updates on actions and progress			
Date opened	**Action / Update**	**BRAG**	**Target completion**
Jan 2023	As agreed at May Executive Management Team and PCCC, this content of this risk (previously on the transition of services) has been replaced by the resilience of NHS general dental services. Active engagement with the dental profession to understand the challenges they are facing. Monthly meetings with the LDC and LPN established. Dental Development Group has met twice with regular meetings established for 2023/2024 to agree short term commissioning plans by September 2023 and the Dental Strategy by March 2024 Engagement with other ICBs in the region to agree regional approach to commissioning where appropriate and beneficial Workforce data analysis underway. There are no NHS dental practices accepting new NHS patients in Norfolk and Waveney – propose to increase risk rating to 20 due to the current state of provision.		30/09/2023
Sept 2023	The ICB has approved an Urgent Treatment Service pilot that is being mobilised and will be live during September for patients with an urgent dental need to receive urgent care. Nearly 30% of practices across Norfolk and Waveney have signed up to offer urgent treatment appointments. The pilot will be in place for 12 months with an option to extend for a further 6 months. A short term initiative for 2023/2024 to support children's oral health education has also been agreed and providers have been invited to submit expressions of interest to the ICB. Other initiatives are under development as part of the ICB's short term plan. The Dental Development Group has supported the ICB's short term plan which will be published in September subject to final ICB approval by Primary Care Commissioning Committee and Executive Management Team. This includes identifying areas for access improvement in areas of greatest need using the Oral Health Needs Assessment as an evidence base to inform commissioning intentions, support to practices for quality improvement and workforce plans. Development of the ICB's long term dental plan is underway and subject to approval will be published in March 2024. All opportunities are being taken to actively engage with the dental profession which will help inform these plans in addition to a wider stakeholder engagement. Meetings of the ICB Dental Services Operational Delivery Group are taking place enabling the ICB and key stakeholders to take a deep dive when making decisions about important and urgent matters related to NHS dental services within the Scheme of Delegation of the Primary Care Commissioning Committee. The year end process for activity in 2022/2023 is underway which has identified a high level of underperformance largely due to difficulties in recruitment. The ICB is working with all providers to manage the		31/03/24

	financial impact of clawback. A lack of access to NHS dental services also has an impact on patient charge revenue received by the ICB as part of the dental budget allocation.		
Nov 2023	The ICB's Short Term Dental Plan was approved in September 2023 and widely shared with key stakeholders and is available to view on the ICB website. Ongoing development and mobilisation of individual elements of the plan are underway. The Urgent Treatment Service pilot was mobilised in October 2023 with more than 20 providers offering appointments every week (approximately 50 hours in total per week). The pilot remains open to providers to participate. Seven providers have signed up to the children's oral health scheme for 2023/2024. Three contract terminations have been received since April 2023 impacting more than 30,000 patients. The ICB is developing plans for approval to replace this activity through local commissioning. The year end process is now complete with more than 50% of providers unable to achieve their activity last year mainly due to recruitment difficulties. If access is low, patient charge revenue is reduced. A range of workforce recruitment and retention initiatives were agreed by the ICB's Primary Care Commissioning Committee in October and are being offered out to providers. Recruitment and retention remains one of the biggest challenges for providers and the ICB to resolve. The mid year review process has identified that 35% of providers may not achieve their contracted activity this year. The ICB will be contacting these providers to offer support and to mitigate any risks for the provider and the ICB. NHS England has published guidance on flexible commissioning for ICBs to use and this is being reviewed by the ICB to determine how to maximise the opportunities for flexible commissioning in its short and long term plans to improve access for our local population.		31/03/2024

Visual Risk Score Tracker – 2023/24												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	16	16	20	20	20	20	20					
Change	→	→	↑	→	→	→	→					

BAF20

Risk Title	**Industrial Action (IA)**
Risk Description	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. We have multiple professional groups now engaged in industrial action, including Nurses, Therapists, Paramedics and Junior Doctors. To date, strike action has affected the following local NHS 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 system is also impacted by other strike actions that impact on our staff, including Teachers. There is an ongoing resilience risk, related to consecutive and simultaneous periods of IA.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Ema Ojiako	People Board	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	3	3	9

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. • Communication plan through the national team to ICB Comms Lead in progress. • ICB have reviewed clinical staff for potential redeployment. • As of Nov 2023 the system has now managed 15 strike periods for nurses, junior doctors, physiotherapists and ambulance staff. • Robust and clear processes are established for System incident command and control in place	**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. ICS EMT N&W Emergency Preparedness, Resilience & Response networks

with 'hot debriefs' in place following each incident to ensure a cycle of continuous improvement. • The Norfolk & Waveney system is managing IA well, mitigating risks and working together to maintain workforce morale, wellbeing, and relationships with staff groups • Additional support for senior leads is available and will be enhanced as we move into winter. This will include leadership circles, Schwartz rounds, and access to trauma informed coaching as required. • A focus on Gold and Silver on call commander support and resilience during IA periods is under review – co-design through our System Control Centre and People Teams.	

Gaps in controls or assurances

- The sustained, cumulative action is impacting on staff morale, creating increased work for remaining staff and frontline impact of distressed and upset patients. This presents a risk of burnout and staff absence exacerbating stress and moral injury associated with delivering care in such challenging circumstances.
- The impact on our on senior leaders who are leading the incident response should be recognised given the time, pressure, and additional energy required to make sound planning and responsive decisions leading up to, during and revering from each incident. 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 emerging with immediate impacts (i.e. significant risk to system resilience and patient safety for each strike action period) and longer term (ie delays to elective and planned activity, workforce resilience),
- There is the potential for this to impact on health inequalities.
- There is a lack of a consistent and streamlined national process for safety derogations, for organisations to follow. This is being mitigated as far as possible by local plans.

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
13/11/23	ICB command and control approach has evolved in the last 12 months. The preparation, response, and recovery for each incident are led jointly through the N&W System Control Centre and People/Workforce, working with system partners to mitigate risks. Industrial action for medical workforce is anticipated – we await updates from GMC for the next round of IA. Our Winter preparations include assumptions for IA during this period which includes workforce and system resilience plans to mitigate as far as possible the impact on our patients and workforce.	G	Ongoing
13/11/23	Risk title amended to articulate that the risk focus is for Workforce relating to IA. SRR includes a new risk SRR52 which focuses on the impact of IA on quality and patient safety which is proposed to be included in the SRR in November.	G	13/11/23

Visual Risk Score Tracker – 2023/24

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16	16	12	12	12	12	16					
Change	↑	→	↓	→	→	→	↑					

Agenda item: 13

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:	28 November 2023

Purpose of Paper

To provide the Board with an update on the work of the Quality and Safety Committee for the period of 26 September to 28 November 2023.

Committee:	**Quality and Safety**
Committee Chair:	Aliona Derrett
Meetings since the previous update:	**05 October 2023,14:00 – 17:00** **02 November 2023, 14:00 – 17:00**

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:	**05 October 2023: regular meeting of the Committee covering all standing items plus the following focus areas:** • ICS Quality Strategy Draft Implementation Plan • Ambulance and Urgent & Emergency Care (UEC) Resilience • Adult Mental Health Collaborative • Mental Health Crisis Provision Evaluation Report • Children and Young People (CYP) System Collaborative • Safeguarding Children with Disabilities • CYP Neurodevelopmental Service Provision • Social Care Quality Programme • Medicines Optimisation and Safety Assurance Report **02 November 2023: regular meeting of the Committee covering all standing items plus the following focus areas:** • Local Maternity and Neonatal System (LMNS) Assurance Report • Update from Discharge Programme Board • Adult Mental Health Transformation Update • Norfolk and Suffolk Annual Safeguarding Impact Reports • Pharmacy, Dental and Optometry Report • Learning from Adverse Events and Complaints Report • Research and Evaluation Report
BAF and any significant risks relevant / aligned to this Committee:	**Quality and Safety Committee BAF risks:** 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 BAF21: Grant Thornton Mortality Review (NSFT) **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 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 SR19: CYP Podiatry Provision in Central Norfolk SR20: CYP Speech and Language Therapy Provision SR22: Digital Maternity Care Records SR26: Deconditioning and Hospital Acquired Infections SR42: Discharge & Short-Term Feeding Tubes

	SR43: Tuberculosis Service Capacity SR44: Wheelchair Service Waiting Times SR45:12hr Decision to Admit Breaches: NOF 4 Exit Criteria SR46:12hr Decision to Admit Breaches: Patient Experience SR47: Familial Hypercholesterolemia Services SR48: Lynch Syndrome Pathway (Cancer) SR49: Equitable Access to End of Life Care SR50: E3 Maternity Information System **NEW** SR51: Delegation of Specialised Commissioning Oversight **NEW** SR52: Industrial Action Clinical Impact **CLOSED** SR18: LD CAMHS Psychiatry Provision **CLOSED** SR21: CYP Service Disruption (Changes in Workforce) **Committee also has oversight of a small number of risks that do not currently meet the BAF or Significant Risk threshold:** QIC-All-026 s117 Mental Health Act Personal Health Budgets LC001 Community Epilepsy Commissioning LC002 Community Neurology Commissioning LC003 Adult Speech & Language Therapies Commissioning LMNS04 Maternity & Neonatal Workforce NQ45 BPAS CQC Improvement Plan NQ46 Learning from Patient Safety Events System Go-Live LMNS05 Smoking in Pregnancy **NEW** CYP137e Integrated Front Door Interoperability and Readiness **NEW** QICSGA29 Deprivation of Liberty Safeguards Backlog **NEW** NQ47 Pharmacy Workforce **CLOSED** QIC-LD-007 LD and Mental Health Hospital Discharge
Key items for assurance/noting:	**<u>05 October 2023</u>** **ICS Quality Strategy Draft Implementation Plan** Committee received draft strategic objectives set to consider each of the four priority areas around compassionate leadership, improving quality care and outcomes, keeping services safe and sustainable and making sure outcomes are fair across populations and people. The plan also considered the NHS England guidance on quality functions and responsibilities of Integrated Care Systems: • Strategic and Operational Management of Quality • Patient Safety • Experience and Effectiveness • Safeguarding • Mental Health, Learning Disabilities and Autism Performance indicators for measuring the success of the quality strategy will be developed and refined, through the system quality governance structure and will be reported through the System Quality Dashboard. Committee Chair emphasised the importance of outcome measurement tools, to help identify impact on people's lived experiences of giving and receiving care and support. The Chair encouraged all Committee members to share any further observations or suggestions in readiness for approval of the plan at Board in January 2024.

Ambulance and Urgent & Emergency Care (UEC) Resilience
Committee noted that the system Front Door Working Group and the Emergency Care Improvement Support Team (ESICT) have supported the NNUH with a review of ambulance conveyances. Missed opportunity audits have been undertaken, looking at admission avoidance and use of pre-hospital pathways through the recently launched Unscheduled Care Coordination Hub (UCCH). Mental Health and Frailty pathways are a system focus. Committee reviewed an additional report exploring EEAST data looking at potential links between ambulance delays, deprivation, and health inequalities. A trend was noted in the 2022/23 period around men over the age of 75. It was agreed that there may be benefit in EEAST interrogating this further to understand wider influences and outcomes. EEAST advised that the subdivision of Category 2 response times was implemented on 20th September 2023. As their data comes online, local impact will be reviewed.

Adult Mental Health Collaborative
The collaborative brings commissioners, providers, and partners together to improve services. The initial local focus has been on dementia, delirium, and depression, exploring system leadership, staff education, confidence and knowledge and data collection. The secondary area of focus for the collaborative is developing interfaces between service areas and organisations to improve patient experience. A data collection/feedback exercise took place across District Councils, the three Acute Hospitals, Community Providers, NSFT and General Practice. A rich stream of information was received and informed three overarching themes: communication, mental health bed capacity and understanding and simplifying the referral routes into mental health services. Committee members raised the importance of engaging the voluntary sector, academic and research networks and service users and carers within this work.

Mental Health Crisis Provision Evaluation Report
Committee received reports on the impact and effectiveness of two of the recent locally commissioned VCSE-led crisis avoidance initiatives. Evaluation found that the Mental Health Joint Response Car regularly provides an emergency mental and physical health response to individuals experiencing crises, reducing the need for double staffed ambulance callouts and unnecessary A&E conveyances. Feedback identified opportunities to streamline its referral processes and increase capacity. Evaluation found that the Evening Crisis Support Hubs offer an alternative space for the assessment, de-escalation and treatment of people presenting in mental health crisis. It was reported the Hub experience is good in terms of accessibility, flexibility, and a person-centered approach. Staff in surrounding services felt that the service was currently under-utilised, and evaluation found that a lot of the interventions delivered through the Hubs are around the wider determinants of people's mental health, such as social, interpersonal, housing and support needs. The importance of exploring the interface between these services and the NSFT Community Mental Health Teams was noted, to help understand the trigger points for patients accessing emergency services. Wider promotion and socialisation of

	the service was also felt to be needed, to increase referrals into the Hubs from partner organisations. **Children and Young People (CYP) System Collaborative** Committee were briefed on the principles of the System Collaborative, which has a focus on early intervention and prevention, moving the resource and support further upstream over time and reducing the reliance on specialist and acute support. The collaborative looks holistically rather than separately at how physical and mental health, education and social needs all interact and moves away from a clinical model which focuses on diagnosis or labelling of needs to one which is rooted in community-led early help, and which empowers children, families, and communities. Recent developments driven by the Collaborative include developing an Integrated Front Door into services, implementing a shared Practice Model across organisations, expanding Mental Health Support in Schools, and developing School & Community Zones, refreshing the Healthy Child Programme, and exploring alternatives to acute or inpatient care. This work is underpinned by the **FLOURISH** outcome framework. Committee discussed the possibility of smoothing out some of the pathways for children within the educational system, to ensure that the right support can be accessed at the right time. **Safeguarding Children with Disabilities** The second report on the national Safeguarding Review of Children with Complex Needs and Disabilities in Residential Settings and its nine recommendations for strengthened oversight was shared. The ICB is working collaboratively with NCC, SCC and host local authorities to be assured that systems are robust for the early identification of safeguarding issues and that children who are not legally 'looked after' have the same appropriate level of oversight to provide assurance that their needs are met within residential care. **CYP Neurodevelopmental Service Provision** Committee discussed the risk around the inequity of access to support and early interventions. The ICB CYP Commissioning and Transformation Team continues to monitor the impact of additional pathway funding to reduce waiting times and identify opportunities for expansion, alongside a system review of referral pathways to ensure they are working effectively. The system is implementing a dynamic purchasing system to establish a quality assurance mechanism for independent providers and a local tariff to enable patient choice and quality oversight. Additional priorities include improving the collaborative systemwide response to meeting families' needs during the diagnostic process, improving communication with schools and families when new services come online or offers change, implementing a transition protocol with adult services and improving surveillance and prescribing for ADHD medication. It was highlighted that the CYP waiting list initiative at JPUH was delayed by five months, with transfers commencing in September 2023. **Social Care Quality Programme** Committee were briefed on the Quality Improvement Programme for Social Care. Improving the quality of care is a priority for partnership organisations across the ICS with the aim to have at least 85% of all

	types of care provision rated either Good or Outstanding. The system approach is to promote quality care, experience, and outcomes, to upskill and develop the workforce, support the providers struggling the most, and to empower all services to improve. This is driven by the development of a strategic framework to deliver a system wide evidence-based approach to identify, plan, and strengthen the infrastructure for improvement and support. **Medicines Optimisation and Safety Assurance Report** Committee received an update on quality and spend indicators, supported by the latest prescribing data from June 2023, and current quality and efficiency projects. The Prescribing Quality Scheme 2023-24 aims to support practices to improve performance on key quality and high spend areas. Committee discussed the system's marked improvement from its position as a national outlier for high dose opiates. Committee felt that it was important to consider what can be done as a system to offer alternative options for people living with chronic pain, including psychological and social support. It was agreed that an 'action learning set' approach could enable partners to collectively respond and that evidence of the impact of community 'Pain Cafes' in other systems could offer useful insights. **<u>02 November 2023</u>** **Local Maternity and Neonatal System (LMNS) Assurance Report** Committee noted that the September 2023 intake of newly qualified Midwives will support workforce growth, and that Acute Hospital Practice Development Teams are working with staff to embed them safely. Smoking in pregnancy continues to be a concern, and partners are working collaboratively to implement the Smoking in Pregnancy tobacco dependency pathway. The ICB is currently undertaking a deep dive into preterm and stillbirths in response to a national rise in rates reported. Early investigations at a local level reflect the national trend, however, clinical care standards are not felt to be the underlying driver; the LMNS is working with Public Health to explore interventions around prevention and healthy lifestyles, particularly within areas of high social deprivation. The positive impact of the collaborative LMNS approach was noted. **Update from Discharge Programme Board** Committee noted the positive impact of the programme, with the number of discharges improving and escalation bed use decreasing. It was agreed that focus continues to be needed to ensure this is sustainable, particularly as we move into seasonal pressures. Patient transport needs were also discussed, with NNUH sharing their 'Home for Lunch' work to increase morning discharges, improving patient experiences and flow. It was highlighted that there is a challenge securing transport in the mornings to support this ambition. **Adult Mental Health Transformation Update** Committee received case studies provided by NSFT, Norfolk & Waveney Mind, and Access Community Trust, detailing the impact of new interventions in primary care as part of Community Transformation work and through the five wellbeing hubs operating across the system, including initial findings from their adoption of the

	Dialog+ outcomes scale. The location of the Wellbeing Hubs was discussed with concerns raised for patients, particularly in South Norfolk. It was felt that geography was one of the biggest critical factors in how the services are used. Committee noted the wider network of support provided outside of the physical hubs but noted that geography and accessibility need to be part of future planning. Findings from site accessibility reports were shared and six areas for action were identified. One area of concern was the wheelchair access at the Aylsham hub; an action plan has been developed and this will be reviewed with Mind through their quarterly Contract Meetings. **Norfolk and Suffolk Annual Safeguarding Impact Reports** Committee received the Norfolk and Suffolk headlines on the work of the partnerships to safeguard babies, children, and young people, highlighting both the achievements and the challenges of the previous year. Independent scrutiny, safeguarding culture, and analysis of data have continued to strengthen the partnerships' focus and learning and evidence from multiagency audit, safeguarding children practice reviews, rapid reviews, and child death continues to inform practice. Both partnerships highlighted the importance of a focus on Trauma Informed Practice, investing in training for frontline staff and leaders. Norfolk's joint safeguarding supervision model (JAGS) has been highly recommended at the NHS innovation awards and continues to be monitored to understand impact on practice. **Pharmacy, Dental and Optometry Report** Oversight of Pharmacy, Optometry and Dental provision in Norfolk and Waveney was delegated to the ICB from 01 April 2023. Committee received a report on current challenges and opportunities from a transformation and quality improvement perspective. Highlights were as follows: • Community Pharmacy provision is well distributed and there is excellent access to a range of services. Quality and resilience priorities, flagged outside of the PNA, relate to workforce pressures and stock shortages that have led to long waits at some pharmacies and changes to opening times resulting in people struggling to access medication. Committee highlighted the impact of unexpected pharmacy closures. Work is taking place to support individual organisations around pharmacist cover and a pilot is in place to provide PCN liaison so that when a pharmacy closes, communication is clear and consistent, and impact is minimised. • Committee received an update on the Eye Care Transformation Plan and the risk around Acute Hospital capacity to review patients with long term Ophthalmic conditions, particularly impacting patients with glaucoma, and those on the medical retina pathway, which inform the focus of the Plan. Work is also ongoing to embed pathways between acute and community providers managing cataract surgery and post-surgical follow up, as well as planning around community optometry quality oversight.

- The ICB Dental Development Group brings together clinicians from across the profession in primary, secondary and community care along with other key stakeholders such as local authority Public Health, and Healthwatch representing the patient voice, to support the system's Short Term Dental Plan for the year ahead. The current focus is on building resilience in Primary Care, improving access to appointments, supporting the workforce, and developing processes for assurance, clinical engagement, and advice. The ICB is currently commissioning an urgent treatment service pilot and interim children's oral health initiative, alongside developing an oral health pathway for individuals needing complex medical care, such as cardiac surgery and oncology treatment.

Learning from Adverse Events and Complaints Report
Committee members received a themes and analysis report, which highlighted a small number of 'never events' reported by local Trusts. Learning was shared around nerve block anesthesia and the Acute Hospitals are developing a standardised operating procedure to help mitigate and prevent further incidents. Committee noted the increasing number of complaints reported, following the transition of primary care commissioning to the ICB, and the resulting queries received around access to general practice and dental appointments. It was noted that Acute Hospital and community providers have moved over to the Patient Safety Incident Framework from 01 September 2023.

Research and Evaluation Report
The report provided an update to committee on the activity of the Research and Evaluation Team from July-September 2023. The overview focused on the impact of work on the quality and safety of services experienced by our population and the role of the team around facilitating system wide research leadership and facilitating and supporting colleagues in out of hospital settings. Committee noted the progress made with the ICS Hydration Pilot, which is a collaboration between the ICB Infection Prevention & Control Team and the University of East Anglia. This has been recognised by the national evaluation team. The monthly programme of lunchtime learning for ICB staff launched in May 2023 continues to develop, focusing on how research and evaluation evidence can be used to improve the health and care of people in our communities.

Committee Assurance Level
The items discussed above gave assurance on scheduled items that meet the delegated aims and functions of Committee, plus emerging areas of risk and/or importance. Points that reflect the most significant risk on the October and November Agendas are as follows:

- Ambulance and Urgent & Emergency Care (UEC) Resilience
- Sustainability of Discharge Improvements
- Adult Mental Health Transformation Progress
- Access to CYP Neurodevelopmental Services
- Pharmacy and Dental Workforce Resilience and Access

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** ICB Patient Choice Policy (November) Committee reflected on the need for clear caveats and guidance for referrers, to be able to implement the policy in practice. Committee approved the policy, subject to clarifications made, as described above.
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 October and November 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: 14

Subject:	**Finance Committee Report**
Presented by:	**Hein van den Wildenberg, Non-executive Member, Finance Committee Chair**
Prepared by:	**Emma Kriehn-Morris, Director of Commissioning Finance**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**20th November 2023**

Purpose of paper:

To provide the Board with an update on the work of the Finance Committee up to including the 20th November 2023

Committee:	Finance Committee
Committee Chair:	Hein van den Wildenberg
Meetings since the previous update	Last update provided: 26.09.2023 Subsequent Meetings: 03.10.2023 & 31.10.2023
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 (NHS entities in the) ICS, and ICB.
BAF and any significant risks relevant / aligned to this Committee:	BAF 11 – Achieve the 2023/24 financial plan BAF 11A – Underlying deficit position
Key items for assurance/noting:	The main items discussed at the Finance Committee were as follows, **<u>(NHS entities in) ICS</u>** 1. The position year-to-date at September (Month 6) is a £25.3m deficit, which is £11.3m adverse against the plan. This is driven by the impacts of unfunded Industrial Action, Independent Sector activity costs and delays in Efficiency identification and/or delivery.

	1. Whilst presently all six organisations report a full year forecast outturn of break even, there remains significant risks to this delivery. **The Committee was therefore not assured that the collective of NHS entities in the ICS will meet the 23/24 financial plan.** 2. The Year-to-Date system CDEL (Capital) expenditure as at September (Month 6) was £26.5m, £9.0m behind plan, due to slippage/delays in project roll-out and RAAC schemes. For the financial year, the system is forecasting to deliver the CDEL expenditure as per the financial plan. 3. Due to the risk and pressures on N&W forecast outturn, the N&W ICS system has instigated the so-called 'double lock' process for agreeing proposals that will negatively impact upon the system's forecast outturn. Practically this means that unplanned revenue investment requests over £50k needs sign-off by all NHS partners in the system to ensure a balanced ICS overall delivery. 4. An update was received on the work done in preparation of the Medium-Term Financial Plan. Formal planning guidance is awaited, before this can be finalised. No further NHSEI submissions are expected. **ICB** 1. The ICB has reported a September year to date (Month 6) break-even position and forecasts a full year break even position. 2. The estimated value of net potential risks to the full year position amounts to some £28m, these are items which have not yet crystalised but have been identified as having the possibility of causing a financial issue on a risk-assessed basis. **Spotlights** Several Spotlight topics were presented and discussed at the Committee over the course of the two meetings held in October: - **VCSE:** this included the general context for VCSE working with the health and care sector in Norfolk & Waveney, and focused on where Finance plays a key role

	- **<u>Queen Elizabeth Hospital Kings Lynn (QEHKL)</u>**: The CFO presented key facets of the financial recovery plan, that was being developed. - **<u>ICB</u>**: The committee engaged on three areas: o A more in-depth review of the **ICB Finances** with a focus on risks. o **Primary Care**, including the impact of dentistry, community pharmacy, and optometry now falling under ICB's delegated commissioning. The meeting also discussed medicines management. o **Continuing Health Care (CHC)**: a review of the drivers of the significant cost increases, and some of the plans and efficiency schemes to manage a challenging area, which helps look after the longer term-care for the most complex cases.
Items for escalation to Board:	1. Whilst the financial risks to delivery of a balanced 2023/24 plan have reduced since the last report to Board, they remain significant, 2. The Committee was not assured that the collective of NHS entities in the ICS will meet the 23/24 financial plan 3. N&W ICS System has instigated a 'double lock' on unplanned revenue investment expenditure that would if approved negatively impact upon the system's forecast outturn, and 4. The reliance on non-recurrent measures informs an underlying deficit which in the ICB is deteriorating on a month-by-month basis.
Items requiring approval:	None
Confirmation that the meeting was quorate:	Confirmed that both meetings were 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 the collective of NHS entities in the ICS, 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 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

Only the most recent financial results at the time of preparing this report, i.e. September 2023, are included in this report. These were discussed by the Committee at their October 31st meeting.

1. **The points below follow from the October 31st Finance Committee where the Month 6 (September) position was considered.**

Part 1 (System overview: NHS entities within ICS)

- The Revenue position year-to-date at September (Month 6) is a £25.3m deficit, which is £11.3m adverse against the plan. Whilst presently all six organisations report a full year forecast of break even, there remain significant risks to this delivery.

- Factors impacting the year-to-date deficit include phasing of efficiency delivery, impact of lost income from planned elective activity, and the impact of industrial action for pay costs.

- The agency costs for the first six months are £29m, £9m over budget. The forecast agency costs for the year are £13m over budget, largely occurring within one acute hospital where all agency personnel were assumed in the plan to have ceased with an intention to recruit substantively to vacant roles.

- The Medium-Term Financial Plan development and progress was shared noting utilisation of NHSE baseline allocations, convergence, and net growth rates.

  Next steps were agreed to progress the plans and ensure system consistency whilst allowing for recovery plans where required. Recurrent efficiencies and funded inflation are likely to be the most significant risk areas. Final clarity of funding for growth and therefore risk to exceptional areas of inflation pressure along with the need for efficiencies will be confirmed once the 2024/25 financial planning guidance is received by the ICB.

The Spotlight for this meeting was on the ICB. Three areas were discussed.

1. **ICB Finances**: the Part 2 section below refers to key areas discussed. Areas or risks were noted with focus on both operational and strategic risks, with the ICB being the largest single holder of risk within the (NHS entities in the) ICS.

2. **Primary Care**.
   The expected spend for the financial year for Primary Care, including Dental, Optometry, Community Pharmacy, in Norfolk & Waveney is some £ 540m.

   The Director of Primary Care gave an update on the operational pressures within primary care. This manifests itself in a number of areas, most notably in dentistry, as well as General Practice resilience.

   The ICB's responsibility for dentistry started in April of this year. Both building the ICB team, and managing through the many issues faced with this service, such as lack of access, dental contracts being handed back, etc
   Primary care is vital in supporting other parts of the system and avoid admissions.

   The committee also heard on medicines management. Primary care prescribing is running at 11 - 12% annual inflation at the present time, far higher than values funded or budgeted for. The key drivers in relation to adverse overspends are price increase relating to shortage of drugs and national price tariffs. There are however some non-recurrent mitigations as a result of shortages of diabetes/CGLT type drugs within primary care, due to global markets. The other key driver of price increases is NICE guidance. The committee heard of the efficiency schemes in this area and recognised the success in its delivery, often at a recurrent level.

3. **Continuing Health Care (CHC)**:
   CHC has seen a dramatic increase in costs since the pre-pandemic years, driven by a growth in packages of care of patients and their medical needs. The cost pressures, also seen in the current financial year, are a result from high inflation in the care market, acuity in patients, an increase in Learning Disability patients, and so-called fast track referrals for care at end-of-life. Norfolk & Waveney is not unique in these challenges but is seeing levels of rises that are far exceeding the exceptional matched social care inflation rises of 8%.

   The Director of Quality & Care explained that there are a range of actions underway to address both the best care for patients, and addressing the cost challenges, also by taking a system lens on CHC. Risk was also shared about the unintended consequences delays to placement of CHC care may bring whilst negotiating appropriate rate costs in relation to acute discharges; the balance of financial delivery and discharge support was noted as an important focus.

Part 2 (ICB specific)

- The ICB has reported a September year to date (Month 6) break-even position and forecasts a full year break even position.

- The estimated value of potential risks to the full year position amount to some £28m, these are items which have not yet crystalised but have been identified as having the possibility of causing a financial issue. These include as yet unidentified efficiency savings and reliance on investment slippage.
  This is down from the £38m M05 reported risk values.

- The ICB is required to reduce their running costs by 30% over a 2-year period and this equates to a £5.9m overall and is anticipated to reduce against the running costs. As part of the reduction the ICB is currently going through a restructuring process. Any redundancy costs incurred, voluntary or compulsory are not included in the budget, and pose a financial risk in the current financial year.

2. The points below follow from the October 3rd Finance Committee

Part 1 (System overview: NHS entities within ICS)

- A Spotlight was held on the VSCE Sector, led by the VCSE representative on the committee, and the Senior VCSE Partner Lead in the ICB.

  The VCSE sector across the country and within Norfolk and Waveney is diverse in terms of size of organisation, purpose, income sources and organisational structures. Within the VCSE in Norfolk and Waveney there are around 12,000 voluntary sector organisations, the vast majority are small and local, with a handful of them being large frontline delivery organisations. The diversity brings both value and challenge.

  A key area of relevance of the VCSE to the ICB is the role the VCSE can play in the prevention agenda, as well as helping to alleviate current pressures on parts of the healthcare system.

  There are barriers to working with the VCSE and a recent Kings Fund and NHS England report highlighted three key areas where barriers and challenges are experienced when trying to integrate VCSE and statutory provision:
  • Commissioning and strategic planning
  • Sharing data, intelligence, and insight
  • Funding, sustainability, and investment in the VCSE sector

The discussion within the committee focused around how the Finance function could play a stronger role in supporting further integration with VCSE. We will try to frame this into one or two concrete follow-up steps.

- A Spotlight was held on the Queen Elizabeth Hospital Kings Lynn (QEHKL), where the CFO shared a brief history of the financial results for QEHKL, and key drivers of its financials. The CFO explained the financial pressures faced by QEHKL, that have to do with additional costs in running/staffing two escalation wards, and the efficiency delivery not keeping pace with the plan.

  The discussion then focused on the key facets of the Financial Recovery Plan, that was being developed but noted at the committee as being works-in-progress at that stage.

Part 2 (ICB specific)

- The meeting discussed the work that had taken place to date on the development of the Medium-Term Financial Plan, including key drivers. This points to a challenging outlook for the underlying deficit. The time to secure an underlying surplus was noted as being unlikely to be supported by NHSEI.

  Areas of risk in relation to exceptional inflation and efficiency delivery were noted with several assumptions taken at a local level whereby the national indicative rates for growth are considered to be unrealistic.

  The official planning guidance from NHS England, expected in December, will allow this work to be firmed up.

- The committee reviewed the finance risk register for the ICB.

Norfolk and Waveney
Integrated Care Board

Agenda item: 15

Subject:	**Primary Care Commissioning Committee Report**
Presented by:	**Debbie Bartlett, Local Authority Member**
Prepared by:	**Sadie Parker, Director of Primary Care**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**28 November 2023**

Purpose of paper:

To provide the Board with an update on the work of the Primary Care Commissioning Committee for the October 2023 meeting.

Committee:	Primary Care Commissioning Committee
Committee Chair:	Debbie Bartlett, Local Authority Member (Hein van den Wildenberg, Non-Executive Member chaired in September)
Meetings since the previous update on 26 September 2023:	11 October 2023
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, and since 1 April 2023 the commissioning of dental, pharmaceutical and optometry services under a Delegation Agreement with NHS England. All committee papers can be found here.
Main purpose of meeting:	To contribute to the overall delivery of the ICB's objectives to create opportunities for the benefit of local residents, to support Health and Wellbeing, to bring care closer to home and to improve and transform services by providing oversight and assurance to the ICB Board on the exercise of the ICB's delegated primary care commissioning functions and any

	resources received for investment in primary care.
BAF and any significant risks relevant / aligned to this Committee:	**BAF16 – the resilience of general practice** **Current mitigated score – 4x4=16** There is a risk to the resilience of general practice due to several factors including 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 resilience of NHS dental services in Norfolk and Waveney** **Current mitigated score – 5x4=20** Primary care services became the responsibility of the Integrated Care Board from 1st April 2023; the risk is the resilience, stability and quality of dental services, and critical challenges relating to the recruitment and retention of dentists and dental care professionals and the limitations of the national dental contract, leading to a poor patient experience for our local population with a lack of access to NHS general dental services and Level 2 dental services.
Key items for assurance/noting:	• Joint forward plan – progress on delivery of the primary care ambitions was noted, including the publication of the short-term dental plan. The opportunities to engage with both targeted groups and the general population using the Community Voices work was discussed, along with the need to work closely with the population health management team. • Contract assurance framework –how the ICB gives assurance to NHS England that it is delivering against the Delegation Agreement was noted, including that this year would include all primary care contractors, rather than just general

	practice. The first assurance meeting had taken place and NHSE had been supportive, noting the challenges for ICBs in the inherited resilience of all services. No dates for submission had yet been published, however the intention was for committee to have sight prior to submission. • Finance report – members noted an improved position relating to the budget 'gap', however work to identify efficiencies across the ICB was ongoing. There was discussion around the dental budget, with the significant underperformance noted, which linked to the BAF risk to the resilience of NHS dental services. The risks to the budget from the lack of patient charge revenue being collected was also discussed. There was a significant underspend in 2022/23 and a similar position is likely to arise in 2023/24.
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. The ICB's progress on its plan to recover access to primary care and address interface issues would be brought to the ICB Board in November and March. The resilience of dental services, summarised in BAF18 is of grave concern, with the short-term plan approved at the September meeting. The risks in the dental budget through the lower-than-expected level of patient charge revenue being collected, and the significant underspend is of great concern to committee members. The financial claw back of underperformance process has the potential to place struggling contractors at further resilience risk.
Items requiring approval:	• The system delivery plan for recovering access to primary care – the plan was approved and would be monitored through regular assurance meetings with NHS England, and internally through the committee. Members were keen to see a more public-friendly document produced, perhaps with the support of Healthwatch, and were also keen to see the Support Primary Care campaign ramped up to have a greater impact. It was noted that this document would form the foundation for the development of our longer-term strategic plans for general practice, due to be published in March.

	• Workforce and training plans – the short-term pillar targets were approved. The concerning health and wellbeing survey results were noted, along with the efforts to support the workforce. The link to the Support Primary Care campaign were again discussed and the opportunities to work across the whole system to support the messages. Around half of our external funding bids had been successful, which was particularly important due to the lack of funding for our new primary care contractor responsibilities through our delegation agreement. • Committee membership – recruiting to the vacant practice manager attendee role. Committee noted that this would be recruited as a speciality advisor, as agreed by the Remuneration Committee, and approved the process.
Confirmation that the meeting was quorate:	There are four voting members and three are required to be quorate. The meeting was quorate with the following attendance: Debbie Bartlett, local authority partner member and chair of the committee Steven Course, executive director of finance, ICB Karen Watts, director of nursing and quality (deputising for Patricia D'Orsi, executive director of nursing)

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 prescribing, learning disability and severe mental illness health checks uptake. Access data is reviewed annually through the GP Patient Survey report. The annual contractual e-declaration requirement for practices is reported. A primary care dashboard is being developed.
Impact Assessment (environmental and equalities):	N/A
Reputation:	The committee meeting is held in public and includes attendance 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, quality, finance, primary care estates, primary care workforce, primary care digital, prescribing, locality and BI teams
Reference document(s):	Primary care 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: 16

Subject:	**Performance Committee Report**
Presented by:	**Dr Hilary Byrne**
Prepared by:	**Tessa Litherland**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**28 November 2023**

Purpose of paper:

To provide the Board with an update on the work of the Performance Committee for the period 26 September 2023 to 28 November 2023

Committee:	Performance Committee
Committee Chair:	Dr Hilary Byrne
Meetings since the previous update on 26 September 2023	• 11 November 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 NOF4 measures and improvement of NOF 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:	• NOF segmentation progress was noted and process to move out of NOF4 discussed. A comprehensive update on the ICB's current submission was noted. • Regular performance updates were received from Urgent and Emergency Care (UEC) and Mental Health. • UEC confirmed their focus is currently on discharges and ambulance handover times, also resetting the governance for the UEC programme area to streamline meetings and monitor delivery more closely. • Mental Health confirmed their focused work on Out of Area Placements is seeing an impact with a reduction of 6 people last month being repatriated. • Children and Young People update was received at Committee for the first time. The Neuro Developmental Delay (NDD) pathway demand was impacting on waiting times and the waiting list was increasing. It was agreed to do a deep dive on this next meeting. • Deep Dives on Ambulance Handover Plan and Elective Recovery Board were presented. • A first draft Ambulance Handover Plan was circulated to the meeting, however, there had been an additional work undertaken to strengthen the plan to reduce handover delays at hospitals to improve the category 2 ambulance response for patients waiting in the community. A verbal update was provided with the more robust plan being due to go to Regional and National colleagues on 17th November. • A comprehensive update from the Elective Recovery Board included progress on workstreams; Single PTL, Outpatients, Theatre optimisation, Diagnostics and Cancer. The three acute hospitals are working together on the workstreams and sharing learning from best practices. Diagnostic imaging pressures

	particularly in CT and MRI, and pressures on histopathology reporting delays due to capacity were highlighted. Cancer Faster Diagnostic Service was also raised as a pressure point as not meeting trajectory targets.
Items for escalation to Board:	Items of concern to note: • Ambulance Handover more robust plan being developed. • Out of Area Placements for mental health beds above seeing an improvement but still a focus area. • Elective waiting times increasing due to the Industrial Action and UEC pressures. Confirmed agreement to continue to prioritise cancer activity. • NDD waiting list waiting times was raised as a risk, with a proposal being brought forward by the team to review and increase capacity • LIMS pathology system was raised as a risk as it is fragile and needs to be updated/replaced. A business case is being prepared.
Items requiring approval:	Nothing requiring approval.
Confirmation that the meeting was quorate:	Yes, meeting was quorate.

Key Risks	
Clinical and Quality:	Identifying and improving poor performance will impact quality of service delivery and outcomes.
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 is 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: 17

Subject:	**Patients and Communities Committee Report**
Presented by:	**Aliona Derrett, Chair of the Patients and Communities Committee**
Prepared by:	**Rachael Parker, Executive Assistant - Norfolk and Waveney ICB**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**28 November 2023**

Purpose of paper:

To provide the Board with an update on the work of the Patients and Communities Committee for the period to 28 November 2023

Committee:	Patients and Communities Committee
Committee Chair:	Aliona Derrett, Non-Executive Director
Meetings since the previous update on 28 November 2023	Monday 25 September 2023 Monday 27 November **the update from this meeting will be included in January's update**
Overall objectives of the committee:	• Monitoring and coming back to the 'so what' conversation question during meetings • As part of the deep dive sessions – all presentations and presenters must include – as a result of doing this, **what has changed, including experience, outcomes and access.** This will be a core focus of the Committee to scrutinise these metrics. • How many people are we reaching/connecting with as part of engagement and co-production activities? • What evidence is there to identify how health inequalities are reducing?
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:	**Healthwatch Updates** <u>Healthwatch Norfolk</u> The Committee was pleased to receive an overview from Heatlhwatch Norfolk of the various projects currently in progress, including: • An engagement exercise with pharmacies across Norfolk to gauge understanding of issues being faced by both the public and service providers. The Norfolk Local Pharmaceutical Committee is also involved in this project. • A project looking at the digital tools available to people with hearing loss, and testing and reviewing various products in conjunction with the third sector. • Understanding the issues facing staff and service recipients when transitioning from Children's Services to Adult Services • An evaluation of the discharge programme at the Queen Elizabeth Hospital in Kings Lynn, in relation to the commissioned ICB service around discharge back into the community. The committee also heard that following publication of all three reports for the 'Three Hospitals, Three Weeks' project an overarching report would be presented to the Urgent and Emergency Care Board, and Committees in Common. The committee thanked Healthwatch Norfolk for the way in which the project had been managed, noting it had been very well received by the hospitals and was a good example of collaboration across multiple sectors. <u>Healthwatch Suffolk</u> Heathwatch Suffolk's update focused on the launch of a survey for asthmatic young people (11+) and parents and carers of

	children with asthma (aged 5-18) in Waveney. It was noted that the survey was specific to Suffolk and Waveney and the outcome of the survey would be shared at November's committee. **Spotlight on: Joint Forward Plan Older People – Ageing Well Ambition** The Committee was updated on the current position in relation to the development of the vision and strategy for Ageing Well in Norfolk and Waveney, and the key work that had been undertaken to date, including stakeholder engagement with older residents, and a review of current best practice and national recommendations. The programme will broadly categorise older people and associated interventions into three stages of ageing: • Entering old age: prevention of ill health, promote and extend healthy active life and compress morbidity (period of life before death spent in frailty and dependency) • Transitional phase: (between healthy active life and frailty) • Frailer older people The committee heard about the work ongoing to map all current services which will be brought together by the new Ageing Well Programme Board. It is anticipated the Ageing Well Strategy will be co-created by the end of December 2023 with a road map for implementation by the end of March 2024. The committee noted the importance and complexities of this piece of work, but it is vitally important for the Norfolk and Waveney system to understand the health needs of the Norfolk and Waveney population and how we plan the future. **Changes to the Prescribing of Over the Counter Medicines and Clinical Threshold Policies** The committee was updated on some changes linked to how some medicines and clinical services would be available across Norfolk and Waveney in future, in light of the current financial pressure and a focus on efficiencies to ensure the right resource is available for the highest priority clinical areas. Following a review of all Norfolk and Waveney clinical threshold policies and policies applying to procedures of limited clinical value, a number of recommendations were made and implemented to support the restriction. A review was also undertaken of the NHS England items that should not be routinely prescribed in primary care and

	consequently updated, clear guidance for prescribers has been issued. Comms to patients, parents, carers and families have also been produced to support the changes. **Progress on Digital Transformation Initiatives** The committee received an update on the digital transformation activities underway, with a particular focus on the impact on patients and patient outcomes. It was noted that the residents of Norfolk and Waveney have shown excellent uptake of digital tools, with the area having the second highest number of online consultations submitted two years in a row, and half of all registered patients have signed up for the NHS app. However digital skills have been identified as a barrier to adoption both among the general population, and in staff employed in health and social care. There is recognition that digital initiatives to date have focused on the main health and social care providers and that a next step needs to be to plan how other partners and providers in the ICS can access and share data, and ultimately how patients can have full access to their health and care record. The committee noted some frustrations with the NHS app particularly for routine prescription requests, which did not always work, but recognised it is still in development and is improving all the time. **Integration with VCSE Update** The VCSE Partnering Lead attended to provide an overview of the work undertaken over the past few months. The committee heard that Norfolk and Waveney is one of only two ICBs in the country with a VCSE chair sitting on the main ICB Board with full voting rights. It was recognised that joint working is fundamental along with developing a shared common purpose. The committee heard about the VCSE road map which had been supported by VCSE Assembly members in July 2023. **Transformation Board Update** The committee received its first update from the Transformation Board. The update highlighted the key areas of focus of the Transformation Board which include: • The Norfolk and Waveney Integrated Care Strategy • Joint Forward Plan (JFP) • Community Services Review

	• Transition of the commissioning of services from NHSE to the ICB Future areas of focus include: • Joint Forward Plan refresh and monitoring • Alignment of strategies across the system • Single system transformation workplan In relation to the JFP and future workplan it was noted that an implementation plan which will support the JFP is in progress and will be presented to the Patients and Communities Committee in early 2024. **Community Services Review (CSR) Update** The committee noted that the first stage of the review had been a listening exercise, about the experiences of our staff, communities and people who use our services and future phases of the review will consider how might services be provided differently. The CSR workshops had generated several key themes including improving join up of care and information sharing, and the expectation that providers and organisations communicate and collaborate better with each other. However, it was noted that due to the high number of professionals attending the workshops, there was some uncertainty around how representative the workshops were in terms of engagement with the wider population. The committee felt a reality check at some point in the future is important to ensure we are still up to date with what residents think will be good. However, the committee noted the positive start to the review and that there was still much work to be done.
Items for escalation to Board:	None
Items requiring approval:	None
Confirmation that the meeting was quorate:	Yes

Key Risks	
Clinical and Quality:	The Committee's 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 the end of 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:

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:	**28 November 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 June 2023 to November 2023.

Committee:	**Remuneration, Culture and People Committee**
Committee Chair:	Cathy Armor
Committee update to Board on 30 May 2023.	30 May 2023 – November 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** • Latest period of action - Consultants 19-21 & Jnr Dr 21-23 Sep / Consultants & Jnr Dr 2-5 Oct • Actions are now being combined with OPEL 4 escalation and step down • Reviews ongoing to manage impact going forward including if IA should be considered BAU, impact on admin staff (sickness levels increasing), and how system can manage staff better on strike days **ICB Change programme** • ICB consultation process continuing • VR requests open and consideration expected November **Upscaling HR services** • Four (4) areas identified for collaborative development • Recruitment Pathways, (ii) Collaborative Bank, (iii) Leadership Development, (iv) 3rd Party contracts • Programmes aim to reduce corporate running costs with a focus on consolidation, standardisation, and automation to deliver services at scale across the ICS **Organisational Development (OD)** • Significant work continuing to support the ICB restructure

	• Continued support for ICS Board development and the development of and ICS OD strategy in progress • Diagnostics for Culture and Health & Wellbeing being launched • ICS Inclusion action plan still in progress • Menopause accreditation for the system has been achieved **EDI update** • Three areas of focus have been identified: reducing abuse and discrimination, debiasing our processes and leading in a compassionate way. • Workforce Inclusion proposal and action plan, co-produced with ICS partners, ready for sign off • EDI deep dive to taken place and action plan being developed **Workforce planning and Education** • Workforce/education planning meetings taking place with every organisation, supporting planning cycle and commissioning • Clinical Education developments to support workforce requirements in line with Long Term Workforce Plan • Increased placement capacity work ongoing, this month focus on physio placements, working with HEI's **Retention programme** • N&W continues to have the lowest leaver levels in EofE • National Retention KPIs to be reported into People Board from October • Flexible working: ICB to produce step by step guide to erostering supported by SME workshop with national and local trusts. **Agency Reduction Programme** • System wide agency reduction programme launched in August – ICB DoF SRO for programme • An ICB temporary staffing workforce working groups will be established to develop system wide actions and controls which can be adopted across all providers within the system • Agency costs are £7.6m above plan YTD driven by QEHKL (£6.7m, NNUH £0.7m, NSFT £0.4m)

	• Agency KPI is currently 4.5% against a YTD planned KPI of 3.1% • Targeted support going into QEH to drive efficiency and reduce spend
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