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

Tue 26 March 2024, 13:30 - 14:30

Agenda

13:30 - 13:30 0 min

Meeting agenda

00. 2024.03.26 NW ICB Public Meeting Agenda.pdf (3 pages)

13:30 - 13:30 0 min

1. Welcome and introductions - Apologies for absence

13:30 - 13:30 0 min

2. Minutes from previous meeting and matters arising

02. DRAFT NW ICB Board Part 1 Minutes 23012024.pdf (8 pages)

13:30 - 13:30 0 min

3. Declarations of interest

03. ICB Board ROI - Mar 24.pdf (4 pages)

13:30 - 13:30 0 min

4. Chair’s Action Log

13:30 - 13:30 0 min

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

05. ICB Board Action Log March 2024.pdf (1 pages)

13:30 - 13:30 0 min

6. Chair and Chief Executive’s Report

06. 2024-03-26 - Chair and Chief Executive's Board report - Final.pdf (6 pages)

13:30 - 13:30 0 min

Learning from people, staff, and communities

13:30 - 13:30 0 min

7. Primary care support for people living with diabetes

13:30 - 13:30 0 min

Items for Sharing and Board Consideration

13:30 - 13:30 0 min

8. Delegated Specialised Commissioning Update

08. Spec Comm Board Report March 2024v1.pdf (6 pages)

08.1 App A-N&W Delegation Agreement for Specialised Services 0.03 CLEAN.pdf (68 pages)
08.2 App B-EoE ICB Collaboration Agreement - v.0.08 CLEAN.pdf (49 pages)
08.3 App C-Programme Risk Register.pdf (1 pages)

13:30 - 13:30
0 min

9. Joint Forward Plan Refresh for Approval

09. ICB Board report 26 March 2024.pdf (5 pages)
09.1 ICB_Part_1 - 19 march 2024.pdf (133 pages)
09.2 ICB Part_2 - 19 March 2024.pdf (52 pages)

13:30 - 13:30
0 min

Finance and Corporate Affairs

13:30 - 13:30
0 min

10. Financial Report for Month 10

10. ICB Finance Report - Month 10 - Board.pdf (9 pages)

13:30 - 13:30
0 min

11. Fit and Proper Persons Test Report

11. FPPT Annual Assurance Report- March 24 Board.pdf (3 pages)

13:30 - 13:30
0 min

12. Governance Handbook

12. Board paper Gov Handbook changes March2024.pdf (4 pages)
12. App A - SoRD amends.pdf (1 pages)
12. App B - PCCC Terms of Reference proposed amends (final draft).pdf (10 pages)

13:30 - 13:30
0 min

13. Board Assurance Framework

13. BAF Paper for ICB Board Part 1- Mar 24.pdf (3 pages)
13.1 ICB Board Assurance Framework (BAF) 2023-24.pdf (50 pages)

13:30 - 13:30
0 min

Committees Updates and Questions from the Public

13:30 - 13:30
0 min

14. Report from the Quality and Safety Committee

14. 2024 03 26 - Quality and Safety Committee Report to Board v1.0.pdf (9 pages)

13:30 - 13:30
0 min

15. Report from the Finance Committee

15. Fin Com Chair Report to Mar24 Board.pdf (4 pages)

13:30 - 13:30
0 min

16. Report from the Primary Care Commissioning Committee

16. 24-03-15 PCCC paper for Board.pdf (6 pages)

13:30 - 13:30
0 min

17. Report from the Performance Committee

17. Performance Committee Report to Board - March 2024.pdf (4 pages)

13:30 - 13:30
0 min

18. Report from Patients and Communities

18. ICB Board - Patients and Communities Committee Update March 2024.pdf (6 pages)

13:30 - 13:30
0 min

19. Report from the Audit and Risk Committee

19. 2024.01.20-ARC Report to Board.pdf (5 pages)

13:30 - 13:30
0 min

20. Report from the Remuneration, People and Culture Committee

20. Remuneration People and Culture Comm Report to Board - March 2024.pdf (6 pages)

13:30 - 13:30
0 min

21. Report from the Conflicts of Interest Committee

13:30 - 13:30
0 min

22. Questions from the Public

13:30 - 13:30
0 min

23. Any other business

Norfolk and Waveney
Integrated Care Board

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

Tuesday, 26 March 2024, 1.30pm – 2.30pm

(In Public)

Hethel Engineering Centre, Chapman Way, Norwich, Norfolk NR14 8FB

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

Our goals:

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

Chair: Rt Hon. Patricia Hewitt

Item	Time	Agenda Item	Lead
1.	1.30	**Welcome and introductions - Apologies for absence**	Chair
2.		**Minutes from previous meeting and matters arising** To approve the part 1 public minutes of the previous Board meeting.	Chair
3.		**Declarations of interest** To declare any interests that board members may have specific to agenda items that could influence the decisions they make. Declarations made by members of the ICB Board are listed in the ICB's Register of Interests. The Register is available via the ICB's website.	Chair
4.		**Chair's Action Log** To receive an update from the Chair on actions taken since the last meeting. There are no Chairs Action to report at this meeting.	Chair
5.		**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.	1.35	**Chair and Chief Executive's Report** To note an update from the Chair and the Chief Executive of the ICB about the work the ICB has done since the last meeting.	Chair and Tracey Bleakley

Item	Time	Agenda Item	Lead
		Learning from people, staff, and communities	
7.	1.45	Primary care support for people living with diabetes - We will hear the lived experience of a patient in Norfolk and Waveney who has had support from their local primary care team to live well in the community with diabetes. We will also hear from local NHS staff who lead diabetes care and provide diabetes care services in NWICS	Tricia D'Orsi
		Items for Sharing and Board Consideration	
8.	2.00	**Delegated Specialised Commissioning Update** To seek Board approval for the delegation of 59 specialised services and authorise sign off the Delegation Agreement between the ICB and NHS England. To also approve the Collaboration Agreement between the ICBs in the East of England and NHS England	Andrew Palmer
9.		**Joint Forward Plan Refresh for Approval** To present the refreshed 5-year Joint Forward Plan for 2024/25 to 2028/29 for approval by the ICB Board.	Andrew Palmer
		Finance and Corporate Affairs	
10.		**Financial Report for Month 10** To receive a summary of the financial position as at month 10	Steven Course
11.		**Fit and Proper Persons Test Report** To update and provide assurance to the board, in respect of the ICB's compliance with the Fit and Proper Persons Test (FFPT).	Chair Karen Barker
12.		**Governance Handbook** To share details of amendments to two committee terms of reference for Board approval. • Specialised Commissioning • PCCC ToR	Karen Barker
13.	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	
14.	3.10	**Report from the Quality and Safety Committee**	Aliona Derrett
15.		**Report from the Finance Committee**	Hein Van Den Wildenberg
16.		**Report from the Primary Care Commissioning Committee**	Debbie Bartlett
17.		**Report from the Performance Committee**	Dr Hilary Byrne
18.		**Report from Patients and Communities**	Aliona Derrett

Item	Time	Agenda Item	Lead
19.		**Report from the Audit and Risk Committee**	David Holt
20.		**Report from the Remuneration, People and Culture Committee**	Cathy Armor
21.		**Report from the Conflicts of Interest Committee** Verbal update as the meeting date of 19 March will not allow time for preparation of a full written report.	David Holt
22.		**Questions from the Public.** Where questions in advance relate to items on the agenda.	Chair
		Any other business	Chair
Date, time and venue of next meeting: Virtual meeting via Microsoft teams, 1.30pm – 3.30pm, Wednesday 22 May 2024			
Any queries or items for the next agenda please contact: nwccg.corporateaffairs@nhs.net			

Some explanations of terms used in this Agenda.

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

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

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

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

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

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

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

NHS Norfolk and Waveney Integrated Care Board

DRAFT Minutes of the meeting on Tuesday, 23 January 2024

PART 1 – Meeting in public

Board members present:

- Rt Hon. Patricia Hewitt (PH), Chair, NHS Norfolk and Waveney ICB
- Tracey Bleakley (TB), Chief Executive, NHS Norfolk and Waveney ICB
- Steven Course (SC), Executive Director of Finance, NHS Norfolk and Waveney ICB
- Patricia D'Orsi (PD'O), Executive Director of Nursing, NHS Norfolk and Waveney ICB
- Dr Frankie Swords (FS), Executive 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 Borrett (BB), Chair, Norfolk Health and Wellbeing Board, and Chair, Norfolk and Waveney ICP
- Dr Hilary Byrne (HB), Partner Member – NHS Primary Medical Services
- Jonathan Barber (JBa), Partner Member – NHS Trusts (Acutes)
- Stuart Keeble (SK), Local Authority Partner Member
- Debbie Bartlett (DB), Local Authority Partner Member

Participants and observers in attendance:

- Andrew Palmer (AP), Executive Director of Performance, Transformation and Strategy, and Deputy Chief Executive, NHS Norfolk and Waveney ICB
- Karen Barker (KB), Executive Director of Corporate Affairs and ICS Development, NHS Norfolk and Waveney ICB
- Jocelyn Pike (JP), Acting Executive Director of Mental Health Transformation, NHS Norfolk and Waveney ICB
- Ian Riley (IR), Executive Director of Digital and Data, NHS Norfolk and Waveney ICB
- Andrew Jones (AnJ), Interim Deputy Director of People, NHS Norfolk and Waveney ICB
- Stuart Lines (SL), Director of Public Health, Norfolk County Council
- Alex Stewart (AS), Chief Executive, Healthwatch Norfolk
- Andy Yacoub (AY), Chief Executive, Healthwatch Suffolk

Attending to support the meeting:

- Lorna Bright (LB), Assistant Director of Integrated Operations, Mental Health and Learning Disabilities, Adult Social Services, Norfolk County Council (for item 8)
- Amanda Johnson (AmJ), Business Lead (Working Age Adults), Adult Social Services, Norfolk County Council (for item 8)
- Andrew Jones (AnJ), Interim Deputy Director of People, NHS Norfolk and Waveney (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. Apologies were received from the following Board members: • Caroline Donovan (CD), Partner Member – NHS Trusts • Emma Ratzer (ER), Voluntary, Community and Social Enterprise Sector Board Member	
2.	**Minutes from previous meeting and matters arising**	
	Agreed: The draft minutes from the meeting held on 28 November 2023 were approved as an accurate record of the meeting, with two amendments: firstly to page five, to change 'community care' to 'secondary care' under bullet point five of the Primary Care Recovery Plan item, and secondly to remove AP from the list of participants in attendance.	
3.	**Declarations of interest**	
	The Chair noted that declarations of interest were kept up-to-date and were available on the ICS's website.	
4.	**Chair's action log**	
	KB explained that there was one action regarding procurement for the Child and Families Therapeutic Service, as set-out in the papers for the meeting.	
5.	**Action log**	
	The report was noted.	
6.	**Chair and Chief Executive's Report**	
	The Chair highlighted the significant progress the system had made with reducing ambulance handover delays and improving ambulance response times. She explained it was not perfect and there was more to do, adding that the reason for the progress was the way we had built the partnership and that everyone was sharing ownership of the problem, which was important for the wider transformation the system wants to achieve. TB thanked colleagues from across the system for their work on reducing ambulance handover delays and improving ambulance response times, as well as how the system had managed the industrial action. She also explained there had been an extraordinary meeting of the Board to sign-off the Electronic Patient Record Full Business Case. TB noted that we had received three questions from members of the public about Benjamin Court and explained that all the answers would be put on website and sent to the people who had asked the questions. Questions and comments from Board members: • BB congratulated everyone involved in the work to improve ambulance handovers and response times, noting that it demonstrated we can make real change as a system. The report was noted.	

	Learning from people, staff, and communities	
7.	**Learning disability health checks**	
	PD'O introduced the item and a short video was played about health checks, which included the experiences of people with learning disabilities who had received a health check. PD'O asked all Board members to act as a champion for health checks. She noted the importance of people knowing what was happening / going to happen with their care, of good communications and making reasonable adjustments. She asked that all Board members undertake the Oliver McGowan training. Questions and comments from Board members: • The Chair committed to undertaking the Oliver McGowan training. • DH asked how many people weren't having health checks. • CA asked about take-up rates for other checks, such as cervical screening and mammograms, and whether a similar approach was taken. • BB noted that this was an issue the Primary Care Commissioning Committee had looked at over a number of years and that there had been a huge improvement in take-up, adding that health checks were a great example of prevention. • HB noted it was encouraging and helpful to hear the feedback on the video. She added that there had been some challenges with the data and that this continued to be worked on. • SK commented that often the reasonable adjustments made for particular groups of people are done to achieve the same things we would want for other people too, such as better communication. He highlighted that it was important to consider not just how many checks were had, but also how good the health checks were. • PD'O explained that there were 7,000 people on LD register, that we want 100% to have a health check, but the target was 75%. She added that this was very nearly achieved last year and that extra resource had been identified this year to help. She explained that in the checks they cover off areas such as breast examination, cervical screening and CVD screening, which then correlate with the other checks offered in primary care. The report was noted.	
	Items for Sharing and Board Consideration	
8.	**Learning Disability Plan**	
	PD'O, AmJ and LB introduced the item by highlighting key points from the report. PD'O noted it was a great example of collaborative work, and LB asked that as well as signing-off the plan, that the Board go on to champion it too. Questions and comments from Board members:	

	• AP welcomed the way the system had worked with people with LD. He noted that the system was refreshing the Joint Forward Plan and that he wanted to make sure this work was linked with and reflected in the refreshed plan. • The Chair highlighted that it was a great example of partnership working and that all Board members would commit to championing it. **Agreed:** The ICB Board approved the Learning Disabilities Plan for 2023-28, as part of the agreed sign-off process set-out in the paper.	
9.	**Mortality Review**	
	PD'O introduced the item by highlighting key points from the report, explaining that it was an update on the work and actions that had been taken since the publication of the Grant Thornton and Forever Gone reports. It was noted that the same paper would be presented to the boards of NHS Suffolk and North East Essex ICB and the Norfolk and Suffolk NHS Foundation Trust (NSFT), that it had been to the Norfolk Health Overview and Scrutiny Committee and it would be going to the Suffolk scrutiny committee as well. Questions and comments from Board members: • AD asked if NSFT were part of the learning from deaths forum. PD'O confirmed that they were. • FS noted that wider work was being done to improve care and to learn from when people die. She explained that all trusts have a learning from deaths forum, and that the system forum enables us to learn together, adding that the January deep dive had been on NSFT deaths. • BB welcomed the update, noting that transparency is important. He added that he was glad the report would be going to both the Norfolk and Suffolk Health Overview and Scrutiny Committees. **Agreed:** The ICB Board reviewed the report and noted the papers shared with both Norfolk and Suffolk Health Overview and Scrutiny Communities, which outlined the future governance arrangements and commitment to co-production.	
10.	**ICS Quality Strategy Implementation Plan and Matrix**	
	PD'O introduced the item by highlighting key points from the report. Questions and comments from Board members: • FS highlighted the development of the plan and matrix as a fantastic piece of work as it would enable us to measure if the Quality	

	Strategy was having an impact. She added that the dashboard would be crucial for the system. • AD commented that it had been hard work to get to this point and thanked everyone involved. • SK asked if we have an ambition as a system to cut the data in data lake by different protected characteristics, as doing more would really help to tell the story. PD'O explained that there were still conversations to be had about this, but that she was passionate about using population health management. • JB asked if we need to make a more specific ask of providers to embed this in their quality strategies. PD'O explained this would be in the paper that goes to each of the providers. • DB noted it was great to see the commitment to getting the right social care metrics included, as this would help us to avoid unintended consequences. **Agreed:** The ICB Board: • approved the ICS Quality Strategy Implementation Plan. • approved the recommendation for the plan to be taken through provider boards and other quality and clinical leadership forums to ensure that a system approach is taken to delivering on the strategy objectives. • approved the recommendation for the plan to be tabled at the Integrated Care Partnership meeting to support a joined up partnership approach to deliver on the strategy objectives.	
11.	**Equality and Diversity Standard (EDS2) and WRES update**	
	AnJ introduced the item by highlighting key points from the report. Questions and comments from Board members: • DH asked if the report just covered the ICB or if it covered NHS partners too. AnJ explained it just covered the ICB, each NHS partner has their own duty to do their own report. • DH asked how we perform as a system. AnJ noted this was something he would take away and report back to the Board on. **Action: EO to provide the Board with information about system benchmarking against the EDS2 and WRES.** The report was noted.	
	Finance and Corporate Affairs	
12.	**Financial Report for Month 9**	
	SC introduced the item, noting that the report covered month 8 and not month 9. He explained that the forecast outturn position for the ICB for the year remained a break-even position in line with our plan.	

	He added that the organisation was likely to go beyond its cash drawdown allowance, so colleagues were working with NHS England to try and find a solution. He noted that this was a common issue amongst ICBs in the financial climate and that the issue would be escalated if a resolution could not be found by the end of January. SC 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 £16.1m at month eight, which was adverse to our plan by £5.6m. He added that this was before the industrial action in January. 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. Questions and comments from Board members: • HvdW highlighted that the underlying deficit was a concern. He noted the underspend in dental contracts and that there was unmet need for dental care. He asked for assurance that the ICB was making maximum use of flexible commissioning as allowed by the dental contract. • SC explained that the ICB had been investing in dental services where it could, for example in the Urgent Treatment Service, but that the limited supply of dentists made investment difficult. • BB commented that the state of dentistry inherited by the system was dreadful and reinforced that it had been difficult to invest, but that the ICB was committed to improving dentistry. • The Chair confirmed that the ICB was working hard to get dentists to do more NHS work. The report was noted.	
13.	**Governance Handbook**	
	KB introduced the item by highlighting key points from the report. **Agreed:** The ICB Board approved the proposed changes to the Governance Handbook to enable the establishment of the Commissioning and Performance Committee.	
14.	**Board Assurance Framework**	
	KB introduced the item by highlighting key points from the report. Questions and comments from Board members: • DH commented that he thought the Board should look again at some stage at the level of risk in the system and the Board's ambitions and tolerance for risk.	

	The Board received and reviewed the risks presented on the Board Assurance Framework.	
	Committees update and questions from the public	
15.	**Report from the Quality and Safety Committee**	
	AD noted that the committee had discussed adult eating disorder provision, dementia pathways and the Neurological Rehabilitation Service. The report was noted.	
16.	**Report from the Finance Committee**	
	HvdW reiterated the concern about the system's underlying deficit. The report was noted.	
17.	**Report from the Primary Care Commissioning Committee**	
	DB noted the committee's operational delivery groups were enabling the committee to have more strategic conversations. She added that at the last meeting they had discussed optical services and also Pharmacy First, as well as the resilience of dental services and general practice. The report was noted.	
18.	**Report from the Performance Committee**	
	HB highlighted the very significant improvement in ambulance handovers. The report was noted.	
19.	**Report from the Patients and Communities Committee**	
	AD noted that the committee had discussed community mental health transformation and an update from the Ageing Well Programme Board, as well as the monitoring of mortality rates and the extension of the medical examiner system. The report was noted.	
20.	**Report from the Audit and Risk Committee**	
	DH noted that the committee had discussed the ICB organisational review and restructure, Specialised Commissioning, an update on whistleblowing and freedom to speak-up and the front half of the annual report and accounts. The report was noted.	
21.	**Report from the Remuneration, People and Culture Committee**	
	CA noted that the committee had discussed the ICB organisational review and restructure, as well as the ongoing industrial action. The report was noted.	
22.	**Report from the Conflicts of Interest Committee**	

	DH noted that progress was being made with mandatory training. The report was noted.	
23.	**Questions from the public**	
	The Chair noted that the responses to the three questions about Benjamin Court would be put on the website.	
24.	**Any other business**	
	No other business was raised.	
Date, time and venue of next meeting: **Tuesday, 26 March 2024, 1.30pm-3.30pm, Hethel Engineering Centre, Chapman Way, Wymondham Road, Hethel, Norwich NR14 8FB**		
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 adviser, FTI Consulting	2015	Present	Since January 2022 I have not done any work relating to
		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, Advisory Board, Oxford India Centre for Sustainable Development	2018	Present	No conflicts have arisen or foreseen
		ORA Singers			X	Direct	Chair, Board of Trustees, ORA Singers	2020	Present	No conflicts have arisen or foreseen
		Age UK Norfolk			X	Direct	Volunteer, Age UK Norfolk	2020	Present	Will declare in any relevant conversation
		Future Public Services Taskforce			X	Direct	Member, advisory board, Future Public Services Taskforce, Demos	Sep-23	Present	No conflicts have arisen or foreseen
Catherine Armor	Non-Executive Member, Norfolk and Waveney ICB	Educational Association			X	Direct	Trustee, Workers' Educational Association	Dec-23	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		Norwich University of the Arts			X	Direct	Deputy Chair of Council, Norwich University of the Arts	2019	Present	
		Evolution Academy Trust			X	Direct	Trustee, Evolution Academy Trust	2022	Present	
		Cambridge University Press Pension Schemes		X		Direct	Trustee, Cambridge University Press Pension Schemes	2018	Present	
		East of England Ambulance Service NHS Trust				Indirect	Daughter-in-law is Technician for East of England Ambulance Service NHS Trust		Present	
		Brundall Medical Practice			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
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 and partner 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	X			Direct	Director MPT Healthcare	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.
		SNHIP PCN				Direct	Clinical Director SNHIP PCN	2023	Present	
		Norfolk Community Health Care				Indirect	Husband is an employee of NCHC	2021	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	Removal from any decision making that may involve the supplier
Aliona Derrett	Non-Executive Member, Norfolk and Waveney ICB	Norfolk and Norwich University Hospital NHS FT				Indirect	My son-in-law, Richard Wharton, is a consultant surgeon at NNUHFT	2004	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Hear Norfolk	X			Direct	I am the Chief Executive Officer of Hear for Norfolk (Norfolk Deaf Association). The charity holds contracts with the N&W ICB	2010	Present	
		Derrett Consultancy Ltd	X			Direct	I am the Director of Derrett Consultancy Ltd	2018	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		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.

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	
		MoldovaDAR Ltd	X			Direct	I am Director of MoldovaDAR Ltd	2019	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		St Stephen's Gate Medical Practice			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Caroline Donovan	Partner Member - Mental Health and Community	Norfolk and Suffolk NHS Foundation Trust	X			Direct	Chief Executive Officer, Norfolk and Suffolk NHS Foundation Trust	2023	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.
		CMD - Health	X			Direct	Director CMD - Health	2023	2023	Previous role in consultancy with no activity from October 2023
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		
Stuart Keeble	Director of Public Health and Communities for Suffolk and member elect of Norfolk and Waveney ICB	Nothing to Declare					N/A			N/A
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 decision will be taken in the best interests of the system with the necessary due-diligence taking place prior to final decision being made
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.

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	
		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
Dr Frankie Swords	Executive Medical Director, Norfolk and Waveney ICB	Norfolk and Norwich University Hospitals		X		Direct	Honorary Consultant Physician and Endocrinologist at Norfolk and Norwich University Hospitals NHS FT (1 day a week)	2008	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest
		Multiple patient charities		X		Direct	Ad hoc Clinical Advisor for multiple patient charities - Addison Self Help Group - Pituitary Patient Support Group - Turner syndrome Society	2008	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest
		British Medical Association		X		Direct	Member of the British Medical Association	1999	Present	Inform Chair and will not take part in any discussions or decisions relating to BMA
		Emerging Futures and St Martin's Housing Trust				Indirect	Husband is a mental health counsellor and undertakes work independently and with the private provider Better Help, and VCSE providers: Emerging Futures and St Martin's Housing Trust	Sep-22	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of counselling services by Emerging Futures, St Martin's Housing Trust or Better Help
		Long Stratton Medical Partnership			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Hein van den Wildenberg	Non-Executive Member, Norfolk and Waveney ICB	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. 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
		Lakenham Surgery			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared

NORFOLK & WAVENEY ICB Action Log Part 1 - Tuesday 26 March 2024							
No:	**Date of Meeting**	**Description**		**RESP**	**Due Date**	**ACTION / UPDATE**	**Status**
24	23-jan-24	Information about system benchmarking against the EDS2 and WRES.	EO to provide the Board with information about system benchmarking against the EDS2 and WRES.	EO	jul-24	Following the EDI board deep dive we will incorporate this action in to a broader action to progress an ICS EDI plan and delivery of the NHSE High Impact Actions. This will come back in Quarter 2.	Open

Agenda item: 06

Norfolk and Waveney
Integrated Care Board

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:	**26 March 2024**

Purpose of paper:

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

Executive Summary:

The report covers the following:

A. Norfolk and Waveney Integrated Care System progresses out of national support
B. Norfolk and Waveney to become an innovation site
C. ICB organisational review and restructure
D. Volunteering in health and care
E. Meetings and visits

Report

A. Norfolk and Waveney Integrated Care System progresses out of national support

Board members will have seen the announcement that NHS England has confirmed the Norfolk and Waveney Integrated Care System is no longer in NHS oversight framework segment 4 and has been removed from the Recovery Support Programme (RSP), formerly known as “special measures”. This is excellent news and testament to our work as a system, the hard work of staff and the leadership that each and every member of the Board has shown.

The announcement highlights some of the key improvements we’ve made. It is a list that’s worth repeating and demonstrates that together we can make real and sustained improvement:

- Key quality improvements and progress at two of the system’s providers. The Queen Elizabeth Hospital King’s Lynn NHS Trust exited special measures in April 2022 and last February the Norfolk and Suffolk NHS Foundation Trust moved from a CQC rating of Inadequate to Requires Improvement.
- Sustained improvement in performance in urgent and emergency care services, including the establishment of virtual wards at all three acute trusts.
- Improvements in discharge planning and patient flow, helping to reduce the length of time people stay in hospital, decreasing their need to be readmitted and improving their overall experience.
- Significant and sustained improvement in ambulance response times and handovers, enabling ambulances to quickly get back on the road so they can get to the next person who needs help.
- A system wide reduction in the longest waits for people who require a mental health bed, with further ongoing improvements planned.
- Greater efficiencies and progress against financial plans through closer collaborative working with partners.

We are absolutely delighted that the hard work and dedication of our 27,000 NHS staff working in Norfolk and Waveney has been recognised, and that together we have made the improvements needed to exit the Recovery Support Programme.

This is just the first step towards our ambition of improving individual services for local people and making the whole health and care system work better together to help people live longer, healthier and happier lives. There’s much to do over the coming months and years, but we would like to say a huge thank you to everyone who is working so hard in health, care and public services across Norfolk and Waveney.

The change also reflects the strong partnership that we have been developing within the NHS and with many other partners including colleagues in local government; voluntary, community and social enterprise organisations; and residential and domiciliary social care.

We hope that this achievement will give everyone confidence that, by working together, we can continue to improve and ensure that all our residents get the high quality, integrated care they deserve.

B. Norfolk and Waveney to become an innovation site

We are really excited that Norfolk and Waveney is to become one of the Clinical Entrepreneur Programme Innovation Sites. Supported by NHS England, the programme focuses on testing new and innovative ways of delivering patient care, evaluating these in real-world settings, and preparing healthcare organisations to be more readily able to adopt, scale, spread and sustain innovations. The ICB will join the ten original participants from last year, along with seven other organisations that are joining the programme this year.

A range of pioneering solutions were trialled in the first year, including using artificial intelligence to predict non-attendance in outpatient clinics, developing a virtual reality platform providing information and support to children and their families before, during and after procedures, and testing a community-based lifestyle programme for diabetic patients to reduce medications.

This year, the participating organisations will collaborate to address their key needs such as reducing the waiting time for patients, creating more capacity in the system, and supporting the NHS workforce.

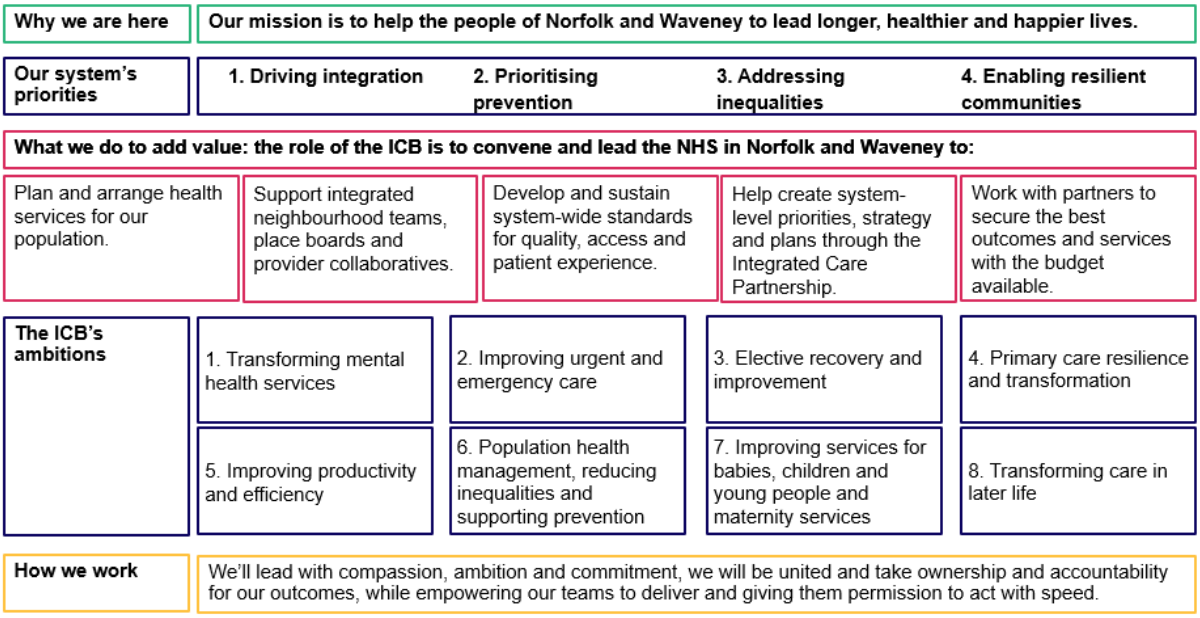
More information about this can be read here: https://improvinglivesnw.org.uk/nhs-norfolk-and-waveney-integrated-care-board-on-behalf-of-the-integrated-care-system-becomes-an-nhse-supported-innovation-site-insite/

C. ICB organisational review and restructure

On 15 February we shared the final structure with our staff. We have worked closely with our trade unions, staff and partners to get to this point. The process has taken longer than we initially planned. We deliberately lengthened the timeline to undertake a public engagement exercise about the Prescription Ordering Direct service and to run the voluntary redundancy scheme to enable us to see how we could mitigate compulsory redundancies within the organisation.

We are now going through the process of ringfencing, slotting and filling of posts. It continues to be a difficult time for ICB staff and we are grateful for the understanding being shown by partners.

The new structure will enable the ICB to better support system working and collaboration, to meet our statutory duties and to deliver against our new operating model shown below. The structure takes account of the organisation's new functions and role as a convener of the system, as well as what we have collectively learnt since the organisation was formed in July 2022.



D. Volunteering in health and care

We wanted to highlight some of the great work we are doing to improve volunteering with our providers and Helpforce, a national charity dedicated to promoting volunteering within health and care. Here are a few examples:

- **Volunteer to Career in EEAST,** which has established a new pathway that provides volunteers with paramedic training and support through interviews into a career with EEAST. The model is being looked at nationally to roll out to other ambulance trusts.
- **Volunteer to Career in Primary Care**, which aims to develop new volunteering roles in general practice and dentistry. The ICB will provide support to both employers and volunteers. Volunteers will take on roles with additional career mentoring and conversations with practitioners. The pilot site is established and we are currently recruiting the first volunteers. It is the only pilot across the Helpforce portfolio that is focusing on primary care. We are looking to develop further pathways for the Armed Forces Community and Adult Social Care.
- **Volunteers reducing non-attendance of diagnostic appointments.** We are implementing a service whereby volunteers undertake phone calls to prevent non-attendance (and on the day cancellations resulting from inappropriate preparation) for patients having an outpatient diagnostic appointment. The NNUH and QEH are piloting it in Norfolk and Waveney, along with the George Eliot Hospital in Mid and South Essex. Based on the reduction of people not attending their appointment at the George Eliot for physiotherapy services, non-attendance could be reduced by up to 5.8%. We will have more data as the work progresses.

E. 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:

- NHS England held their Board meeting in Norwich in February, which Tracey and Nick Hulme spoke at. The Board then spent a day visiting a range of our services. I joined Amanda Pritchard, Richard Meddings and Sarah-Jane Marsh at NSFT, where we had a really open and constructive discussion about the actions we are taking as a system to improve people's mental health and wellbeing, as well as the challenges we face and next steps. Feedback from NHS England colleagues was that they found the visits incredibly helpful and they were impressed by the services they saw and the innovation they witnessed.
- Tracey and I both attended a briefing for councillors about dentistry. It was excellent to get so many colleagues from local government together to talk through what we are doing as a system and what more we need to do to improve access to dentistry and people's oral health.
- I deputised for Cllr Bill Borrett, chairing this month's meetings of the Norfolk Health and Wellbeing Board and the Norfolk and Waveney Integrated Care Partnership. These meetings are increasingly interesting and informative, bringing together colleagues from every part of the ICS. Not surprisingly, an important theme this month was the financial pressure that every organisation and partner is facing, underlining the need for us all to work together even more closely.
- I attended the Norfolk Public Sector Leaders Board. I am particularly grateful to Mark Burgis for presenting the update from the ICB on primary care and other matters. I have had a number of other meetings, including with the Norfolk and Waveney Local Medical Committee (LMC).
- I attended a really interesting roundtable run by the Institute for Government about how the government can shift spending towards preventative services.
- The Hewitt Review Stakeholder Steering Group continues to meet, looking at how the recommendations from my review can be taken forward. At our last meeting we focused on payment mechanisms, a national ICP Forum and national targets.
- I spoke at a national event for the many local partnerships involved in Complete Care Communities, a programme initiated and led by Dr James Kingsland that tackles health inequalities through transformational partnerships between primary care and local communities. It was a particular pleasure to meet those involved in the excellent Lowestoft partnership.
- I also spoke at the District Councils Network's national conference in St Albans which was very well-attended by councillor and senior executive colleagues from almost all the district and borough councils in Norfolk and Waveney. And I spoke at a very well-attended Good Governance institute

(GGI) webinar on the Hewitt Review 1 Year On, where again it was a pleasure to see so many Norfolk and Waveney colleagues.

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

- There have been a range of system, regional and national meetings about financial and operational planning for 2024/25 that I and other executive colleagues have attended.
- I continue to attend the Oversight Group for Mental Health Services across Norfolk and Suffolk. These meetings are an important opportunity for us to look in detail at progress with the actions we are taking to improve services and people's care.
- To ensure we sustain the recent improvements with urgent and emergency care, particularly regarding ambulance handovers, colleagues and I continue to attend meetings with Sarah-Jane Marsh, NHS England's National Director of Urgent and Emergency Care and Deputy Chief Operating Officer, as part of the 'Tier 1' support programme.
- I really enjoyed meeting with Lesley Dwyer, the new Chief Executive at the NNUH and then with Andy Wood, the new Chair of ECCH. Both will bring a huge amount of expertise and experience to our system, from different sectors and different parts of the world.
- I visited the Thetford Healthy Living Centre, which is nearly ready to be used. When completed, it will be a modern, fully accessible and digitally enabled facility where local people can access a range of health and care services in a central location. It will be a real asset to the community and is one of four primary care projects being undertaken using £25.2m of capital funding we secured for the system.
- I attended a Prescribing Prevention roundtable organised by Age UK colleagues. The session was excellent and fits well with the priority in our Joint Forward Plan about living well in later life.
- I attended an East of England workshop about implementing the NHS England Operating Framework, where the regional team provided an update on work underway across NHS England to implement the principles outlined in the operating framework. Systems shared the reciprocal changes they are making to their system architecture and ways of working.
- I attended a reception for Doctors in Distress, which is a charity that exists to promote and protect the mental wellbeing of the NHS workforce and to prevent suicide across all healthcare workers. It is a really important charity and the event was a stark reminder of why we are making changes to how we work and investing in the health and wellbeing of our workforce.

Norfolk and Waveney
Integrated Care Board

Agenda item: 08

Subject:	**Delegation of 59 Specialised Services from NHS England to the six ICBs in the East of England**
Presented by:	**Andrew Palmer, Executive Director of Performance, Transformation and Strategy and Deputy CEO**
Prepared by:	**Geoff Stokes, NHS England Governance Lead Specialised Commissioning** *(local amendments by Amanda Brown, ICB Head of Corporate Governance)*
Submitted to:	**ICB Board**
Date:	**26 March 2024**

Purpose of paper:

To ask the Board to approve the delegation of 59 specialised services and authorise the signing of the Delegation Agreement between the ICB and NHS England and to approve the Collaboration Agreement between the ICBs in the East of England and NHS England.

Executive Summary:

1 Introduction

1.1 From 1 April 2024, the responsibility for commissioning 59 specialised services will be delegated from NHS England to the six ICBs in the East of England. The six ICBs will collaborate to commission these services, with NHS Bedfordshire, Luton and Milton Keynes (BLMK) ICB acting as host ICB.

1.2 In order to fulfil the requirement for delegation to take place, a Delegation Agreement between the ICB and NHS England, and a Collaboration Agreement between the six ICBs and NHS England need to be signed and submitted to NHS England by the 31 March 2024.

1.3 This paper seeks approval from the Board for both documents to be signed.

Report

2 Background

2.1 NHS England has an ambition to integrate specialised services with integrated care systems and since 1 April 2023 there has been a joint committee in each of the nine regions to oversee those services including members from the ICBs and the NHSE regional office.

2.2 From 1 April 2024, 59 services are due to be delegated to the ICBs in the East of England (and also to the ICBs in the Midlands and North West). A further tranche of services is due to be delegated on 1 April 2025, which will also include the rest of England.

2.3 A safe delegation checklist, produced by NHS England, has been used to test the readiness for delegation and demonstrates that there are no significant 'red flags' which would indicate that delegation should not proceed.

2.4 On 7 December 2023, the Board of NHS England approved template documents to be used in the delegation. These include a Delegation Agreement and a Collaboration Agreement, which set out how the six ICBs will work together to commission services, in conjunction with the Specialised Commissioning Team (SCT).

2.5 The Delegation Agreement template only has a few areas that can be amended, whereas the Collaboration Agreement can be amended to suit the purposes of the ICBs. The Collaboration Agreement also includes as Schedule 6, the commissioning team arrangements which has been adapted from a stand-alone template also approved by the NHS England Board.

2.6 Work has been underway since the production of the templates to edit them to ensure they are fit for purpose and to socialise amongst key ICB officers. Much of the detailed content has been developed by the specialised commissioning leads, directors of finance and governance leads from the ICBs and NHS England. This has included drafts being circulated and amended based on feedback received.

3 Delegation Agreement

3.1 The Delegation Agreement is the formal basis on which responsibility for the commissioning of specialised services will be delegated from NHS England to the ICB. As a result, only the particulars and Schedule 8 have areas that can be amended.

3.2 The Delegation Agreement makes clear that accountability for fulfilling the statutory duties in respect of the commissioning of delegated specialised services remains with NHS England. It is the responsibility for delivery of the functions that is being delegated to the ICB.

3.3 There are a number of areas where further guidance is being provided by NHS England, especially related to the annual planning guidance, which has yet to be published.

3.4 Schedule 8 makes extensive reference to the Collaboration Agreement where more details are provided.

4 Collaboration Agreement

4.1 The ICBs in the East of England have agreed a 'collaborative endeavour' to collectively manage the commissioning of the delegated specialised services in conjunction with the NHSE regional office.

4.2 The Collaboration Agreement is the document that sets out how the commissioning of specialised services will be carried out in the East of England. Whilst the template

agreed by NHS England was intended only to relate to the ICBs, with a separate Commissioning Teams Agreement, it was felt to be more straightforward to have one document that includes commissioning team arrangements as a schedule. This also reflects the on-going partnership between NHS England, East of England Region and ICBs in relation to non-delegated services.

4.3 Consequently, NHS England, East of England Region is also a signatory to the Collaboration Agreement, although not all the clauses will apply. To make this clear, clauses relating to the ICBs only are identified separately from those relating to the 'Partners', i.e. including NHS England.

4.4 Although there is no fixed term in the Collaboration Agreement, a review will take place after six months as it is expected that it will be replaced for 1 April 2025 when further services will be delegated and the NHSE staff will be TUPE transferred to BLMK ICB.

5 Financial Arrangements and Risk Sharing

5.1 The allocation to cover the cost of specialised services being delegated, including any uplift added in in the 2024/25 planning round, will be allocated to the ICB in order to pay providers for the specialised services delegated.

5.2 The directors of finance of the six ICBs have agreed not to create a pool from which to pay providers. Instead, ICBs will retain the allocation within their own ledger, which will be debited every month to pay the ICB's share of costs to providers.

5.3 For this ICB, the allocation for specialised services is £186.6m in 2024/25 (£1,297m for the East of England in total). The finance pack shows the breakdown of those costs by ICB. It will be presented to the Finance Committee and is available to Board members on request.

5.4 It has also been agreed that each ICB will reserve 1% of their allocation as a contingency to cover any in-year adjustments that may be needed between the ICBs. This amount is expected to be sufficient to cover any anticipated volatility and any unused reserve will be retained by the ICB. A further 0.5% has been reserved centrally to cover developments and transformations that occur during the year.

6 Dispute Resolution

6.1 The nature of the arrangement is one of collaboration and therefore each ICB is committed to working together to resolve any issues that arise.

7 Governance Arrangements

7.1 As referenced in 2.1, a joint committee (the Specialised Services Joint Commissioning Committee) has been in place in the East of England since 1 April 2023 with representatives from all six ICBs and the NHS England regional office. This has overseen the currently commissioned specialised services and the preparation for delegation.

7.2 From 1 April 2024, the existing joint committee will be replaced by a Joint Commissioning Consortium to oversee and make operational decisions in relation to the delegated services and to advise NHS England on those specialised services that are not being delegated.

7.3 The Consortium is not a committee of the Board and decisions taken by the Consortium will only be those that are already within the delegated authority of the individual members. The ICB's member of the Consortium will be Andrew Palmer, Executive Director of Performance, Transformation and Strategy & Deputy Chief Executive Officer.

7.4 Any decisions that fall outside of the delegated authority of the Consortium member as set out in the ICB's Scheme of Reservation and Delegation will be referred back to the ICB for approval before being enacted.

7.5 The terms of reference for the Joint Commissioning Consortium have been drafted based on the template agreed by the Board of NHS England.

8 Commissioning Team Arrangements

8.1 The existing SCT will remain employed by NHS England and deliver all the functions currently delivered, including contract management, financial management, quality and performance oversight of providers, amongst many other functions.

8.2 Schedule 6 of the Collaboration Agreement describes the commissioning team arrangements and the table in appendix 4 of that schedule shows the functions to be carried out by the SCT on behalf of all the ICBs.

8.3 The current expectation is that the SCT will transfer to BLMK ICB under TUPE regulations on 1 April 2025, at which point BLMK ICB will take over responsibility for the management of the team. Although BLMK ICB will act as host for the SCT from 1 April 2024, it will not be the 'lead commissioner' as each ICB will receive its own financial allocation from NHS England and remain responsible for funding and reporting its activity, under the terms of the Delegation Agreement.

8.4 A Managing Director for Specialised Commissioning is being appointed by BLMK ICB on behalf of all the ICBs to work alongside the existing NHSE management in 2024/25 and take over line management responsibilities for the team from 1 April 2024.

8.5 The budget to employ the Managing Director will be transferred from NHS England to BLMK ICB during 2024/25. From 1st April 2025, the budget for the Specialised Commissioning Team will transfer, along with the staff, to BLMK ICB.

9 Risks

9.1 As with any major transition there are risks to all parties. The general mitigations in place include the Safe Delegation Checklist, the phased approach by NHSE to delegating services, their retention of the Specialised Commissioning Team until 1 April 2025 and their retention of the financial liability for high cost drugs associated with the delegated specialised services.

9.2 The programme risk register is shown at appendix C and the highest rated risks are described below. The ICB has also included this matter on the BAF as risk number BAF 22.

Staffing

9.3 Members of the SCT are aware that they have been identified as potential transferees under TUPE so their employment status will change from 1 April 2025.

This may lead to a level of anxiety and staff choosing to leave the team. This, alongside existing vacancies could leave the team short of both numbers of staff and the experience they hold.

Delays in moving to target allocation.

9.4 Recent analysis has shown that ICBs in the East of England are below their target allocation of funds for specialised services and NHS England is committed to addressing this. If this rebalancing takes too long then it will take longer for patients in the East of England to realise those benefits.

9.5 This risk does not specifically relate to the transition programme, but to the wider issue around equity of specialised commissioning services which will affect patients, irrespective of whether the delegation takes place.

Insufficient leadership capacity within host ICB in 2024/25

9.6 The transition of the SCT from NHS England to BLMK ICB may stretch the existing capacity of the BLMK ICB leadership team. The appointment of a Managing Director will provide explicit leadership for specialised services.

10 Indicative Timetable

10.1 The Board of NHS England has determined that responsibility for the commissioning of 59 services will be delegated to the ICBs in the East of England on 1 April 2024. Similar arrangements are also taking place in the North West and Midlands regions.

10.2 The Specialised Commissioning Team will continue to be employed by NHS England until 1 April 2025 from when they will be transferred to BLMK ICB under TUPE arrangements.

10.3 From 1 April 2025, it is also anticipated that a further tranche of specialised services will be delegated to ICBs.

11 Conclusions

11.1 Whilst there is likely to be little change to the current commissioning arrangements in 2024/25, the delegation of the commissioning of specialised services will enable the ICB to work with providers to streamline and further integrate treatment pathways and to develop more localised commissioning where it is safe to do so.

11.2 The Delegation Agreement and Collaboration Agreement are key documents in enabling the delegation of specialised services.

List of appendices

Appendix A Delegation Agreement
Appendix B Collaboration Agreement
Appendix C Programme risk register

Recommendation to the Board:

12 Recommendations

12.1 The Board is asked to,

a) **Approve** the delegation of 59 specialised services and **authorise** the signing of the Delegation Agreement between the ICB and NHS England. An updated Delegation Agreement is being produced by NHS England with minor amendments. The Board is asked to authorise the signing of the final version Delegation Agreement/contract variation as appropriate.

b) **Approve** the Collaboration Agreement between the ICBs in the East of England and NHS England to manage the commissioning of the specialised services in a joint endeavour.

c) **Agree** that the ICB will be bound by decisions taken collectively with the other ICBs in the East of England in line with the Collaboration Agreement, relating to delegated specialised services.

Key Risks	
Clinical and Quality:	This is a transfer of specialised commissioning functions from NHS England to the ICB.
Finance and Performance:	As noted under section 5 of this report
Impact Assessment (environmental and equalities):	
Reputation:	Noted
Legal:	Statutory delegation pursuant to section 65Z5 of the NHS Act
Information Governance:	Reviewed as part of the transition workgroup
Resource Required:	N/A
Reference document(s):	Attached
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	BAF22

Governance

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

Dated 2024

(1) **NHS ENGLAND**

- and -

(2) **NHS NORFOLD AND WAVENEY INTEGRATED CARE BOARD**

Delegation Agreement between NHS England and Norfolk and Waveney ICB in relation to Specialised Commissioning Functions

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DELEGATION AGREEMENT FOR SPECIFIED FUNCTIONS

1. **PARTICULARS**

1.1 This Agreement records the particulars of the agreement made between NHS England and the Integrated Care Board (ICB) named below.

Integrated Care Board	NHS NORFOLK AND WAVENEY ICB
Area	The District of Breckland, District of Broadland, Borough of Great Yarmouth, Borough of King's Lynn and West Norfolk, District of North Norfolk, City of Norwich, District of South Norfolk and the following Lower Layer Super Output Areas in the District of East Suffolk: E01030240, E01030241, E01030242, E01030259, E01030260, E01030261, E01030262, E01030277, E01030279, E01030281, E01030266, E01030267, E01030271, E01030278, E01030280, E01030246, E01030248, E01030249, E01030250, E01030264, E01030265, E01030255, E01030263, E01030270, E01030289, E01030290, E01030233, E01030235, E01030268, E01030269, E01030288, E01030247, E01030254, E01030256, E01030258, E01030276, E01030257, E01030274, E01030275, E01030287, E01030291, E01030234, E01030236, E01030237, E01030238, E01030223, E01030224, E01030225, E01030227, E01030228, E01030226, E01030286, E01030292, E01030293, E01030294, E01030239, E01030251, E01030252, E01030253, E01030272, E01030273, E01030230, E01030231, E01030232, E01030285, E01030282, E01030283, E01030284, E01030295, E01030229, E01030243, E01030244, E01030245
Date of Agreement	[Date]
ICB Representative	Andrew Palmer, Executive Director of Strategy and Deputy CEO
ICB Email Address for Notices	nwicb.corporateaffairs@nhs.net
NHS England Representative	Ruth Derrett, Regional Director of Specialised Commissioning
NHS England Email Address for Notices	ruth.derrett@nhs.net alex.ridgeon@nhs.net

1.2 This Agreement comprises:

1.2.1 the Particulars (Clause 1),

1.2.2 the Terms and Conditions (Clauses 2 to 32),

1.2.3 the Schedules, and

1.2.4 the Mandated Guidance

Signed by **NHS England**

Clare Panniker

Regional Director - NHS England – East of England

(for and on behalf of NHS England)

Signed by **NHS Norfolk and Waveney Integrated Care Board**

Tracey Bleakley

Chief Executive Officer

for and on behalf of NHS Norfolk and Waveney Integrated Care Board

TERMS AND CONDITIONS

2. **INTERPRETATION**

2.1 This Agreement is to be interpreted in accordance with Schedule 1 (Definitions and Interpretation).

2.2 If there is any conflict or inconsistency between the provisions of this Agreement, that conflict or inconsistency must be resolved according to the following order of priority:

2.2.1 the Developmental Arrangements,

2.2.2 the Particulars and Terms and Conditions (Clauses 1 to 32),

2.2.3 Mandated Guidance,

2.2.4 all Schedules excluding Developmental Arrangements and Local Terms, and

2.2.5 Local Terms.

2.3 This Agreement constitutes the entire agreement and understanding between the Parties relating to the Delegation and supersedes all previous agreements, promises and understandings between them, whether written or oral, relating to its subject matter.

2.4 Where it is indicated that a provision in this Agreement is not used, that provision is not relevant and has no application in this Agreement.

2.5 Where a particular clause is included in this Agreement but is not relevant to the ICB because that clause relates to matters which do not apply the ICB (for example, if the clause only relates to functions that are not Delegated Functions in respect of the ICB), that clause is not relevant and has no application to this Agreement.

3. **BACKGROUND**

3.1 NHS England has statutory functions (duties and powers) conferred on it by legislation to make arrangements for the provision of prescribed services known as Specialised Services. These services support people with a range of rare and complex conditions. They are currently set out in the Prescribed Specialised Services Manual. The legislative basis for identifying these Specialised Services is Regulation 11 and Schedule 4 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996.

3.2 The ICBs have statutory functions to make arrangements for the provision of services for the purposes of the NHS in their Areas, apart from those commissioned by NHS England.

3.3 Pursuant to section 65Z5 of the NHS Act, NHS England is able to delegate responsibility for carrying out its Commissioning Functions to an ICB. NHS England will remain accountable to Parliament for ensuring that statutory requirements to commission all Specialised Services, and duties set out in the mandate, are being met.

3.4 By this Agreement, NHS England delegates the functions of commissioning certain Specialised Services (the “Delegated Functions”) to the ICB under section 65Z5 of the NHS Act.

3.5 This Agreement also sets out the elements of commissioning those Specialised Services for which NHS England will continue to have responsibility (the “Reserved Functions”).

3.6 Arrangements made under section 65Z5 may be made on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the ICB.

3.7 This Agreement sets out the terms that apply to the exercise of the Delegated Functions by the ICB. It also sets out each Party's responsibilities and the measures required to ensure the effective and efficient exercise of the Delegated Functions and Reserved Functions.

4. TERM

4.1 This Agreement has effect from the Date of Agreement set out in the Particulars and will remain in force unless terminated in accordance with Clause 27 (Termination) below.

5. PRINCIPLES

5.1 In complying with the terms of this Agreement, NHS England and the ICB must:

5.1.1 at all times have regard to the Triple Aim,

5.1.2 at all times act in good faith and with integrity towards each other,

5.1.3 consider how they can meet their legal duties to involve patients and the public in shaping the provision of services, including by working with local communities, under-represented groups and those with protected characteristics for the purposes of the Equality Act 2010,

5.1.4 consider how in performing their obligations they can address health inequalities,

5.1.5 at all times exercise functions effectively, efficiently and economically,

5.1.6 act in a timely manner,

5.1.7 share information and Best Practice, and work collaboratively to identify solutions and enhance the evidence base for the commissioning and provision of health services, eliminate duplication of effort, mitigate risk and reduce cost, and

5.1.8 have regard to the needs and views of the other Party and as far as is lawful and reasonably practicable, take such needs and views into account.

6. DELEGATION

6.1 In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England hereby delegates the exercise of the Delegated Functions to the ICB to empower it to commission a range of services for its Population, as further described in this Agreement ("Delegation").

6.2 The Delegated Functions are the functions described as being delegated to the ICB as have been identified and included within Schedule 3 to this Agreement but excluding the Reserved Functions set out within Schedule 4.

6.3 The Delegation in respect of each Delegated Function has effect from the Effective Date of Delegation.

6.4 Decisions of the ICB in respect of the Delegated Functions and made in accordance with the terms of this Agreement shall be binding on NHS England and the ICB.

6.5 Unless expressly provided for in this Agreement, the ICB is not authorised by this Agreement to take any step or make any decision in respect of Reserved Functions. Any such purported decision of the ICB is invalid and not binding on NHS England

unless ratified in writing by NHS England in accordance with the NHS England Scheme of Delegation and Standing Financial Instructions.

6.6 NHS England may, acting reasonably and solely to the extent that the decision relates to the Delegated Functions, substitute its own decision for any decision which the ICB purports to make where NHS England reasonably considers that the impact of the ICB decision could, in relation to the Delegated Functions, cause the ICB to be acting unlawfully, in breach of this Agreement including Mandated Guidance, or in breach of any Contract. The ICB must provide any information, assistance and support as NHS England requires to enable it to determine whether to make any such decision.

6.7 The terms of Clauses 6.5 and 6.6 are without prejudice to the ability of NHS England to enforce the terms of this Agreement or otherwise take action in respect of any failure by the ICB to comply with this Agreement.

7. EXERCISE OF DELEGATED FUNCTIONS

7.1 The ICB must establish effective, safe, efficient and economic arrangements for the discharge of the Delegated Functions.

7.2 The ICB agrees that it will exercise the Delegated Functions in accordance with:

7.2.1 the terms of this Agreement,

7.2.2 Mandated Guidance,

7.2.3 any Contractual Notices,

7.2.4 the Local Terms,

7.2.5 any Developmental Arrangements,

7.2.6 all applicable Law and Guidance,

7.2.7 the ICB's constitution,

7.2.8 the requirements of any assurance arrangements made by NHS England, and

7.2.9 Good Practice.

7.3 The ICB must perform the Delegated Functions in such a manner:

7.3.1 so as to ensure NHS England's compliance with NHS England's statutory duties in respect of the Reserved Functions and to enable NHS England to fulfil its Reserved Functions, and

7.3.2 having regard to NHS England's accountability to the Secretary of State and Parliament in respect of both the Delegated Functions and Reserved Functions, and

7.3.3 so as to ensure that the ICB complies with its statutory duties and requirements including those duties set out in Section 14Z32 to Section 14Z44 and the NICE Regulations.

7.4 In exercising the Delegated Functions, the ICB must comply with all Mandated Guidance as set out in this Agreement or as otherwise may be issued by NHS England from time to time including, but not limited to, ensuring compliance with National Standards and following National Specifications.

7.5 Where Developmental Arrangements conflict with any other term of this Agreement, the Developmental Arrangements shall take precedence until such time as NHS England agrees to the removal or amendment of the relevant Developmental Arrangements in accordance with Clause 26 (Variations).

7.6 The ICB must develop an operational scheme(s) of delegation defining those individuals or groups of individuals, including committees, who may discharge aspects of the Delegated Functions. For the purposes of this clause, the ICB may include the operational scheme(s) of delegation within its general organisational scheme of delegation.

7.7 NHS England may by Contractual Notice allocate Contracts to the ICB such that they are included as part of the Delegation. The Delegated Functions must be exercised both in respect of the relevant Contract and any related matters concerning any Specialised Service Provider that is a party to a Contract. NHS England may add or remove Contracts where this is associated with an extension or reduction of the scope of the Delegated Functions.

7.8 Subsequent to the Effective Date of Delegation and for the duration of this Agreement, unless otherwise agreed any new Contract entered into in respect of the Delegated Functions shall be managed by the ICB in accordance with the provisions of this Agreement.

7.9 Subject to the provisions of this Agreement, the ICB may determine the arrangements for the exercise of the Delegated Functions.

8. REQUIREMENT FOR ICB COLLABORATION ARRANGEMENT

8.1 Subject to the provisions of Clause 12 (Further Arrangements), the ICB must establish appropriate ICB Collaboration Arrangements with other ICBs in order to ensure that the commissioning of the Delegated Services can take place across an appropriate geographical footprint for the nature of each particular Delegated Service with consideration of population size, provider landscape and patient flow. Such ICB arrangements in respect of the Delegated Functions must be approved in advance by NHS England.

8.2 The ICB must establish, as part of or separate to the arrangements set out in Clause 8.1, an agreement that sets out the arrangements in respect of the Commissioning Team as required by Clause 13.

8.3 The ICB must participate in discussions, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view with the other ICBs within the ICB Collaboration Arrangement. The members of the ICB Collaboration Arrangement shall have a collective responsibility for the operation of the ICB Collaboration Arrangement.

8.4 The ICB shall ensure that any ICB Collaboration Arrangement is documented and such documentation must include (but is not limited to) the following:

8.4.1 membership which is limited solely to ICBs unless otherwise approved by NHS England,

8.4.2 clear governance arrangements including reporting lines to the ICBs' Boards,

8.4.3 provisions for independent scrutiny of decision making,

8.4.4 the Delegated Functions or elements thereof which are the subject of the arrangements,

8.4.5 the Delegated Services which are subject to the arrangements,

8.4.6 financial arrangements and any pooled fund arrangements,

8.4.7 data sharing arrangements including evidence of a Data Protection Impact Assessment,

8.4.8 terms of reference for decision making, and

8.4.9 limits on onward delegation.

8.5 The ICB must not terminate an ICB Collaboration Arrangement in respect of the Delegated Functions without the prior written approval of NHS England.

9. PERFORMANCE OF THE RESERVED FUNCTIONS AND COMMISSIONING SUPPORT ARRANGEMENTS

9.1 NHS England will remain responsible for the performance of the Reserved Functions.

9.2 For the avoidance of doubt, the Parties acknowledge that the Delegation may be amended, and additional functions may be delegated to the ICB, in which event consequential changes to this Agreement shall be agreed with the ICB pursuant to Clause 26 (Variations) of this Agreement.

9.3 Where it considers appropriate NHS England will work collaboratively with the ICB when exercising the Reserved Functions.

9.4 If there is any conflict or inconsistency between functions that are named as Delegated Functions and functions that are named as Reserved Functions, then such functions shall be interpreted as Reserved Functions unless and until NHS England confirms otherwise. If an ICB identifies such a conflict or inconsistency, it will inform NHS England as soon as is reasonably practicable.

9.5 The Parties acknowledge that they may agree for the ICB to provide Administrative and Management Services to NHS England in relation to certain Reserved Functions and Retained Services in order to assist in the efficient and effective exercise of such functions. Any such Commissioning Team Arrangements shall be set out in writing.

9.6 Notwithstanding any arrangement for or provision of Administrative and Management Services in respect of the Retained Services and Reserved Functions, NHS England shall retain statutory responsibility for, and be accountable for, the commissioning of the Retained Services.

9.7 The Parties acknowledge that they may agree for NHS England to provide Administrative and Management Services to ICBs in relation to certain Delegated Functions and Delegated Services in order to assist in the efficient and effective exercise of such Delegated Functions. Any such Administrative and Management Services shall be set out in writing.

9.8 Notwithstanding any arrangement for or provision of Administrative and Management Services in respect of the Delegated Services, the ICB shall retain delegated responsibility for the commissioning of the Delegated Services.

10. FINANCE

10.1 Without prejudice to any other provision in this Agreement, the ICB must comply with the Finance Guidance and any such financial processes as required by NHS England for the management, reporting and accounting of funds used for the purposes of the Delegated Functions.

10.2 The ICB acknowledges that it will receive funds from NHS England in respect of the Delegated Functions (the "Delegated Funds") and that these are in addition to the funds allocated to it within its Annual Allocation.

10.3 Subject to Clause 10.4 and any provisions in the Schedules or Mandated Guidance, the ICB may use:

10.3.1 its Annual Allocation and the Delegated Funds in the exercise of the Delegated Functions, and

10.3.2 the Delegated Funds and its Annual Allocation in the exercise of the ICB's Functions other than the Delegated Functions.

10.4 The ICB's expenditure on the Delegated Functions must be sufficient to:

10.4.1 ensure that NHS England is able to fulfil its functions, including without limitation the Reserved Functions, effectively and efficiently,

10.4.2 meet all liabilities arising under or in connection with all Contracts in so far as they relate to the exercise of the Delegated Functions,

10.4.3 appropriately commission the Delegated Services in accordance with Mandatory Guidance, National Specifications, National Standards and Guidance, and

10.4.4 meet national commitments from time to time on expenditure on specific Delegated Functions.

10.5 NHS England may increase or reduce the Delegated Funds in any Financial Year, by sending a notice to the ICB of such increase or decrease:

10.5.1 in order to take into account any monthly adjustments or corrections to the Delegated Funds that NHS England considers appropriate, including without limitation, adjustments following any changes to the Delegated Functions, changes in allocations, changes in Contracts, to implement Mandated Guidance or otherwise,

10.5.2 in order to comply with a change in the amount allocated to NHS England by the Secretary of State pursuant to section 223B of the NHS Act,

10.5.3 to take into account any Losses of NHS England for which the ICB is required to indemnify NHS England under Clause 17 (Claims and Litigation),

10.5.4 to take into account any adjustments that NHS England considers appropriate (including without limitation in order to make corrections or otherwise to reflect notional budgets) to reflect funds transferred (or that should have been transferred) to the ICB in respect of the Delegated Functions or funds transferred (or that should have been transferred) to the ICB in respect of Administrative and Management Services, and

10.5.5 in order to ensure compliance by NHS England with its obligations under the NHS Act (including, Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State in respect of NHS England under the NHS Act.

10.6 NHS England acknowledges that the intention of Clause 10.5 is to reflect genuine corrections and adjustments to the Delegated Funds and may not be used to change the allocation of the Delegated Funds unless there are significant or exceptional circumstances that would require such corrections or adjustments.

10.7 The ICB acknowledges that it must comply with its statutory financial duties, including those under Part 11 of the NHS Act to the extent that these sections apply in relation to the receipt of the Delegated Funds.

10.8 NHS England may in respect of the Delegated Funds:

10.8.1 notify the ICB regarding the required payment of sums by the ICB to NHS England in respect of charges referable to the valuation or disposal of assets and such conditions as to records, certificates or otherwise,

10.8.2 by notice, require the ICB to take such action or step in respect of the Delegated Funds, in order to ensure compliance by NHS England of its duties or functions under the NHS (including Part 11 of the NHS Act) or any action taken or direction made by the Secretary of State under the NHS Act.

10.9 The Schedules to this Agreement may identify further financial provisions in respect of the exercise of the Delegated Functions.

10.10 NHS England may issue Mandated Guidance in respect of the financial arrangements in respect of the Delegated Functions.

10.11 NHS England will pay the Delegated Funds to the ICB using the revenue transfer process as used for the Annual Allocation or such other process as notified to the ICB from time to time.

10.12 Without prejudice to any other obligation upon the ICB, for the purposes of the Delegated Functions the ICB agrees that it must use its resources in accordance with:

10.12.1 the terms and conditions of this Agreement including any Mandated Guidance issued by NHS England from time to time in relation to the use of resources for the purposes of the Delegated Functions (including in relation to the form or contents of any accounts),

10.12.2 any NHS payment scheme published by NHS England,

10.12.3 the business rules as set out in NHS England's planning guidance or such other documents issued by NHS England from time to time,

10.12.4 any Capital Investment Guidance,

10.12.5 the HM Treasury Guidance *Managing Public Money* (dated September 2022) as replaced or updated from time to time, and

10.12.6 any other Guidance published by NHS England with respect to the financial management of Delegated Functions.

10.13 Without prejudice to any other obligation upon the ICB, the ICB agrees that it must provide:

10.13.1 all information, assistance and support to NHS England in relation to the audit and/or investigation (whether internal or external and whether under Law or otherwise) in relation to the use of or payment of resources for the purposes of the Delegated Functions and the discharge of those functions,

10.13.2 such reports in relation to the expenditure on the Delegated Functions as set out in Mandated Guidance, the Schedules to this Agreement or as otherwise required by NHS England.

Pooled Funds

10.14 Subject to the provisions of this Agreement, the ICB may, for the purposes of exercising the Delegated Functions under this Agreement, establish and maintain a pooled fund(s) in respect of any part of the Delegated Funds with:

10.14.1 NHS England in accordance with sections 13V or 65Z6 of the NHS Act,

10.14.2 one or more ICBs in accordance with section 65Z6 of the NHS Act as part of a Further Arrangement, or

10.14.3 NHS England and one or more ICBs in accordance with section 13V of the NHS Act, and

10.15 NHS England and one or more ICBs in accordance with section 65Z6 of the NHS Act. Where the ICB has decided to enter into arrangements under Clause 10.14 the agreement must be in writing and must specify:

10.15.1 the agreed aims and outcomes of the arrangements,

10.15.2 the payments to be made by each partner and how those payments may be varied,

10.15.3 the specific Delegated Functions which are the subject of the arrangements,

10.15.4 the Delegated Services which are subject to the arrangements,

10.15.5 the duration of the arrangements and provision for the review or variation or termination of the arrangements,

10.15.6 the arrangements in place for governance of the pooled fund, and

10.15.7 the arrangements in place for assuring, oversight and monitoring of the ICB's exercise of the functions referred to in 10.15.3.

10.16 At the date of this Agreement, details of the pooled funds (including any terms as to the governance and payments out of such pooled fund) of NHS England and the ICB are set out in the Local Terms.

11. INFORMATION, PLANNING AND REPORTING

11.1 The ICB must provide to NHS England:

11.1.1 such information or explanations in relation to the exercise of the Delegated Functions, as required by NHS England from time to time, and

11.1.2 all such information (and in such form), that may be relevant to NHS England in relation to the exercise by NHS England of its other duties or functions including, without limitation, the Reserved Functions.

11.2 The provisions of this Clause 11 are without prejudice to the ability of NHS England to exercise its other powers and duties in obtaining information from and assessing the performance of the ICB.

Forward Plan and Annual Report

11.3 Before the start of each Financial Year, the ICB must describe in its joint forward plan prepared in accordance with section 14Z52 of the NHS Act how it intends to exercise the Delegated Functions.

11.4 The ICB must report on its exercise of the Delegated Functions in its annual report prepared in accordance with section 14Z58 of the NHS Act.

Risk Register

11.5 The ICB must maintain a risk register in respect of its exercise of the Delegated Functions and periodically review its content. The risk register must follow such format as may be notified by NHS England to the ICB from time to time.

12. FURTHER ARRANGEMENTS

12.1 In addition to any ICB Collaboration Arrangement agreed in accordance with Clause 8 (ICB Collaboration Arrangements) the ICB must give due consideration to whether any of the Delegated Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act ("Further Arrangements").

12.2 The ICB may only make Further Arrangements with another person (a "Sub-Delegate") with the prior written approval of NHS England.

12.3 The approval of any Further Arrangements may:

12.3.1 include approval of the terms of the proposed Further Arrangements, and

12.3.2 require conditions to be met by the ICB and the Sub-Delegate in respect of that arrangement.

12.4 All Further Arrangements must be made in writing.

The ICB must not terminate Further Arrangements without the prior written approval of NHS England.

12.5 If the ICB enters into a Further Arrangement it must ensure that the Sub-Delegate does not make onward arrangements for the exercise of any or all of the Delegated Functions without the prior written approval of NHS England.

12.6 The terms of this Clause 12 do not prevent the ICB from making arrangements for assistance and support in the exercise of the Delegated Functions with any person, where such arrangements reserve the consideration and making of any decision in respect of a Delegated Function to the ICB.

12.7 Where Further Arrangements are made, and unless NHS England has otherwise given specific prior written agreement, any obligations or duties on the part of the ICB under this Agreement that are relevant to those Further Arrangements shall also require the ICB to ensure that all Sub-Delegates comply with such obligations or duties and support the ICB in doing so.

13. STAFFING, WORKFORCE AND COMMISSIONING TEAMS

13.1 Where there is an arrangement for NHS England to provide Administrative and Management Services to the ICB, the ICB shall provide full co-operation with NHS England and enter into any necessary arrangements with NHS England and, where appropriate, other ICBs in respect of the Specialised Services Staff.

13.2 The ICB shall, if and where required by NHS England, enter into appropriate arrangements with NHS England in respect of the transfer of Specialised Services Staff.

13.3 The ICB shall, where appropriate, enter into an agreement with other ICBs, in order to establish arrangements in respect of the Commissioning Team Where appropriate, this agreement may be included as part of the ICB Collaboration Arrangement entered into in accordance with Clause 8.

14. **BREACH**

14.1 If the ICB does not comply with the terms of this Agreement, then NHS England may:

14.1.1 exercise its rights under this Agreement, and

14.1.2 take such steps as it considers appropriate in the exercise of its other functions concerning the ICB.

14.2 Without prejudice to Clause 14.1, if the ICB does not comply with the terms of this Agreement (including if the ICB exceeds its delegated authority under the Delegation), NHS England may (at its sole discretion):

14.2.1 waive its rights in relation to such non-compliance in accordance with Clause 14.3,

14.2.2 ratify any decision in accordance with Clause 6.5,

14.2.3 substitute a decision in accordance with Clause 6.6,

14.2.4 amend Developmental Arrangements or impose new Developmental Arrangements,

14.2.5 revoke the whole or part of the Delegation and terminate this Agreement in accordance with Clause 27 (Termination) below,

14.2.6 exercise the Escalation Rights in accordance with Clause 15 (Escalation Rights), and/or

14.2.7 exercise its rights under common law.

14.3 NHS England may waive any non-compliance by the ICB with the terms of this Agreement provided that the ICB provides a written report to NHS England as required by Clause 14.4 and, after considering the ICB's written report, NHS England is satisfied that the waiver is justified.

14.4 If:

14.4.1 the ICB does not comply with this Agreement,

14.4.2 the ICB considers that it may not be able to comply with this Agreement,

14.4.3 NHS England notifies the ICB that it considers the ICB has not complied with this Agreement, or

14.4.4 NHS England notifies the ICB that it considers that the ICB may not be able to comply with this Agreement,

then the ICB must provide a written report to NHS England within ten (10) Operational Days of the non-compliance (or the date on which the ICB identifies that it may not be able to comply with this Agreement) setting out:

14.4.5 details of and reasons for the non-compliance (or likely non-compliance) with the Agreement and/or the Delegation, and

14.4.6 a plan for how the ICB proposes to remedy the non-compliance.

15. **ESCALATION RIGHTS**

15.1 If the ICB does not comply with this Agreement, NHS England may exercise the following Escalation Rights:

15.1.1 NHS England may require a suitably senior representative of the ICB to attend a review meeting within ten (10) Operational Days of NHS England becoming aware of the non-compliance, and

15.1.2 NHS England may require the ICB to prepare an action plan and report within twenty (20) Operational Days of the review meeting (to include details of the non-compliance and a plan for how the ICB proposes to remedy the non-compliance).

15.2 If NHS England does not comply with this Agreement, the ICB may require a suitably senior representative of NHS England to attend a review meeting within ten (10) Operational Days of the ICB making NHS England aware of the non-compliance.

15.3 Nothing in Clause 15 (Escalation Rights) will affect NHS England's right to substitute a decision in accordance with Clause 6.76, revoke the Delegation or terminate this Agreement in accordance with Clause 27 (Termination) below.

16. LIABILITY AND INDEMNITY

16.1 NHS England is liable in respect of any Losses arising in respect of NHS England's negligence, fraud, recklessness or deliberate breach in respect of the Delegated Functions and occurring after the Effective Date of Delegation and, if the ICB suffers any Losses in respect of such actions by NHS England, NHS England shall make such adjustments to the Annual Allocation (or other amounts payable to the ICB) in order to reflect any Losses suffered by the ICB (except to the extent that the ICB is liable for such Losses pursuant to Clause 16.3).

16.2 For the avoidance of doubt, NHS England remains liable for a Claim relating to facts, events or circumstances concerning the Delegated Functions before the Effective Date of Delegation.

16.3 The ICB is liable to (and shall pay) NHS England for any Losses suffered by NHS England that result from or arise out of the ICB's negligence, fraud, recklessness or breach of the Delegation (including any actions that are taken that exceed the authority conferred by the Delegation) or this Agreement. In respect of such Losses, NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB or make such adjustments to the Delegated Funds pursuant to Clause 10.5. The ICB shall not be liable to the extent that the Losses arose prior to the Effective Date of Delegation.

16.4 Each Party acknowledges and agrees that any rights acquired, or liabilities (including liabilities in tort) incurred, in respect of the exercise by the ICB of any Delegated Function are enforceable by or against the ICB only, in accordance with section 65Z5(6) of the NHS Act.

16.5 Each Party will at all times take all reasonable steps to minimise and mitigate any Losses or other matters for which one Party is entitled to be indemnified by or to bring a claim against the other under this Agreement.

17. CLAIMS AND LITIGATION

17.1 Nothing in this Clause 17 (Claims and Litigation) shall be interpreted as affecting the reservation to NHS England of the Reserved Functions.

17.2 Except in the circumstances set out in Clause 17.5 and subject always to compliance with this Clause 17 (Claims and Litigation), the ICB shall be responsible for and shall retain the conduct of any Claim.

17.3 The ICB must:

17.3.1 comply with any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims and the pro-active management of Claims,

17.3.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify NHS England and send to NHS England all copies of such correspondence,

17.3.3 co-operate fully with NHS England in relation to such Claim and the conduct of such Claim,

17.3.4 provide, at its own cost, to NHS England all documentation and other correspondence that NHS England requires for the purposes of considering and/or resisting such Claim, and

17.3.5 at the request of NHS England, take such actions or step or provide such assistance as may in NHS England's discretion be necessary or desirable having regard to the nature of the Claim and the existence of any time limit in relation to avoiding, disputing, defending, resisting, appealing, seeking a review or compromising such Claim or to comply with the requirements of the provider of an Indemnity Arrangement in relation to such Claim.

17.4 Subject to Clauses 17.3 and 17.5 the ICB is entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit.

NHS England Stepping into Claims

17.5 NHS England may, at any time following discussion with the ICB, send a notice to the ICB stating that NHS England will take over the conduct of the Claim and the ICB must immediately take all steps necessary to transfer the conduct of such Claim to NHS England unless and until NHS England transfers conduct back to the ICB. In such cases:

17.5.1 NHS England shall be entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit, provided that if NHS England wishes to invoke Clause 17.5.3 it agrees to seek the ICB's views on any proposal to pay or settle that Claim prior to finalising such payment or settlement, and

17.5.2 the Delegation shall be treated as being revoked to the extent that and for so long as NHS England has assumed responsibility for exercising those of the Delegated Functions that are necessary for the purposes of having conduct of the Claim, and

17.5.3 NHS England may, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or make an adjustment to the Delegated Funds pursuant to Clause 10.5.3 for the purposes of meeting any Claim Losses associated with that Claim.

Claim Losses

17.6 The ICB and NHS England shall notify each other as soon as reasonably practicable of becoming aware of any Claim Losses.

17.7 The ICB acknowledges that NHS England will pay to the ICB the funds that are attributable to the Delegated Functions. Accordingly, the ICB acknowledges that it must pay any Claim Losses out of either the Delegated Funds or its Annual Allocation. NHS England may, in respect of any Claim Losses, at its discretion and without prejudice to any other rights, either require payment from the ICB for such Claim Losses or pursuant

to Clause 10.5.3 make such adjustments to the Delegated Funds to take into account the amount of any Claim Losses (other than any Claim Losses in respect of which NHS England has retained any funds, provisions or other resources to discharge such Claim Losses). For the avoidance of doubt, in circumstances where NHS England suffers any Claim Losses, then NHS England shall be entitled to recoup such Claim Losses pursuant to Clause 10.5.3. If and to the extent that NHS England has retained any funds, provisions or other resources to discharge such Claim Losses, then NHS England may either use such funds to discharge the Claim Loss or make an upward adjustment to the amounts paid to the ICB pursuant to Clause 10.5.3.

18. DATA PROTECTION, FREEDOM OF INFORMATION AND TRANSPARENCY

18.1 The Parties must ensure that all Personal Data processed by or on behalf of them while carrying out the Delegated Functions and Reserved Functions is processed in accordance with the relevant Party's obligations under Data Protection Legislation and Data Guidance and the Parties must assist each other as necessary to enable each other to comply with these obligations.

18.2 The ICB must respond to any information governance breach in accordance with Information Governance Guidance for Serious Incidents. If the ICB is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach then as soon as reasonably practical and in any event on or before the first such notification is made the ICB must fully inform NHS England of the information governance breach. This clause does not require the ICB to provide NHS England with information which identifies any individual affected by the information governance breach where doing so would breach Data Protection Legislation.

18.3 Whether or not a Party is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The Parties acknowledge that a Party may act as both a Data Controller and a Data Processor.

18.4 NHS England may, from time to time, issue a data sharing protocol or update a protocol previously issued relating to the data sharing in relation to the Delegated Functions and/or Reserved Functions. The ICB shall comply with such data sharing protocols.

18.5 Each Party acknowledges that the other is a public authority for the purposes of the Freedom of Information Act 2000 ("FOIA") and the Environmental Information Regulations 2004 ("EIR").

18.6 Each Party may be required by statute to disclose further information about the Agreement and the Relevant Information in response to a specific request under FOIA or EIR, in which case:

18.6.1 each Party shall provide the other with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR,

18.6.2 each Party shall consult the other regarding the possible application of exemptions in relation to the information requested, and

18.6.3 subject only to Clause 17 (Claims and Litigation), each Party acknowledges that the final decision as to the form or content of the response to any request is a matter for the Party to whom the request is addressed.

18.7 NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the handling and responding to of FOIA or EIR requests in relation to the Delegated Functions. The ICB shall comply with such FOIA or EIR protocols.

18.8 Schedule 6 (Further Information Governance and Sharing Provisions) makes further provision about information sharing, information governance and the Data Sharing Agreement.

19. IT INTER-OPERABILITY

19.1 The Parties will work together to ensure that all relevant IT systems they operate in respect of the Delegated Functions and Reserved Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

19.2 The Parties will use their respective reasonable endeavours to help develop initiatives to further this aim.

20. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

20.1 The ICB must ensure that, in delivering the Delegated Functions, all Staff comply with Law, with Managing Conflicts of Interest in the NHS and other Guidance, and with Good Practice, in relation to gifts, hospitality and other inducements and actual or potential conflicts of interest.

20.2 Without prejudice to the general obligations set out in Clause 20.1, the ICB must maintain a register of interests in respect of all persons making decisions concerning the Delegated Functions. This register must be publicly available. For the purposes of this clause, the ICB may rely on an existing register of interests rather than creating a further register.

21. PROHIBITED ACTS AND COUNTER-FRAUD

21.1 The ICB must not commit any Prohibited Act.

21.2 If the ICB or its Staff commits any Prohibited Act in relation to this Agreement with or without the knowledge of NHS England, NHS England will be entitled:

21.2.1 to revoke the Delegation,

21.2.2 to recover from the ICB the amount or value of any gift, consideration or commission concerned, and

21.2.3 to recover from the ICB any loss or expense sustained in consequence of the carrying out of the Prohibited Act.

21.3 The ICB must put in place and maintain appropriate arrangements, including without limitation, Staff training, to address counter-fraud issues, having regard to any relevant Guidance, including from the NHS Counter Fraud Authority.

21.4 If requested by NHS England or the NHS Counter Fraud Authority, the ICB must allow a person duly authorised to act on behalf of the NHS Counter Fraud Authority or on behalf of NHS England to review, in line with the appropriate standards, any counter-fraud arrangements put in place by the ICB.

21.5 The ICB must implement any reasonable modifications to its counter-fraud arrangements required by a person referred to in Clause 21.4 in order to meet the appropriate standards within whatever time periods as that person may reasonably require.

21.6 The ICB must, on becoming aware of:

21.6.1 any suspected or actual bribery, corruption or fraud involving public funds, or

21.6.2 any suspected or actual security incident or security breach involving Staff or involving NHS resources,

promptly report the matter to NHS England and to the NHS Counter Fraud Authority.

21.7 On the request of NHS England or NHS Counter Fraud Authority, the ICB must allow the NHS Counter Fraud Authority or any person appointed by NHS England, as soon as it is reasonably practicable and in any event not later than five (5) Operational Days following the date of the request, access to:

21.7.1 all property, premises, information (including records and data) owned or controlled by the ICB, and

21.7.2 all Staff who may have information to provide.

relevant to the detection and investigation of cases of bribery, fraud or corruption, or security incidents or security breaches directly or indirectly in connection with this Agreement.

22. CONFIDENTIAL INFORMATION OF THE PARTIES

22.1 Except as this Agreement otherwise provides, Confidential Information is owned by the disclosing Party and the receiving Party has no right to use it.

22.2 Subject to Clauses 22.3 to 22.5, the receiving Party agrees:

22.2.1 to use the disclosing Party's Confidential Information only in connection with the receiving Party's performance under this Agreement,

22.2.2 not to disclose the disclosing Party's Confidential Information to any third party or to use it to the detriment of the disclosing Party, and

22.2.3 to maintain the confidentiality of the disclosing Party's Confidential Information.

22.3 The receiving Party may disclose the disclosing Party's Confidential Information:

22.3.1 in connection with any dispute resolution procedure under Clause 25,

22.3.2 in connection with any litigation between the Parties,

22.3.3 to comply with the Law,

22.3.4 to any appropriate Regulatory or Supervisory Body,

22.3.5 to its Staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Party's duty under Clause 22.2,

22.3.6 to NHS bodies for the purposes of carrying out their functions,

22.3.7 as permitted under or as may be required to give effect to Clause 21 (Prohibited Acts and Counter-Fraud), and

22.3.8 as permitted under any other express arrangement or other provision of this Agreement.

22.4 The obligations in Clauses 22.1 and 22.2 will not apply to any Confidential Information which:

22.4.1 is in, or comes into, the public domain other than by breach of this Agreement,

22.4.2 the receiving Party can show by its records was in its possession before it received it from the disclosing Party, or

22.4.3 the receiving Party can prove it obtained or was able to obtain from a source other than the disclosing Party without breaching any obligation of confidence.

22.5 This Clause 22 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by the ICB where necessary for the purposes of exercising its functions in relation to the ICB.

22.6 The Parties acknowledge that damages would not be an adequate remedy for any breach of this Clause 22 by the receiving Party, and in addition to any right to damages the disclosing Party will be entitled to the remedies of injunction, specific performance and other equitable relief for any threatened or actual breach of this Clause 22.

22.7 This Clause 22 will survive the termination of this Agreement for any reason for a period of five (5) years.

22.8 This Clause 22 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

23. INTELLECTUAL PROPERTY

23.1 The ICB grants to NHS England a fully paid-up, non-exclusive, perpetual licence to use the ICB Deliverables for the purposes of the exercise of its statutory and contractual functions.

23.2 NHS England grants the ICB a fully paid-up, non-exclusive licence to use the NHS England Deliverables for the purpose of performing this Agreement and the Delegated Functions.

23.3 The ICB must co-operate with NHS England to enable it to understand and adopt Best Practice (including the dissemination of Best Practice to other commissioners or providers of NHS services), and must supply such materials and information in relation to Best Practice as NHS England may reasonably request, and (to the extent that any Intellectual Property Rights ("IPR") attaches to Best Practice) grants NHS England a fully paid-up, non-exclusive, perpetual licence for NHS England to use Best Practice IPR for the commissioning and provision of NHS services and to share any Best Practice IPR with other commissioners of NHS services (and other providers of NHS services) to enable those parties to adopt such Best Practice.

24. NOTICES

24.1 Any notices given under this Agreement must be sent by e-mail to the other Party's address set out in the Particulars or as otherwise notified by one Party to another as the appropriate address for this Clause 24.1.

24.2 Notices by e-mail will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

25. DISPUTES

25.1 This clause does not affect NHS England's right to exercise its functions for the purposes of assessing and addressing the performance of the ICB.

25.2 If a Dispute arises out of, or in connection with, this Agreement then the Parties must follow the procedure set out in this clause:

25.2.1 either Party must give to the other written notice of the Dispute, setting out its nature and full particulars ("Dispute Notice"), together with relevant supporting documents. On service of the Dispute Notice, the Agreement Representatives must attempt in good faith to resolve the Dispute,

25.2.2 if the Agreement Representatives are, for any reason, unable to resolve the Dispute within twenty (20) Operational Days of service of the Dispute Notice, the Dispute must be referred to the Chief Executive Officer (or equivalent person) of the ICB and a director of or other person nominated by NHS England (and who has authority from NHS England to settle the Dispute) who must attempt in good faith to resolve it, and

25.2.3 if the people referred to in Clause 25.2.2 are for any reason unable to resolve the Dispute within twenty (20) Operational Days of it being referred to them, the Parties may attempt to settle it by mediation in accordance with the CEDR model mediation procedure. Unless otherwise agreed between the Parties, the mediator must be nominated by CEDR. To initiate the mediation, a Party must serve notice in writing ('Alternative Dispute Resolution' ("ADR) notice") to the other Party to the Dispute, requesting a mediation. A copy of the ADR notice should be sent to CEDR. The mediation will start no later than ten (10) Operational Days after the date of the ADR notice.

25.3 If the Dispute is not resolved within thirty (30) Operational Days after service of the ADR notice, or either Party fails to participate or to continue to participate in the mediation before the expiration of the period of thirty (30) Operational Dys, or the mediation terminates before the expiration of the period of thirty (30) Operational Days, the Dispute must be referred to the NHS England Board, who shall resolve the matter and whose decision shall be binding upon the Parties.

26. VARIATIONS

26.1 The Parties acknowledge that the scope of the Delegated Functions may be reviewed and amended from time to time including by revoking this Agreement and making alternative arrangements.

26.2 NHS England may vary this Agreement without the ICB's consent where:

26.2.1 it is reasonably satisfied that the variation is necessary in order to comply with Legislation, NHS England's statutory duties, or any requirements or direction given by the Secretary of State,

26.2.2 where variation is as a result of amendment to or additional Mandated Guidance,

26.2.3 it is satisfied that any Developmental Arrangements are no longer required,

26.2.4 it reasonably considers that Developmental Arrangements are required under Clause 14 (Breach), or

26.2.5 it is satisfied that such amendment or Developmental Arrangement is required in order to ensure the effective commissioning of the Delegated Services or other Specialised Services.

26.3 Where NHS England wishes to vary the Agreement in accordance with Clause 26.2 it must notice in writing to the ICB of the wording of the proposed variation and the date on which that variation is to take effect which must, unless it is not reasonably practicable, be a date which falls at least thirty (30) Operational Days after the date on which the notice under that clause is given to the ICB.

26.4 For the avoidance of doubt, NHS England may issue or update Mandated Guidance at any point during the term of the Agreement.

26.5 Either Party ("the Proposing Party") may notify the other Party (the "Receiving Party") of a Variation Proposal in respect of this Agreement including, but not limited to the following:

26.5.1 a request by the ICB to add, vary or remove any Developmental Arrangement, or

26.5.2 a request by NHS England to include additional Specialised Services or NHS England Functions within the Delegation, and

the Proposing Party will identify whether the proposed variation may have the impact of changing the scope of the Delegated Functions or Reserved Functions so that NHS England can establish the requisite level of approval required.

26.6 The Variation Proposal will set out the variation proposed and the date on which the Proposing Party requests the variation to take effect.

26.7 When a Variation Proposal is issued in accordance with 26.6, the Receiving Party must respond within thirty (30) Operational Days following the date that it is issued by serving notice confirming either:

26.7.1 that it accepts the Variation Proposal, or

26.7.2 that it refuses to accept the Variation Proposal and setting out reasonable grounds for that refusal.

26.8 If the Receiving Party accepts the Variation Proposal issued in accordance with Clause 26.5, the Receiving Party agrees to take all necessary steps (including executing a variation agreement) in order to give effect to any variation by the date on which the proposed variation will take effect as set out in the Variation Proposal.

26.9 If the Receiving Party refuses to accept a Variation Proposal submitted in accordance with 26.5 to 26.7, or to take such steps as are required to give effect to the variation, then the provisions of Clause 15 (Escalation Rights) shall apply.

26.10 When varying the Agreement in accordance with Clause 26, the Parties must consider the impact of the proposed variation on any ICB Collaboration Arrangements and any Further Arrangements.

27. TERMINATION

27.1 The ICB may:

27.1.1 notify NHS England that it requires NHS England to revoke the Delegation, and

27.1.2 terminate this Agreement,

with effect from the end of 31 March in any calendar year, provided that:

27.1.3 on or before 30 September of the previous calendar year, the ICB sends written notice to NHS England of its requirement that NHS England revoke the Delegation and its intention to terminate this Agreement, and

27.1.4 the ICB meets with NHS England within ten (10) Operational Days of NHS England receiving the notice set out at Clause 27.1.3 above to discuss arrangements for termination and transition of the Delegated Functions to a successor commissioner in accordance with Clause 28.2, and

27.1.5 the ICB confirms satisfactory arrangements for terminating any ICB Collaboration Arrangements or Further Agreements in whole or part as required including agreed succession arrangements for Commissioning Teams,

in which case NHS England shall revoke the Delegation and this Agreement shall terminate with effect from the end of 31 March in the next calendar year.

27.2 NHS England may revoke the Delegation in whole or in part with effect from 23.59 hours on 31 March in any year, provided that it gives notice to the ICB of its intention to terminate the Delegation on or before 30 September in the year prior to the year in which the Delegation will terminate, and in which case Clause 27.4 will apply.

27.3 The Delegation may be revoked in whole or in part, and this Agreement may be terminated by NHS England at any time, including in (but not limited to) the following circumstances:

27.3.1 the ICB acts outside of the scope of its delegated authority,

27.3.2 the ICB fails to perform any material obligation of the ICB owed to NHS England under this Agreement,

27.3.3 the ICB persistently commits non-material breaches of this Agreement,

27.3.4 NHS England is satisfied that its intervention powers under section 14Z61 of the NHS Act apply,

27.3.5 to give effect to legislative changes, including conferral of any of the Delegated or Reserved Functions on the ICB,

27.3.6 failure to agree to a variation in accordance with Clause 26 (Variations),

27.3.7 NHS England and the ICB agree in writing that the Delegation shall be revoked and this Agreement shall terminate on such date as is agreed, and/or

27.3.8 the ICB merges with another ICB or other body.

27.4 This Agreement will terminate upon revocation or termination of the full Delegation (including revocation and termination in accordance with this Clause 27 (Termination)) except that the provisions referred to in Clause 29 (Provisions Surviving Termination) will continue in full force and effect.

27.5 Without prejudice to Clause 14.3 and to avoid doubt, NHS England may waive any right to terminate this Agreement under this Clause 27 (Termination). Any such waiver is only effective if given in writing and shall not be deemed a waiver of any subsequent right or remedy.

27.6 As an alternative to termination of the Agreement in respect of all the Delegated Functions, NHS England may terminate the Agreement in respect of specified Delegated Functions (or aspects of such Delegated Functions) only, in which case this Agreement shall otherwise remain in effect.

28. CONSEQUENCE OF TERMINATION

28.1 Termination of this Agreement, or termination of the ICB's exercise of any of the Delegated Functions, will not affect any rights or liabilities of the Parties that have accrued before the date of that termination or which later accrue in respect of the term of this Agreement. For the avoidance of doubt, the ICB shall be responsible for any Claims or other costs or liabilities incurred in the exercise of the Delegated Functions

during the period of this Agreement unless expressly agreed otherwise by NHS England.

28.2 Subject to Clause 28.4, on or pending termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, NHS England, the ICB and, if appropriate, any successor delegate will:

28.2.1 agree a plan for the transition of the Delegated Functions from the ICB to the successor delegate, including details of the transition, the Parties' responsibilities in relation to the transition, the Parties' arrangements in respect of the Staff engaged in the Delegated Functions and the date on which the successor delegate will take responsibility for the Delegated Functions,

28.2.2 implement and comply with their respective obligations under the plan for transition agreed in accordance with Clause 28.2.1, and

28.2.3 act with a view to minimising any inconvenience or disruption to the commissioning of healthcare in the Area.

28.3 For a reasonable period before and after termination of this Agreement or termination of the ICB's exercise of any of the Delegated Functions, the ICB must:

28.3.1 co-operate with NHS England and any successor delegate to ensure continuity and a smooth transfer of the Delegated Functions, and

28.3.2 at the reasonable request of NHS England:

28.3.2.1 promptly provide all reasonable assistance and information to the extent necessary for an efficient assumption of the Delegated Functions by a successor delegate,

28.3.2.2 deliver to NHS England all materials and documents used by the ICB in the exercise of any of the Delegated Functions, and

28.3.2.3 use all reasonable efforts to obtain the consent of third parties to the assignment, novation or termination of existing contracts between the ICB and any third party which relate to or are associated with the Delegated Functions.

28.4 Where any or all of the Delegated Functions or Reserved Functions are to be directly conferred on the ICB, the Parties will co-operate with a view to ensuring continuity and a smooth transfer to the ICB.

29. PROVISIONS SURVIVING TERMINATION

29.1 Any rights, duties or obligations of any of the Parties which are expressed to survive, including those referred to in Clause 29.2, or which otherwise by necessary implication survive the termination for any reason of this Agreement, together with all indemnities, will continue after termination, subject to any limitations of time expressed in this Agreement.

29.2 The surviving provisions include the following clauses together with such other provisions as are required to interpret and give effect to them:

29.2.1 Clause 10 (Finance),

29.2.2 Clause 13 (Staffing, Workforce and Commissioning Teams),

29.2.3 Clause 16 (Liability and Indemnity),

29.2.4 Clause 17 (Claims and Litigation),

29.2.5 Clause 18 (Data Protection, Freedom of Information and Transparency),

29.2.6 Clause 25 (Disputes),

29.2.7 Clause 27 (Termination),

29.2.8 Schedule 6 (Further Information Governance and Sharing Provisions).

30. **COSTS**

30.1 Each Party is responsible for paying its own costs and expenses incurred in connection with the negotiation, preparation and execution of this Agreement.

31. **SEVERABILITY**

31.1 If any provision or part of any provision of this Agreement is declared invalid or otherwise unenforceable, that provision or part of the provision as applicable will be severed from this Agreement. This will not affect the validity and/or enforceability of the remaining part of that provision or of other provisions.

32. **GENERAL**

32.1 Nothing in this Agreement will create a partnership or joint venture or relationship of principal and agent between NHS England and the ICB.

32.2 A delay or failure to exercise any right or remedy in whole or in part shall not waive that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy.

32.3 This Agreement does not give rise to any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Agreement.

SCHEDULE 1 DEFINITIONS AND INTERPRETATION

1. The headings in this Agreement will not affect its interpretation.

2. Reference to any statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance, includes a reference to that statute or statutory provision, Law, Guidance, Mandated Guidance or Data Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced in whole or in part.

3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.

4. References to clauses and schedules are to the clauses and schedules of this Agreement, unless expressly stated otherwise.

5. References to any body, organisation or office include reference to its applicable successor from time to time.

6. Any references to this Agreement or any other documents or resources includes reference to this Agreement or those other documents or resources as varied, amended, supplemented, extended, restated and/or replaced from time to time and any reference to a website address for a resource includes reference to any replacement website address for that resource.

7. Use of the singular includes the plural and vice versa.

8. Use of the masculine includes the feminine and all other genders.

9. Use of the term “including” or “includes” will be interpreted as being without limitation.

10. The following words and phrases have the following meanings:

Administrative and Management Services	means administrative and management support provided in accordance with Clause 9.5 or 9.7,
Agreement	means this agreement between NHS England and the ICB comprising the Particulars, the Terms and Conditions, the Schedules and the Mandated Guidance,
Agreement Representatives	means the ICB Representative and the NHS England Representative as set out in the Particulars or such person identified to the other Party from time to time as the relevant representative,
Annual Allocation	means the funds allocated to the ICB annually under section 223G of the NHS Act,
Area	means the geographical area covered by the ICB,
Assurance Processes	has the definition given in paragraph 3.1 of Schedule 3,
Best Practice	means any methodologies, pathway designs and processes relating to this Agreement or the Delegated Functions developed by the ICB or its Staff for the purposes of delivering the Delegated Functions and which are capable of wider use in the delivery of healthcare services for the purposes of the NHS, but not including inventions that are capable of patent protection and for which patent protection is being sought or has been obtained, registered designs, or copyright in software,

Capital Investment Guidance	means any Mandated Guidance issued by NHS England from time to time in relation to the development, assurance and approvals process for proposals in relation to: - the expenditure of Capital, or investment in property, infrastructure or information and technology, and - the revenue consequences for commissioners or third parties making such investment,
CEDR	means the Centre for Effective Dispute Resolution,
Claims	means, for or in relation to the Delegated Functions (i) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (ii) any dispute with, or any investigation, inquiry or enforcement proceedings by, any governmental, regulatory or similar body or agency,
Claim Losses	means all Losses arising in relation to any Claim,
Clinical Commissioning Policies	means a nationally determined clinical policy setting out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure or intervention for patients with a condition requiring a specialised service,
Clinical Reference Groups	means a group consisting of clinicians, commissioners, public health experts, patient and public voice representatives and professional associations, which offers specific knowledge and expertise on the best ways that Specialised Services should be provided,
Collaborative Agreement	Means the 'Collaboration Agreement for the Commissioning of Delegated Specialised Services in the East of England' agreed between all ICBs in the East of England and NHS England, East of England Regional Team,
Collaborative Commissioning Agreement	means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Specialised Services Contracts,
Commissioning Functions	means the respective statutory functions of the Parties in arranging for the provision of services as part of the health service,
Commissioning Team	means those Specialised Services Staff that support the commissioning of Delegated Services immediately prior to this Agreement and, at the point that Staff transfer from NHS England to an identified ICB, it shall mean those NHS England

	Staff and such other Staff appointed by that ICB to carry out a role in respect of commissioning the Delegated Services,
Commissioning Team Arrangements	means the arrangements through which the services of a Commissioning Team are made available to another NHS body for the purposes of commissioning the Delegated Services,
Confidential Information	means any information or data in whatever form disclosed, which by its nature is confidential or which the disclosing Party acting reasonably states in writing to the receiving Party is to be regarded as confidential, or which the disclosing Party acting reasonably has marked 'confidential' (including, financial information, strategy documents, tenders, employee confidential information, development or workforce plans and information, and information relating to services) but which is not information which is disclosed in response to an FOIA request, or information which is published as a result of NHS England or government policy in relation to transparency,
Contracts	means any contract or arrangement in respect of the commissioning of any of the Delegated Services,
Contracting Standard Operating Procedure	means the Contracting Standard Operating Procedure produced by NHS England in respect of the Delegated Services,
Contractual Notice	means a contractual notice issued by NHS England to the ICB, from time to time and relating to allocation of contracts for the purposes of the Delegated Functions,
CQC	means the Care Quality Commission,
Data Controller	shall have the same meaning as set out in the UK GDPR,
Data Guidance	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency and the Information Commissioner,
Data Protection Impact Assessment	means an assessment to identify and minimise the data protection risks in relation to any data sharing proposals,
Data Protection Officer	shall have the same meaning as set out in the Data Protection Legislation,
Data Processor	shall have the same meaning as set out in the UK GDPR,
Data Protection Legislation	means the UK GDPR, the Data Protection Act 2018 and all applicable Law concerning privacy, confidentiality or the processing of personal data including but not limited to the

	Human Rights Act 1998, the Health and Social Care (Safety and Quality) Act 2015, the common law duty of confidentiality and the Privacy and Electronic Communications (EC Directive) Regulations 2003,
Data Sharing Agreement	means a data sharing agreement which should be in substantially the same form as a Data Sharing Agreement template approved by NHS England,
Data Subject	shall have the same meaning as set out in the UK GDPR,
Delegated Commissioning Group (DCG)	means the advisory forum in respect of Delegated Services set up by NHS England currently known as the Delegated Commissioning Group for Specialised Services,
Delegated Functions	means the statutory functions delegated by NHS England to the ICB under the Delegation and as set out in detail in this Agreement,
Delegated Funds	means the funds defined in Clause 10.2,
Delegated Services	means the services set out in Schedule 2 of this Agreement and which may be updated from time to time by NHS England,
Delegation	means the delegation of the Delegated Functions from NHS England to the ICB as described at Clause 6.1,
Developmental Arrangements	means the arrangements set out in Schedule 9 as amended or replaced,
Dispute	a dispute, conflict or other disagreement between the Parties arising out of or in connection with this Agreement,
Effective Date of Delegation	means for the Specialised Services set out in Schedule 2, the date set out in Schedule 2 as the date delegation will take effect in respect of that particular Specialised Service and for any future delegations means the date agreed by the parties as the date that the delegation will take effect,
EIR	means the Environmental Information Regulations 2004,
Escalation Rights	means the escalation rights as defined in Clause 15 (Escalation Rights),
Finance Guidance	means the guidance, rules and operating procedures produced by NHS England that relate to these delegated arrangements, including but not limited to the following: - Commissioning Change Management Business Rules, - Contracting Standard Operating Procedure, - Cashflow Standard Operating Procedure, - Finance and Accounting Standard Operating Procedure,

	- Service Level Framework Guidance,
Financial Year	shall bear the same meaning as in section 275 of the NHS Act,
FOIA	means the Freedom of Information Act 2000,
Further Arrangements	means arrangements for the exercise of Delegated Functions as defined at Clause 12,
Good Practice	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner,
Guidance	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the ICB has a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the ICB by any relevant Regulatory or Supervisory Body but excluding Mandated Guidance,
High Cost Drugs	means medicines not reimbursed though national prices and identified on the NHS England high cost drugs list,
Host ICB	Means the designated host ICB that will employ the Commissioning Team as part of the Commissioning Team Arrangements after 2024/25. During 2024/25 they will take the lead ICB role for managing the work of the Commissioning Team employed within NHS England on behalf of the ICBs.
ICB	means an Integrated Care Board established pursuant to section 14Z25 of the NHS Act and named in the Particulars,
ICB Collaboration Arrangement	means an arrangement entered into by the ICB and at least one other ICB under which the parties agree joint working arrangements in respect of the exercise of the Delegated Functions,
ICB Deliverables	all documents, products and materials developed by the ICB or its Staff in relation to this Agreement and the Delegated Functions in any form and required to be submitted to NHS England under this Agreement, including data, reports, policies, plans and specifications,
ICB Functions	the Commissioning Functions of the ICB,
Information Governance Guidance for Serious Incidents	means the checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation' (2015) as may be amended or replaced,

Indemnity Arrangement	means either: (i) a policy of insurance, (ii) an arrangement made for the purposes of indemnifying a person or organisation, or (iii) a combination of (i) and (ii),
IPR	means intellectual property rights and includes inventions, copyright, patents, database right, trademarks, designs and confidential know-how and any similar rights anywhere in the world whether registered or not, including applications and the right to apply for any such rights,
Law	means any applicable law, statute, rule, bye-law, regulation, direction, order, regulatory policy, guidance or code, rule of court or directives or requirements of any regulatory body, delegated or subordinate legislation or notice of any regulatory body (including any Regulatory or Supervisory Body),
Local Terms	means the terms set out in Schedule 8 (Local Terms) and/or such other Schedule or part thereof as designated as Local Terms,
Losses	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges whether arising under statute, contract or common law,
Managing Conflicts of Interest in the NHS	the NHS publication by that name available at: https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/ ,
Mandated Guidance	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of the Delegated Functions and issued by NHS England to the ICB as Mandated Guidance from time to time, in accordance with Clause 7.35 which at the Effective Date of Delegation shall include the Mandated Guidance set out in Schedule 7,
National Commissioning Group (NCG)	means the advisory forum in respect of the Retained Services currently known as the National Commissioning Group for Specialised, Health and Justice and Armed Forces Services,
National Standards	means the service standards for each Specialised Service, as set by NHS England and included in Clinical Commissioning Policies or National Specifications,
National Specifications	the service specifications published by NHS England in respect of Specialised Services,
Need to Know	has the meaning set out in paragraph 1.2 of Schedule 6 (Further Information Governance and Sharing Provisions),

NICE Regulations	means the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013 as amended or replaced,
NHS Act	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022 and other legislation from time to time),
NHS Counter Fraud Authority	means the Special Health Authority established by and in accordance with the NHS Counter Fraud Authority (Establishment, Constitution, and Staff and Other Transfer Provisions) Order 2017/958,
NHS Digital Data Security and Protection Toolkit	means the toolkit published by NHS Digital and available on the NHS Digital website at: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit ,
NHS England	means the body established by section 1H of the NHS Act,
NHS England Deliverables	means all documents, products and materials NHS England in which NHS England holds IPRs which are relevant to this Agreement, the Delegated Functions or the Reserved Functions in any form and made available by NHS England to the ICB under this Agreement, including data, reports, policies, plans and specifications,
NHS England Functions	means all functions of NHS England as set out in legislation excluding any functions that have been expressly delegated,
Non-Personal Data	means data which is not Personal Data,
Operational Days	a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in England,
Oversight Framework	means the NHS Oversight Framework, as may be amended or replaced from time to time, and any relevant associated Guidance published by NHS England,
Party/Parties	means a party or both parties to this Agreement,
Patient Safety Incident Response Framework	means the framework published by NHS England and made available on the NHS England website at: https://www.england.nhs.uk/patient-safety/incident-response-framework/ ,
Personal Data	shall have the same meaning as set out in the UK GDPR and shall include references to Special Category Personal Data where appropriate,
Population	means the individuals for whom the ICB has responsibility in respect of commissioning the Delegated Services,

Prescribed Specialised Services Manual	means the document which may be amended or replaced from time to time which is currently known as the prescribed specialised services manual which describes how NHS England and ICBs commission specialised services and sets out the identification rules which describe how NHS England and ICBs identify Specialised Services activity within data flows,
Provider Collaborative	means a group of Specialised Service Providers who have agreed to work together to improve the care pathway for one or more Specialised Services,
Provider Collaborative Guidance	means the guidance published by NHS England in respect of Provider Collaboratives,
Prohibited Act	means the ICB: (i) offering, giving, or agreeing to give NHS England (or an of their officers, employees or agents) any gift or consideration of any kind as an inducement or reward for doing or not doing or for having done or not having done any act in relation to the obtaining of performance of this Agreement, the Reserved Functions, the Delegation or any other arrangement with the ICB, or for showing or not showing favour or disfavour to any person in relation to this Agreement or any other arrangement with the ICB, and (ii) in connection with this Agreement, paying or agreeing to pay any commission, other than a payment, particulars of which (including the terms and conditions of the agreement for its payment) have been disclosed in writing to NHS England, or (iii) committing an offence under the Bribery Act 2010,
Regional Quality Group	means a group set up to act as a strategic forum at which regional partners from across health and social care can share, identify and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated,
Regulatory or Supervisory Body	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: (i) CQC, (ii) NHS England, (iii) the Department of Health and Social Care, (iv) the National Institute for Health and Care Excellence, (v) Healthwatch England and Local Healthwatch, (vi) the General Medical Council,

	(vii) the General Dental Council, (viii) the General Optical Council, (ix) the General Pharmaceutical Council, (x) the Healthcare Safety Investigation Branch, and (xi) the Information Commissioner,
Relevant Clinical Networks	means those clinical networks identified by NHS England as required to support the commissioning of Specialised Services for the Population,
Relevant Information	means the Personal Data and Non-Personal Data processed under the Delegation and this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*),
Reserved Functions	means statutory functions of NHS England that it has not delegated to the ICB including but not limited to those set out in the Schedules to this Agreement,
Retained Services	means those Specialised Services for which NHS England shall retain commissioning responsibility, as set out in Schedule 5,
Secretary of State	means the Secretary of State for Health and Social Care,
Shared Care Arrangements	means arrangements put in place to support patients receiving elements of their care closer to home, whilst still ensuring that they have access to the expertise of a specialised centre and that care is delivered in line with the expectation of the relevant National Specification,
Single Point of Contact	means the member of Staff appointed by each relevant Party in accordance with Paragraph 9.6 of Schedule 6,
Special Category Personal Data	shall have the same meaning as in UK GDPR,
Specialised Commissioning Budget	means the budget identified by NHS England for the purpose of exercising the Delegated Functions,
Specialised Commissioning Functions	means the statutory functions conferred on NHS England under Section 3B of the NHS Act and Regulation 11 and Schedule 4 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996 (as amended or replaced),
Specialised Services	means the services commissioned in exercise of the Specialised Commissioning Functions,

Specialised Services Contract	means a contract for the provision of Specialised Services entered into in the exercise of the Specialised Commissioning Functions,
Specialised Services Provider	means a provider party to a Specialised Services Contract,
Specialised Services Staff	means the Staff of roles identified as carrying out the Delegated Services Functions immediately prior to the date of this Agreement,
Specified Purpose	means the purpose for which the Relevant Information is shared and processed, being to facilitate the exercise of the ICB's Delegated Functions and NHS England's Reserved Functions as specified in paragraph 2.1. of Schedule 6 (Further Information Governance and Sharing Provisions) to this Agreement,
Staff or Staffing	means the Parties' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of either Party (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel,
Sub-Delegate	shall have the meaning in Clause 12.2,
System Quality Group	means a group set up to identify and manage concerns across the local system. The system quality group shall act as a strategic forum at which partners from across the local health and social care footprint can share issues and risk information to inform response and management, identify and mitigate quality risks and concerns as well as share learning and best practice,
Triple Aim	means the duty to have regard to wider effect of decisions, which is placed on each of the Parties under section 13NA (as regards NHS England) and section 14Z43 (as regards the ICB) of the NHS Act,
UK GDPR	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018,
Variation Proposal	means a written proposal for a variation to the Agreement, which complies with the requirements of Clause 26.5.

SCHEDULE 2 DELEGATED SERVICES

Delegated Services

NHS England delegates to the ICB the statutory function for commissioning the Specialised Services set out in this Schedule 2 (Delegated Services) subject to the reservations set out in Schedule 4 (Retained Functions) and the provisions of any Developmental Arrangements set out in Schedule 9.

The following Specialised Services were delegated to the ICB on 1 April 2024.

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
2	Adult congenital heart disease services	13X	Adult congenital heart disease services (non-surgical)
		13Y	Adult congenital heart disease services (surgical)
3	Adult specialist pain management services	31Z	Adult specialist pain management services
4	Adult specialist respiratory services	29M	Interstitial lung disease (adults)
		29S	Severe asthma (adults)
		29L	Lung volume reduction (adults)
5	Adult specialist rheumatology services	26Z	Adult specialist rheumatology services
7	Adult Specialist Cardiac Services	13A	Complex device therapy
		13B	Cardiac electrophysiology & ablation
		13C	Inherited cardiac conditions
		13E	Cardiac surgery (inpatient)
		13F	PPCI for ST- elevation myocardial infarction
		13H	Cardiac magnetic resonance imaging
		13T	Complex interventional cardiology (adults)
		13Z	Cardiac surgery (outpatient)
9	Adult specialist endocrinology services	27E	Adrenal Cancer (adults)
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08O	Neurology (adults)
		08P	Neurophysiology (adults)
		08R	Neuroradiology (adults)
		08S	Neurosurgery (adults)
		08T	Mechanical Thrombectomy
		58A	Neurosurgery LVHC national: surgical removal of clival chordoma and chondrosarcoma
		58B	Neurosurgery LVHC national: EC-IC bypass (complex/high flow)
		58C	Neurosurgery LVHC national: transoral excision of dens
		58D	Neurosurgery LVHC regional: anterior skull based tumours
		58E	Neurosurgery LVHC regional: lateral skull based tumours
		58F	Neurosurgery LVHC regional: surgical removal of brainstem lesions
		58G	Neurosurgery LVHC regional: deep brain stimulation
		58H	Neurosurgery LVHC regional: pineal tumour surgeries - resection
		58I	Neurosurgery LVHC regional: removal of arteriovenous malformations of the nervous system
		58J	Neurosurgery LVHC regional: epilepsy
		58K	Neurosurgery LVHC regional: insula glioma's/ complex low grade glioma's
		58L	Neurosurgery LVHC local: anterior lumbar fusion
	Adult specialist neurosciences services (continued)	58M	Neurosurgery LVHC local: removal of intramedullary spinal tumours
		58N	Neurosurgery LVHC local: intraventricular tumours resection
		58O	Neurosurgery LVHC local: surgical repair of aneurysms (surgical clipping)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
		58P	Neurosurgery LVHC local: thoracic discectomy
		58Q	Neurosurgery LVHC local: microvascular decompression for trigeminal neuralgia
		58R	Neurosurgery LVHC local: awake surgery for removal of brain tumours
		58S	Neurosurgery LVHC local: removal of pituitary tumours including for Cushing's and acromegaly
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery (adults)
		34R	Orthopaedic revision (adults)
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis
16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery (adults)
		29Z	Adult thoracic surgery services: outpatients
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services (adults and children)
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services (adults and children)
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services (adults and children)
		08Z	Complex neuro-spinal surgery services (adults and children)
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services (adults and adolescents)
58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis
		04D	Complex urinary incontinence and genital prolapse
58A	Specialist adult urological surgery services for men	41P	Penile implants
		41S	Surgical sperm removal
		41U	Urethral reconstruction
59	Specialist allergy services (adults and children)	17Z	Specialist allergy services (adults and children)
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services (adults and children)
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services (adults and children)
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases
		18E	Specialist Bone and Joint Infection (adults)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
72	Major trauma services (adults and children)	34T	Major trauma services (adults and children)
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services (adults and children)
83	Paediatric cardiac services	23B	Paediatric cardiac services
94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
		51R	Radiotherapy services (Children)
		01S	Stereotactic Radiosurgery / radiotherapy
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer (adults)
		01K	Malignant mesothelioma (adults)
		01M	Head and neck cancer (adults)
		01N	Kidney, bladder and prostate cancer (adults)
		01Q	Rare brain and CNS cancer (adults)
		01U	Oesophageal and gastric cancer (adults)
		01V	Biliary tract cancer (adults)
		01W	Liver cancer (adults)
		01Y	Cancer Outpatients (adults)
		01Z	Testicular cancer (adults)
		04F	Gynaecological cancer (adults)
		19V	Pancreatic cancer (adults)
		24Y	Skin cancer (adults)
		19C	Biliary tract cancer surgery (adults)
		19M	Liver cancer surgery (adults)
		19Q	Pancreatic cancer surgery (adults)
		51A	Interventional oncology (adults)
		51B	Brachytherapy (adults)
		51C	Molecular oncology (adults)
		61M	Head and neck cancer surgery (adults)
		61Q	Ophthalmic cancer surgery (adults)
		61U	Oesophageal and gastric cancer surgery (adults)
		61Z	Testicular cancer surgery (adults)
		33C	Transanal endoscopic microsurgery (adults)
		33D	Distal sacrectomy for advanced and recurrent rectal cancer (adults)
106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer
		23A	Children's cancer
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence (adults)
		33B	Complex inflammatory bowel disease (adults)
107	Specialist dentistry services for children	23P	Specialist dentistry services for children
108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children
109	Specialist endocrinology services for children	23E	Specialist endocrinology and diabetes services for children
110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children
112	Specialist gynaecology services for children	73X	Specialist paediatric surgery services - gynaecology
113	Specialist haematology services for children	23H	Specialist haematology services for children

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
115B	Specialist maternity care for adults diagnosed with abnormally invasive placenta	04G	Specialist maternity care for women diagnosed with abnormally invasive placenta
118	Neonatal critical care services	NIC	Specialist neonatal care services
119	Specialist neuroscience services for children	23M	Specialist neuroscience services for children
		07Y	Paediatric neurorehabilitation
		08J	Selective dorsal rhizotomy
120	Specialist ophthalmology services for children	23N	Specialist ophthalmology services for children
121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children
122	Paediatric critical care services	PIC	Specialist paediatric intensive care services
125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children
126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs (adults and children)
127	Specialist renal services for children	23S	Specialist renal services for children
128	Specialist respiratory services for children	23T	Specialist respiratory services for children
129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children
130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults
		19P	Specialist services for complex pancreatic diseases in adults
		19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults
		19B	Specialist services for complex biliary diseases in adults
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)
		03Y	Specialist services for haemophilia and other related bleeding disorders (Children)
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05P	Prosthetics (adults and children)
135	Specialist paediatric surgery services	23X	Specialist paediatric surgery services - general surgery
136	Specialist paediatric urology services	23Z	Specialist paediatric urology services
139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital
ACC	Adult Critical Care	ACC	Adult critical care

SCHEDULE 3 DELEGATED FUNCTIONS

1 Introduction

1.1 Subject to the reservations set out in Schedule 4 (Reserved Functions) and the provisions of any Developmental Arrangements, NHS England delegates to the ICB the statutory function for commissioning the Delegated Services. This Schedule 3 sets out the key powers and duties that the ICB will be required to carry out in exercise of the Delegated Functions being, in summary:

1.1.1 decisions in relation to the commissioning and management of Delegated Services,

1.1.2 planning Delegated Services for the Population, including carrying out needs assessments,

1.1.3 undertaking reviews of Delegated Services in respect of the Population,

1.1.4 supporting the management of the Specialised Commissioning Budget,

1.1.5 co-ordinating a common approach to the commissioning and delivery of Delegated Services with other health and social care bodies in respect of the Population where appropriate, and

1.1.6 such other ancillary activities that are necessary to exercise the Specialised Commissioning Functions.

1.2 When exercising the Delegated Functions, ICBs are not acting on behalf of NHS England but acquire rights and incur any liabilities in exercising the functions.

2 General Obligations

2.1 The ICB is responsible for planning the commissioning of the Delegated Services in accordance with this Agreement. This includes ensuring at all times that the Delegated Services are commissioned in accordance with the National Standards.

2.2 The ICB shall put in place arrangements for collaborative working with other ICBs in accordance with Clause 8 (Requirement for ICB Collaboration Arrangement).

2.3 The Developmental Arrangements set out in Schedule 9 shall apply.

Specific Obligations

3 Assurance and Oversight

3.1 The ICB must at all times operate in accordance with:

3.1.1 the Oversight Framework published by NHS England,

3.1.2 any national oversight and/or assurance guidance in respect of Specialised Services and/or joint working arrangements, and

3.1.3 any other relevant NHS oversight and assurance guidance,

collectively known as the “Assurance Processes”.

3.2 The ICB must:

3.2.1 develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes,

3.2.2 oversee the provision of Delegated Services and the outcomes being delivered for its Population in accordance with the Assurance Processes,

3.2.3 assure that Specialised Service Providers are meeting, or have an improvement plan in place to meet, National Standards,

3.2.4 provide any information and comply with specific actions in relation to the Delegated Services, as required by NHS England, including metrics and detailed reporting.

4 Attendance at governance meetings

4.1 The ICB must ensure that there is appropriate representation at forums established through the ICB Collaboration Arrangement.

4.2 The ICB must ensure that an individual(s) has been nominated to represent the ICB at the Delegated Commissioning Group (DCG) and regularly attends that group. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

4.3 The ICB should also ensure that they have a nominated representative with appropriate subject matter expertise to attend National Standards development forums as requested by NHS England. This could be a single representative on behalf of the members of an ICB Collaboration Arrangement. Where that representative is not an employee of the ICB, the ICB must have in place appropriate arrangements to enable the representative to feedback to the ICB.

5 Clinical Leadership and Clinical Reference Groups

5.1 The ICB shall support the development of clinical leadership and expertise at a local level in respect of Specialised Services.

5.2 The ICB shall support local and national groups including Relevant Clinical Networks and Clinical Reference Groups that are involved in developing Clinical Commissioning Policies, National Specifications, National Standards and knowledge around Specialised Services.

6 Clinical Networks

6.1 The ICB shall participate in the planning, governance and oversight of the Relevant Clinical Networks, including involvement in agreeing the annual plan for each Relevant Clinical Network. The ICB shall seek to align the network priorities with system priorities and to ensure that the annual plan for the Relevant Clinical Network reflects local needs and priorities.

6.2 The ICB will be involved in the development and agreement of a single annual plan for the Relevant Clinical Network.

6.3 The ICB shall monitor the implementation of the annual plan and receive an annual report from the Relevant Clinical Network that considers delivery against the annual plan.

6.4 The ICB shall actively support and participate in dialogue with Relevant Clinical Networks and shall ensure that there is a clear and effective mechanism in place for giving and receiving information with the Relevant Clinical Networks including network reports.

6.5 The ICB shall support NHS England in the management of Relevant Clinical Networks.

6.6 The ICB shall actively engage and promote Specialised Service Provider engagement in appropriate Relevant Clinical Networks.

6.7 Where a Relevant Clinical Network identifies any concern, the ICB shall seek to consider and review that concern as soon as is reasonably practicable and take such action, if any, as it deems appropriate.

6.8 The ICB shall ensure that network reports are considered where relevant as part of exercising the Delegated Functions.

7 Complaints

7.1 The ICB shall provide full co-operation with NHS England in relation to any complaints received in respect of the Delegated Services which shall retain the function of complaints management in respect of the Delegated Services.

7.2 The ICB shall provide the relevant individuals at NHS England with appropriate access to data held by the ICB necessary to carry out the complaints function.

7.3 At such time as agreed between the ICB and NHS England, the management of complaints function in respect of the Delegated Services shall be delegated to the ICB and the following provisions shall apply:

7.3.1 NHS England shall provide the relevant individuals at the ICB with appropriate access to complaints data held by NHS England necessary to carry out the complaints function as set out in the Complaints Sharing Protocol.

7.3.2 The ICB shall provide information relating to key performance indicators ("KPIs") as requested by NHS England. These KPIs shall include information reporting on the following:

7.3.2.1 acknowledgements provided within three (3) Operational Days,

7.3.2.2 responses provided within forty (40) Operational Days,

7.3.2.3 response not provided within six (6) months

7.3.2.4 open cases with the Parliamentary and Health Services Ombudsman and providing information on any fully or partly upheld complaints, and

7.3.2.5 overall activity by volume (not as a KPI).

7.3.3 The ICB shall co-operate with NHS England in respect of the review of complaints related to the Delegated Services and shall, on request, share any learning identified in carrying out the complaints function.

7.3.4 The ICB shall take part in any peer review process put in place in respect of the complaints function.

7.4 Where NHS England has provided the ICB with a protocol for sharing complaints in respect of any or all Specialised Services then those provisions shall apply and are deemed to be part of this Agreement.

8 Commissioning and optimisation of High Cost Drugs

8.1 The ICB must ensure the effective and efficient commissioning of High Cost Drugs for Delegated Services.

8.2 Where necessary the ICB must collaborate with NHS England in respect of the payment arrangements for High Cost Drugs.

8.3 The ICB must develop and implement Shared Care Arrangements across the Area of the ICB.

8.4 The ICB must provide clinical and commissioning leadership in the commissioning and management of High Cost Drugs. This includes supporting the Specialised Service

Provider pharmacy services and each Party in the development access to medicine strategies, and minimising barriers that may exacerbate health inequalities.

8.5 The ICB must ensure:

8.5.1 safe and effective use of High Cost Drugs in line with national Clinical Commissioning Policies,

8.5.2 effective introduction of new medicines,

8.5.3 compliance with all NHS England commercial processes and frameworks for High Cost Drugs,

8.5.4 Specialised Services Providers adhere to all NHS England commercial processes and frameworks for High Cost Drugs,

8.5.5 appropriate use of Shared Care Arrangements, ensuring that they are safe and well monitored, and

8.5.6 consistency of prescribing and unwarranted prescribing variation are addressed.

8.6 The ICB must have in place appropriate monitoring mechanisms, including prescribing analysis, to support the financial management of High Cost Drugs.

8.7 The ICB must engage in the development, implementation and monitoring of initiatives that enable use of better value medicines. Such schemes include those at a local, regional or national level.

8.8 The ICB must provide support to prescribing networks and forums, including but not limited to, Immunoglobulin Assessment panels, prescribing networks and medicines optimisation networks.

9 Contracting

9.1 The ICB shall be responsible for ensuring appropriate arrangements are in place for the commissioning of the Delegated Services which for the avoidance of doubt includes:

9.1.1 co-ordinating or collaborating in the award of appropriate Specialised Service Contracts,

9.1.2 drafting of the contract schedules so that it reflects Mandatory Guidance, National Specifications and any specific instructions from NHS England, and

9.1.3 management of Specialised Services Contracts.

9.2 In relation to the contracting for NHS England Retained Services where the ICB has agreed to act as the co-ordinating commissioner, to implement NHS England's instructions in relation to those Retained Services and, where appropriate, put in place a Collaborative Commissioning Agreement with NHS England as a party.

10 Data Management and Analytics

10.1 The ICB shall:

10.1.1 lead on standardised collection, processing, and sharing of data for Delegated Services in line with broader NHS England, Department of Health and Social Care and government data strategies,

10.1.2 lead on the provision of data and analytical services to support commissioning of Delegated Services,

10.1.3 ensure collaborative working across partners on agreed programmes of work focusing on provision of pathway analytics,

10.1.4 share expertise and existing reporting tools with partner ICBs in the ICB Collaboration Arrangement,

10.1.5 ensure interpretation of data is made available to NHS England and other ICBs within the ICB Collaboration Arrangement,

10.1.6 ensure data and analytics teams within ICBs and NHS England work collaboratively on jointly agreed programmes of work focusing on provision of pathway analytics,

10.2 The ICB must ensure that the data reporting and analytical frameworks, as set out in Mandated Guidance or as otherwise required by NHS England, are in place to support the commissioning of the Delegated Services.

11 Finance

11.1 The provisions of Clause 10 (Finance) of this Agreement set out the financial requirements in respect of the Delegated Functions.

12 Freedom of Information and Parliamentary Requests

12.1 The ICB shall lead on the handling, management and response to all Freedom of Information and parliamentary correspondence relating to Delegated Services.

13 Incident Response and Management

13.1 The ICB shall:

13.1.1 lead on local incident management for Delegated Services as appropriate to the stated incident level,

13.1.2 support national and regional incident management relating to Specialised Services, and

13.1.3 ensure surge events and actions relating to Specialised Services are included in ICB escalation plans.

13.2 In the event that an incident is identified that has an impact on the Delegated Services (such as potential failure of a Specialised Services Provider), the ICB shall fully support the implementation of any requirements set by NHS England around the management of such incident and shall provide full co-operation to NHS England to enable a co-ordinated national approach to incident management. NHS England retains the right to take decisions at a national level where it determines this is necessary for the proper management and resolution of any such incident and the ICB shall be bound by any such decision.

14 Individual Funding Requests

14.1 The ICB shall provide any support required by NHS England in respect of determining an Individual Funding Request and shall implement the decision of the Individual Funding Request panel.

15 Innovation and New Treatments

15.1 The ICB shall support local implementation of innovative treatments for Delegated Services.

16 Mental Health, Learning Disability and Autism NHS-led Provider Collaboratives

16.1 The ICB shall co-operate fully with NHS England in the development, management and operation of mental health, learning disability and autism NHS-led Provider Collaboratives including, where requested by NHS England, to consider the Provider Collaborative arrangements as part of the wider pathway delivery.

17 **Provider Selection and Procurement**

17.1 The ICB shall:

17.1.1 run appropriate local provider selection and procurement processes for Delegated Services,

17.1.2 align all procurement processes with any changes to national procurement policy (for example new legislation) for Delegated Services,

17.1.3 support NHS England with national procurements where required with subject matter expertise on provider engagement and provider landscape, and

17.1.4 monitor and provide advice, guidance and expertise to NHS England on the overall provider market and provider landscape.

17.2 In discharging these responsibilities, the ICB must comply at all times with Law and any relevant Guidance including but not limited to Mandated Guidance, any applicable procurement law and Guidance on the selection of, and award of contracts to, providers of healthcare services.

17.3 When the ICB makes decisions in connection with the awarding of Specialised Services Contracts, it should ensure that it can demonstrate compliance with requirements for the award of such Contracts, including that the decision was:

17.3.1 made in the best interest of patients, taxpayers and the Population,

17.3.2 robust and defensible, with conflicts of interests appropriately managed,

17.3.3 made transparently, and

17.3.4 compliant with relevant Guidance and legislation.

18 **Quality**

18.1 The ICB must ensure that appropriate arrangements for quality oversight are in place. This must include:

18.1.1 clearly defined roles and responsibilities for ensuring governance and oversight of Delegated Services,

18.1.2 defined roles and responsibilities for ensuring robust communication and appropriate feedback, particularly where Delegated Services are commissioned through an arrangement with one or more other ICBs,

18.1.3 working with providers and partner organisations to address any issues relating to Delegated Services and escalate appropriately if such issues cannot be resolved,

18.1.4 developing and standardising processes that align with regional systems to ensure oversight of the quality of Delegated Services, and participating in local System Quality Groups and Regional Quality Groups, or their equivalent,

18.1.5 ensuring processes are robust and concerns are identified, mitigated and escalated as necessary,

18.1.6 ensuring providers are held to account for delivery of safe, patient-focused and quality care for Delegated Services, including mechanisms for monitoring patient complaints, concerns and feedback, and

18.1.7 the implementation of the Patient Safety Incident Response Framework for the management of incidents and serious events, appropriate reporting of any incidents, undertaking any appropriate patient safety incident investigation and obtaining support as required.

18.2 The ICB must establish a plan to ensure that the quality of the Delegated Services is measured consistently, using nationally and locally agreed metrics triangulated with professional insight and soft intelligence.

18.3 The ICB must ensure that the oversight of the quality of the Delegated Services is integrated with wider quality governance in the local system and aligns with the NHS England National Quality Board's recommended quality escalation processes.

18.4 The ICB must ensure that there is a System Quality Group (or equivalent) to identify and manage concerns across the local system.

18.5 The ICB must ensure that there is appropriate representation at any Regional Quality Groups or their equivalent.

18.6 The ICB must have in place all appropriate arrangements in respect of child and adult safeguarding and comply with all relevant Guidance.

19 Service Planning and Strategic Priorities

19.1 The ICB is responsible for setting local commissioning strategy, policy and priorities and planning for and carrying out needs assessments for the Delegated Services.

19.2 In planning, commissioning and managing the Delegated Services, the ICB must have processes in place to assess and monitor equitable patient access, in accordance with the access criteria set out in Clinical Commissioning Policies and National Specifications, taking action to address any apparent anomalies.

19.3 The ICB must ensure that it works with Specialised Service Providers and Provider Collaboratives to translate local strategic priorities into operational outputs for Delegated Services.

19.4 The ICB shall provide input into any consideration by NHS England as to whether the commissioning responsibility in respect of any of the Retained Services should be delegated.

20 National Standards, National Specifications and Clinical Commissioning Policies

20.1 The ICB shall provide input into national decisions on National Standards and national transformation regarding Delegated Services through attendance at governance meetings.

20.2 The ICB shall facilitate engagement with local communities on National Specification development.

20.3 The ICB must comply with the National Specifications and relevant Clinical Commissioning Policies and ensure that all clinical Specialised Services Contracts accurately reflect Clinical Commissioning Policies and include the relevant National Specification, where one exists in relation to the relevant Delegated Service.

20.4 The ICB must co-operate with any NHS England activities relating to the assessment of compliance against National Standards, including through the Assurance Processes.

20.5 The ICB must have appropriate mechanisms in place to ensure National Standards and National Specifications are being adhered to.

20.6 Where the ICB has identified that a Specialised Services Provider may not be complying with the National Standards set out in the relevant National Specification, the ICB shall consider the action to take to address this in line with the Assurance Processes.

21 Transformation

21.1 The ICB shall:

21.1.1 prioritise pathways and services for transformation according to the needs of its Population and opportunities for improvement in ICB commissioned services and for Delegated Services,

21.1.2 lead ICB and ICB Collaboration Arrangement driven transformation programmes across pathways for Delegated Services,

21.1.3 lead the delivery locally of transformation in areas of national priority (such as Cancer, Mental Health and Learning Disability and Autism), including supporting delivery of commitments in the NHS Long Term Plan,

21.1.4 support NHS England with agreed transformational programmes for Retained Services,

21.1.5 support NHS England with agreed transformational programmes and identify future transformation programmes for consideration and prioritisation for Delegated Services where national co-ordination and enablement may support transformation,

21.1.6 work collaboratively with NHS England on the co-production and co-design of transformation and improvement interventions and solutions in those areas prioritised, and

21.1.7 ensure Relevant Clinical Networks and other clinical networks use levers to facilitate and embed transformation at a local level for Delegated Services.

SCHEDULE 4 RESERVED FUNCTIONS

Introduction

1 Reserved Functions in Relation to the Delegated Services

1.1 In accordance with Clause 6.2 of this Agreement, all functions of NHS England other than those defined as Delegated Functions, are Reserved Functions.

1.2 This Schedule sets out further provision regarding the carrying out of the Reserved Functions as they relate to the Delegated Functions.

1.3 The ICB will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.

1.4 The following functions and related activities shall continue to be exercised by NHS England.

2 Retained Services

2.1 NHS England shall commission the Retained Services set out in Schedule 5.

3 Reserved Specialised Service Functions

3.1 NHS England shall carry out the functions set out in this Schedule 4 in respect of the Delegated Services.

Reserved Functions

4 Assurance and Oversight

4.1 NHS England shall:

4.1.1 have oversight of what ICBs are delivering (inclusive of Delegated Services) for their Populations and all patients,

4.1.2 design and implement appropriate assurance of ICBs' exercise of Delegated Functions including the Assurance Processes,

4.1.3 help the ICB to coordinate and escalate improvement and resolution interventions where challenges are identified (as appropriate),

4.1.4 ensure that the NHS England Board is assured that Delegated Functions are being discharged appropriately,

4.1.5 ensure specialised commissioning considerations are appropriately included in NHS England frameworks that guide oversight and assurance of service delivery, and

4.1.6 host a Delegated Commissioning Group ("DCG") that will undertake an assurance role in line with the Assurance Processes. This assurance role shall include assessing and monitoring the overall coherence, stability and sustainability of the commissioning model of Specialised Services at a national level, including identification, review and management of appropriate cross-ICB risks.

5 Attendance at governance meetings

5.1 NHS England shall ensure that there is appropriate representation in respect of Reserved Functions and Retained Services at local governance forums (for example, the Regional Leadership Team) and at NCG.

5.2 NHS England shall:

5.2.1 ensure that there is appropriate representation by NHS England subject matter expert(s) at National Standards development forums,

5.2.2 ensure there is appropriate attendance by NHS England representatives at nationally led clinical governance meetings, and

5.2.3 co-ordinate, and support key national governance groups.

6 Clinical Leadership and Clinical Reference Groups

6.1 NHS England shall be responsible for the following:

6.1.1 developing local leadership and support for the ICB relating to Specialised Services,

6.1.2 providing clinical leadership, advice and guidance to the ICB in relation to the Delegated Services,

6.1.3 providing point-of-contact and ongoing engagement with key external bodies, such as interest groups, charities, NICE, DHSC, and Royal Colleges, and enabling access to clinical trials for new treatments and medicines.

6.2 NHS England will host Clinical Reference Groups, which will lead on the development and publication of the following for Specialised Services:

6.2.1 Clinical Commissioning Policies,

6.2.2 National Specifications, including National Standards for each of the Specialised Services.

7 Clinical Networks

7.1 Unless otherwise agreed between the Parties, NHS England shall put in place contractual arrangements and funding mechanisms for the commissioning of the Relevant Clinical Networks.

7.2 NHS England shall ensure development of multi-ICB, and multi-region (where necessary) governance and oversight arrangements for Relevant Clinical Networks that give line of sight between all clinical networks and all ICBs whose Population they serve.

7.3 NHS England shall be responsible for:

7.3.1 developing national policy for the Relevant Clinical Networks,

7.3.2 developing and approving the specifications for the Relevant Clinical Networks,

7.3.3 maintaining links with other NHS England national leads for clinical networks not focused on Specialised Services,

7.3.4 convening or supporting national networks of the Relevant Clinical Networks,

7.3.5 agreeing the annual plan for each Relevant Clinical Network with the involvement of the ICB and Relevant Clinical Network, ensuring these reflect national and regional priorities,

7.3.6 managing Relevant Clinical Networks jointly with the ICB, and

7.3.7 agreeing and commissioning the hosting arrangements of the Relevant Clinical Networks.

8 Complaints

8.1 NHS England shall manage all complaints in respect of the Delegated Services at the date of this Agreement and until such time as it agrees the delegation of complaints to the ICB.

8.2 NHS England shall manage all complaints in respect of the Reserved Services.

9 Commissioning and optimisation of High Cost Drugs

9.1 In respect of pharmacy and optimisation of High Cost Drugs, NHS England shall:

9.1.1 comply as appropriate with the centralised process for the reimbursement of Specialised Services High Cost Drugs and, where appropriate, ensuring that only validated drugs spend is reimbursed, there is timely drugs data and drugs data quality meets the standards set nationally,

9.1.2 support the ICB on strategy for access to medicines used within Delegated Services, minimising barriers to health inequalities,

9.1.3 provide support, as reasonably required, to the ICB to assist it in the commissioning of High Cost Drugs for Delegated Services including shared care agreements,

9.1.4 seek to address consistency of prescribing in line with national commissioning policies, introduction of new medicines, and addressing unwarranted prescribing variation,

9.1.5 provide input into national procurement, homecare and commercial processes,

9.1.6 provide expert medicines advice and input into immunoglobin assessment panels and support to the national Programmes of Care and Clinical Reference Groups,

9.1.7 provide expert medicines advice and input into the Individual Funding Request process for Delegated Services, and

9.1.8 collaborate with commissioners of health and justice services to ensure detained people can access High Cost Drugs using the NHS England or ICB commissioning policies in line with community patient access, including who prescribes and supplies the medicine.

10 Contracting

10.1 NHS England shall retain the following obligations in relation to contracting for Delegated Services:

10.1.1 ensure Specialised Services are included in national NHS England contracting and payment strategy (for example, Aligned Payment Incentives),

10.1.2 provide advice for ICBs on schedules to support the Delegated Services,

10.1.3 set, publish or make otherwise available the Contracting Standard Operating Procedure and Mandated Guidance detailing contracting strategy and policy for Specialised Services, and

10.1.4 provide and distribute contracting support tools and templates to the ICB.

10.2 In respect of the Retained Services, NHS England shall:

10.2.1 where appropriate, ensure a Collaborative Commissioning Agreement is in place between NHS England and the ICB(s), and

10.2.2 where appropriate, construct model template schedules for Retained Services and issue to ICBs.

11 Data Management and Analytics

11.1 NHS England shall:

11.1.1 support the ICB by collaborating with the wider data and analytics network (nationally) to support development and local deployment or utilisation of support tools,

11.1.2 support the ICB to address data quality and coverage needs, accuracy of reporting Specialised Services activity and spend on a Population basis to support commissioning of Specialised Services,

11.1.3 ensure inclusion of Specialised Services data strategy in broader NHS England, DHSC and government data strategies,

11.1.4 lead on defining relevant contractual content of the information schedule (Schedule 6) of the NHS Standard Contract for Clinical Services,

11.1.5 work collaboratively with the ICB to drive continual improvement of the quality and coverage of data used to support commissioning of Specialised Services,

11.1.6 provide a national analytical service to support oversight and assurance of Specialised Services, and support (where required) the national Specialised Commissioning team, Programmes of Care and Clinical Reference Groups, and

11.1.7 provide access to data and analytic subject matter expertise to support the ICB when considering local service planning, needs assessment and transformation.

12 Finance

12.1 The provisions of Clause 10 shall apply in respect of the financial arrangements in respect of the Delegated Functions.

13 Freedom of Information and Parliamentary Requests

13.1 NHS England shall:

13.1.1 lead on handling, managing and responding to all national FOIA and parliamentary correspondence relating to Retained Services, and

13.1.2 co-ordinate a response when a single national response is required in respect of Delegated Services.

14 Incident Response and Management

14.1 NHS England shall:

14.1.1 provide guidance and support to the ICB in the event of a complex incident,

14.1.2 lead on national incident management for Specialised Services as appropriate to stated incident level and where nationally commissioned services are impacted,

14.1.3 lead on monitoring, planning and support for service and operational resilience at a national level and provide support to the ICB, and

14.1.4 respond to specific service interruptions where appropriate, for example, supplier and workforce challenges and provide support to the ICB in any response to interruptions.

15 Individual Funding Requests

15.1 NHS England shall be responsible for:

15.1.1 leading on Individual Funding Requests (IFR) policy, IFR governance and managing the IFR process for Delegated Services and Retained Services,

15.1.2 taking decisions in respect of IFRs at IFR Panels for both Delegated Services and Retained Services, and

15.1.3 providing expertise for IFR decisions, including but not limited to pharmacy, public health, nursing and medical and quality.

16 Innovation and New Treatments

16.1 NHS England shall support the local implementation of innovative treatments for Delegated Services.

16.2 NHS England shall ensure services are in place for innovative treatments such as advanced medicinal therapy products recommended by NICE technology appraisals within statutory requirements.

16.3 NHS England shall provide national leadership for innovative treatments with significant service impacts including liaison with NICE.

17 Mental Health, Learning Disability and Autism NHS-led Provider Collaboratives

17.1 NHS England shall commission and design NHS-led Provider Collaborative arrangements for mental health, learning disability and autism services. Where it considers appropriate, NHS England shall seek the input of the ICB in relation to relevant Provider Collaborative arrangements.

18 Provider Selection and Procurement

18.1 In relation to procurement, NHS England shall be responsible for:

18.1.1 setting standards and agreeing frameworks and processes for provider selections and procurements for Specialised Services,

18.1.2 monitoring and providing advice, guidance and expertise on the overall provider market in relation to Specialised Services, and

18.1.3 where appropriate, running provider selection and procurement processes for Specialised Services.

19 Quality

19.1 In respect of quality, NHS England shall:

19.1.1 work with the ICB to ensure oversight of Specialised Services through quality surveillance and risk management and escalate as required,

19.1.2 work with the ICB to seek to ensure that quality and safety issues and risks are managed effectively and escalated to the National Specialised Commissioning Quality and Governance Group (QGG), or other appropriate forums, as necessary,

19.1.3 work with the ICB to seek to ensure that the quality governance and processes for Delegated Services are aligned and integrated with broader clinical quality governance and processes in accordance with National Quality Board Guidance,

19.1.4 facilitate improvement when quality issues impact nationally and regionally, through programme support, and mobilising intensive support when required on specific quality issues,

19.1.5 provide guidance on quality and clinical governance matters and benchmark available data,

19.1.6 support the ICB to identify key themes and trends and utilise data and intelligence to respond and monitor as necessary,

19.1.7 report on quality to both NCG and DCG as well as QGG and Executive Quality Group as required,

19.1.8 facilitate and support the national quality governance infrastructure (for example, the QGG), and

19.1.9 identify and act upon issues and concerns that cross multiple ICBs, coordinating response and management as necessary.

20 National Standards, National Specifications and Clinical Commissioning Policies

20.1 NHS England shall carry out:

20.1.1 development, engagement and approval of National Standards for Specialised Services (including National Specifications, Clinical Commissioning Policies, quality and data standards),

20.1.2 production of national commissioning products and tools to support commissioning of Specialised Services,

20.1.3 maintenance and publication of the Prescribed Specialised Services Manual and engagement with the DHSC on policy matters, and

20.1.4 determination of content for national clinical registries.

21 Transformation

21.1 NHS England shall be responsible for:

21.1.1 co-ordinating and enabling ICB-led specialised service transformation programmes for Delegated Services where necessary,

21.1.2 supporting the ICB to implement national policy and guidance across its Populations for Retained Services,

21.1.3 supporting the ICB with agreed transformational programmes where national transformation support has been agreed for Delegated Services,

21.1.4 providing leadership for transformation programmes and projects that have been identified as priorities for national coordination and support, or are national priorities for the NHS, including supporting delivery of commitments in the NHS Long Term Plan,

21.1.5 co-production and co-design of transformation programmes with the ICB and wider stakeholders, and

21.1.6 providing access to subject matter expertise including Clinical Reference Groups, national clinical directors, Programme of Care leads for the ICB where it needs support, including in relation to local priority transformation.

SCHEDULE 5 RETAINED SERVICES

NHS England shall retain the function of commissioning the Specialised Services that are not Delegated Services and as more particularly set out by NHS England and made available from time to time.

SCHEDULE 6 FURTHER INFORMATION GOVERNANCE AND SHARING PROVISIONS

PART 1

1 Introduction

1.1 This Schedule sets out the scope for the secure and confidential sharing of information between the Parties on a Need To Know basis, in order to enable the Parties to exercise their functions in pursuance of this Agreement.

1.2 References in this Schedule (Further Information Governance and Sharing Provisions) to the Need to Know basis or requirement (as the context requires) should be taken to mean that the Data Controllers' Staff will only have access to Personal Data or Special Category Personal Data if it is lawful for such Staff to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.

1.3 This Schedule and the Data Sharing Agreements entered under this Schedule are designed to:

1.3.1 provide information about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the Parties,

1.3.2 describe the purposes for which the Parties have agreed to share Relevant Information,

1.3.3 set out the lawful basis for the sharing of information between the Parties, and the principles that underpin the exchange of Relevant Information,

1.3.4 describe roles and structures to support the exchange of Relevant Information between the Parties,

1.3.5 apply to the sharing of Relevant Information relating to Specialised Services Providers and their Staff,

1.3.6 apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted,

1.3.7 ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed,

1.3.8 apply to the activities of the Parties' Staff, and

1.3.9 describe how complaints relating to Personal Data sharing between the Parties will be investigated and resolved, and how the information sharing will be monitored and reviewed.

2 Purpose

2.1 The Specified Purpose of the data sharing is to facilitate the exercise of the Delegated Functions and NHS England's Reserved Functions.

2.2 Each Party must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received from any third party organisations from which the Parties must obtain data in order to achieve the Specified Purpose. Where necessary specific and detailed purposes must be set out in a Data Sharing Agreement that complies with all relevant legislation and Guidance.

3 Benefits of information sharing

3.1 The benefits of sharing information are the achievement of the Specified Purpose, with benefits for service users and other stakeholders in terms of the improved delivery of the Delegated Services.

4 Lawful basis for sharing

4.1 The Parties shall comply with all relevant Data Protection Legislation requirements and Good Practice in relation to the processing of Relevant Information shared further to this Agreement.

4.2 The Parties shall ensure that there is a Data Protection Impact Assessment ("DPIA") that covers processing undertaken in pursuance of the Specified Purpose. The DPIA shall identify the lawful basis for sharing Relevant Information for each purpose and data flow.

4.3 Where appropriate, the Relevant Information to be shared shall be set out in a Data Sharing Agreement.

5 Restrictions on use of the Shared Information

5.1 Each Party shall only process the Relevant Information as is necessary to achieve the Specified Purpose and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.

5.2 Access to, and processing of, the Relevant Information provided by a Party must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be handled at all times on a restricted basis, in compliance with Data Protection Legislation requirements, and the Parties' Staff should only have access to Personal Data on a justifiable Need to Know basis.

5.3 Neither the provisions of this Schedule nor any associated Data Sharing Agreements should be taken to permit unrestricted access to data held by any of the Parties.

5.4 Neither Party shall subcontract any processing of the Relevant Information without the prior consent of the other Party. Where a Party subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on the Data Controllers under this Agreement.

5.5 The Parties shall not cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.

5.6 Any particular restrictions on use of certain Relevant Information should be included in a Personal Data Agreement.

6 Ensuring fairness to the Data Subject

6.1 In addition to having a lawful basis for sharing information, the UK GDPR generally requires that the sharing must be fair and transparent. In order to achieve fairness and transparency to the Data Subjects, the Parties will take the following measures as reasonably required:

6.1.1 amendment of internal guidance to improve awareness and understanding among Staff,

6.1.2 amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects,

6.1.3 ensuring that information and communications relating to the processing of data is clear and easily accessible, and

6.1.4 giving consideration to carrying out activities to promote public understanding of how data is processed where appropriate.

6.2 Each Party shall procure that its notification to the Information Commissioner's Office, and record of processing maintained for the purposes of Article 30 UK GDPR, reflects the flows of information under this Agreement.

6.3 The Parties shall reasonably co-operate in undertaking any DPIA associated with the processing of data further to this Agreement, and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.

6.4 Further provision in relation to specific data flows may be included in a Personal Data Agreement between the Parties.

7 Governance: Staff

7.1 The Parties must take reasonable steps to ensure the suitability, reliability, training and competence, of any Staff who have access to Personal Data, and Special Category Personal Data, including ensuring reasonable background checks and evidence of completeness are available on request.

7.2 The Parties agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where any of the Parties' Staff are not healthcare professionals (for the purposes of the Data Protection Act 2018), the employing Parties must procure that Staff operate under a duty of confidentiality which is equivalent to that which would arise if that person were a healthcare professional.

7.3 The Parties shall ensure that all Staff required to access Personal Data (including Special Category Personal Data) are informed of the confidential nature of the Personal Data. The Parties shall include appropriate confidentiality clauses in employment/service contracts of all Staff that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Data Protection Legislation requirements, or cause damage to or loss of the Relevant Information.

7.4 Each Party shall provide evidence (further to any reasonable request) that all Staff that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Data Protection Legislation and this Agreement.

7.5 The Parties shall ensure that:

7.5.1 only those Staff involved in delivery of the Agreement use or have access to the Relevant Information,

7.5.2 that such access is granted on a strict Need to Know basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller, and

7.5.3 specific limitations on the Staff who may have access to the Relevant Information are set out in any Data Sharing Agreement entered into in accordance with this Schedule.

8 Governance: Protection of Personal Data

8.1 At all times, the Parties shall have regard to the requirements of Data Protection Legislation and the rights of Data Subjects.

8.2 Wherever possible (in descending order of preference), only anonymised information, or, strongly or weakly pseudonymised information will be shared and processed by the Parties. The Parties shall co-operate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data or Special Category Personal Data.

8.3 Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need to Know basis.

8.4 If any Party becomes aware of:

8.4.1 any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable, or

8.4.2 any security vulnerability or breach in respect of the Relevant Information,

it shall promptly, within 48 hours, notify the other Parties. The Parties shall fully co-operate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Data Protection Legislation.

8.5 In processing any Relevant Information further to this Agreement, the Parties shall process the Personal Data and Special Category Personal Data only:

8.5.1 in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information,

8.5.2 to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body, and

8.5.3 in accordance with Data Protection Legislation requirements, in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR, and not in such a way as to cause any other Data Controller to breach any of their applicable obligations under Data Protection Legislation.

8.6 The Parties shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection Legislation, and in particular to protect Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

8.6.1 take account of the nature, scope, context and purposes of processing as well as the risks, of varying likelihood and severity for the rights and freedoms of Data Subjects, and

8.6.2 be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data and Special Category Personal Data, and having the nature of the Personal Data and Special Category Personal Data which is to be protected.

8.7 In particular, each Party shall:

8.7.1 ensure that only Staff as provided under this Schedule have access to the Personal Data and Special Category Personal Data,

8.7.2 ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and

proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information,

8.7.3 obtain prior written consent from the originating Party in order to transfer the Relevant Information to any third party,

8.7.4 permit any other party or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable each Party to verify and/or procure that the other is in full compliance with its obligations under this Agreement, and

8.7.5 if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

8.8 The Parties shall adhere to the specific requirements as to information security set out in any Data Sharing Agreement entered into in accordance with this Schedule.

8.9 The Parties shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

8.10 The Parties' Single Points of Contact set out in paragraph 13 will be the persons who, in the first instance, will have oversight of third party security measures.

9 Governance: Transmission of Information between the Parties

9.1 This paragraph supplements paragraph 8 of this Schedule.

9.2 Transfer of Personal Data between the Parties shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net or gcsx) e-mail.

9.3 Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record and/or data is identified.

9.4 Any other special measures relating to security of transfer should be specified in a Data Sharing Agreement entered into in accordance with this Schedule.

9.5 Each Party shall keep an audit log of Relevant Information transmitted and received in the course of this Agreement.

9.6 The Parties' Single Point of Contact notified pursuant to paragraph 13 will be the persons who, in the first instance, will have oversight of the transmission of information between the Parties.

10 Governance: Quality of Information

10.1 The Parties will take steps to ensure the quality of the Relevant Information and to comply with the principles set out in Article 5 UK GDPR.

11 Governance: Retention and Disposal of Shared Information

11.1 A non-originating Party shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically, the Relevant Information will be deleted and formal notice of the deletion sent to the Party that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Party they came from.

11.2 Each Party shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, upon request and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

11.3 If a Party is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy in accordance with this Schedule, it shall notify the other Parties in writing of that retention, giving details of the documents or materials that it must retain.

11.4 Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all Good Practice including the Records Management NHS Code of Practice, as updated or amended from time to time.

11.5 The Parties shall set out any special retention periods in a Data Sharing Agreement where appropriate.

11.6 The Parties shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a cross cut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.

11.7 Each Party shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.

11.8 Electronic records will be considered for deletion once the relevant retention period has ended.

11.9 In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Party shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

12 Governance: Complaints and Access to Personal Data

12.1 The Parties shall assist each other in responding to any requests made under Data Protection Legislation made by persons who wish to access copies of information held about them ("Subject Access Requests"), as well as any other exercise of a Data Subject's rights under Data Protection Legislation or complaint to or investigation undertaken by the Information Commissioner.

12.2 Complaints about information sharing shall be reported to the Single Points of Contact and the ICB. Complaints about information sharing shall be routed through each Parties' own complaints procedure unless otherwise provided for in the Agreement or determined by the ICB.

12.3 The Parties shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Schedule or any data processing carried out further to it.

12.4 Basic details of the Agreement shall be included in the appropriate log under each Party's publication scheme.

13 Governance: Single Points of Contact

13.1 The Parties each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance.

14 Monitoring and review

14.1 The Parties shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Data Protection Legislation and best practice.

Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.

SCHEDULE 7 MANDATED GUIDANCE

Generally applicable Mandated Guidance

- National Guidance on System Quality Groups.
- Managing Conflicts of Interest in the NHS.
- Arrangements for Delegation and Joint Exercise of Statutory Functions.
- Guidance relating to procurement and provider selection.
- Information Governance Guidance relating to serious incidents.
- All other applicable IG and Data Protection Guidance.
- Any applicable Freedom of Information protocols.
- Any applicable Guidance on Counter Fraud, including from The NHS Counter Fraud Authority.
- Any applicable Guidance relating to the use of data and data sets for reporting.
- Guidance relating to the processes for making and handling individual funding requests, including:
    - Commissioning policy: Individual funding requests,
    - Standard operating procedures: Individual funding requests.

Workforce

- Guidance on the Employment Commitment.

Finance

- Guidance on NHS System Capital Envelopes.
- Managing Public Money (HM Treasury).

Specialised Services Mandated Guidance

- Commissioning Change Management Business Rules.
- Cashflow Standard Operating Procedure.
- Finance and Accounting Standard Operating Procedure.
- Provider Collaborative Guidance.
- Clinical Commissioning Policies.
- National Specifications.
- National Standards.
- The Prescribed Specialised Services Manual

SCHEDULE 8 LOCAL TERMS

The ICB, along with the other five ICBs in the East of England region and NHS England, has signed a Collaboration Agreement that sets out the detail needed to ensure that delegated specialised commissioned services are delivered safely and effectively.

This Schedule 8 (Local Terms) makes reference to appropriate clauses or schedules within the Collaboration Agreement, where necessary.

General

Where there is a Dispute as to the content of this Schedule, the Parties should follow the Disputes procedure set out at Clause 25.

Following signature of the Agreement, this Schedule can be amended by the Parties using the Variations procedure at Clause 26.

NHS England can amend this Schedule without the ICB's consent by using the variation procedure set out in Clause 26.2 but the expectation is that variations should be by consent.

Part 1 – the services to be planned or commissioned at an ICB level

In the first instance, all delegated services will be commissioned collectively by all six ICBs. Any changes to this arrangement will be reflected in the Collaboration Agreement, Schedule 3 (Individual Schemes).

Part 2 – the services to be planned or commissioned by an ICB Collaboration Arrangement

In the first instance, all delegated services will be commissioned collectively by all six ICBs. Any changes to this arrangement will be reflected in the Collaboration Agreement, Schedule 3 (Individual Schemes).

Part 3 – Funding arrangements

Funding arrangements are set out in the Collaboration Agreement, Schedule 4 (Financial Arrangements).

Part 3 – Workforce and Commissioning Team Arrangements

Workforce and commissioning team arrangements are set out in the Collaboration Agreement, Schedule 5 (Commissioning Team Arrangements).

Part 4 – ICB Collaboration Arrangements

These are detailed in the Collaboration Agreement signed by the six ICBs in the East of England region and NHS England.

Part 5 – Pooled Funds and Non-Pooled Funds

The ICBs have determined that they will not seek to create Pooled or Non-Pooled Funds. Financial arrangements are set out in the Collaboration Agreement, Schedule 4 (Financial Arrangements).

Part 6 – Provider Collaboratives

There are currently no arrangements to delegate functions to provider collaboratives.

Part 7 – Further Governance Arrangements

The Partners have established a Joint Commissioning Consortium to oversee and take decisions in relation to the Delegated Services. The Joint Commissioning Consortium will also oversee and advise NHS England on its retained commissioning activity. Terms of reference for the Consortium have been agreed as a separate document.

The Joint Commissioning Consortium is not a formal committee of the Board and its members will be Authorised Officers from each of the ICBs and NHS England. The ICB shall ensure that their Authorised

Officer and any substitutes have appropriate delegated authority, in accordance with the ICB's Scheme of Reservation and Delegation, to represent the interests of the ICB on the Consortium and any other sub-groups established by the Consortium.

Further details are set out in the Collaboration Agreement, Schedule 2 (Governance Arrangements).

SCHEDULE 9 DEVELOPMENTAL ARRANGEMENTS

These Development Arrangements take precedence over the terms of this Agreement including other Schedules, and the Agreement shall be read as varied by these Developmental Arrangements. Save as varied by these Developmental Arrangements the Agreement remains in full force and effect.

The Developmental Arrangements

There are no developmental arrangements in place for the ICB for this agreement.

SCHEDULE 10 ADMINISTRATIVE AND MANAGEMENT SERVICES

Administrative and management services are set out in the Collaboration Agreement, Schedule 6 (Commissioning Team Arrangements).

Dated 2024

(1) **NHS BEDFORDSHIRE, LUTON AND MILTON KEYNES INTEGRATED CARE BOARD**

- and -

(2) **NHS CAMBRIDGESHIRE AND PETERBOROUGH INTEGRATED CARE BOARD**

- and -

(3) **NHS HERTFORDSHIRE AND WEST ESSEX INTEGRATED CARE BOARD**

- and -

(4) **NHS MID AND SOUTH ESSEX INTEGRATED CARE BOARD**

- and -

(5) **NHS NORFOLK AND WAVENEY INTEGRATED CARE BOARD**

- and -

(6) **NHS SUFFOLK AND NORTH EAST ESSEX INTEGRATED CARE BOARD**

- and -

(7) **NHS ENGLAND – EAST OF ENGLAND**

Collaboration Agreement for the Commissioning of Delegated Specialised Services in the East of England

DRAFT - NOT AVAILABLE FOR ACCEPTANCE

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THIS AGREEMENT is made on the_____ day of _____2024

BETWEEN:

(1) **NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board** of 3rd Floor, Arndale House, The Mall, Luton, LU1 2LJ (**"BLMK"**) and

(2) **NHS Cambridgeshire and Peterborough Integrated Care Board** of Gemini House, Bartholomew's Walk, Cambridgeshire Business Park, Angel Drove, Ely, Cambridgeshire CB7 4EA ("**C&P")** and

(3) **NHS Hertfordshire and West Essex Integrated Care Board** of Charter House, Parkway, Welwyn Garden City, AL8 6JL ("**HWE"**) and

(4) **NHS Mid and South Essex Integrated Care Board** of PO BOX 6483, Basildon, SS14 0UG ("**MSE"**) and

(5) **NHS Norfolk and Waveney Integrated Care Board** of County Hall, Martineau Lane, Norwich, NR1 2DH ("**N&W")** and

(6) **NHS Suffolk and North East Essex Integrated Care Board** of Aspen House, Stephenson Road, Severalls Business Park, Colchester, CO4 9QR ("**SNEE"**) and

(7) **NHS England of Quarry House, Quarry Hill, Leeds LS2 7UE (acting under the name NHS England) ("NHS England"),**

each a "Partner" and together the “Partners”.

BLMK, C&P, HWE, MSE, N&W and SNEE are together referred to in this Agreement as the **“ICBs”,** and **“ICB”** shall mean any of them.

BACKGROUND

(A) NHS England has statutory functions to make arrangements for the provision of prescribed services for the purposes of the NHS.

(B) The ICBs have statutory functions to make arrangements for the provision of services for the purposes of the NHS in their areas, apart from those commissioned by NHS England.

(C) Pursuant to section 65Z5 of the NHS Act, NHS England and the ICBs are able to establish and maintain joint arrangements in respect of the discharge of their commissioning functions.

(D) Under the Delegation Agreement made pursuant to section 65Z5 NHS England has delegated responsibility for the Delegated Functions to ICBs in relation the Specialised Services as listed in Schedule 3 (Delegated Services). NHS England has retained responsibility for the NHS England Reserved Functions and commissioning of the Retained Services.

(E) It is agreed that in order to exercise the Delegated Functions in the most efficient and effective manner that some of the Delegated Services would be best commissioned on a multi-ICB footprint.

(F) This Agreement sets out the arrangements that will apply between the ICBs and NHS England in relation to the ICBs’ joint commissioning of Specialised Services for the ICBs’ Populations.

(G) This Agreement is intended to govern the relationship between the Partners in respect of the commissioning of delegated Specialised Services on a multi-ICB footprint.

(H) Some clauses will apply specifically only to the ICBs. Where this is the case 'the ICBs' will be used as opposed to 'the Partners', which will include NHS England.

(I) The Partners consider this arrangement as a collaborative endeavour with all having equal responsibility to ensure the effective commissioning of services for the population of the East of England.

NOW IT IS HEREBY AGREED as follows:

1 COMMENCEMENT AND DURATION

1.1 This Agreement has effect from the date of this Agreement and will remain in force until it is terminated in accordance with Clause 23 (Termination and Default) or superseded.

2 PRINCIPLES AND AIMS

2.1 The Partners acknowledge that, in exercising their obligations under this Agreement, each Partner must comply with the statutory duties set out in the NHS Act and must:

2.1.1 consider how it can meet its legal duties to involve patients and the public in shaping the provision of services, including by working with local communities, under-represented groups and those with protected characteristics for the purposes of the Equality Act 2010,

2.1.2 consider how, in performing its obligations, it can address health inequalities,

2.1.3 at all times exercise functions effectively, efficiently and economically, and

2.1.4 act at all times in good faith towards each other.

2.2 The Partners agree:

2.2.1 that the needs of patients and the population of the East of England are at the centre of all decision making,

2.2.2 that successfully implementing the agreement will require strong relationships and an environment based on trust, collaboration, openness and transparency,

2.2.3 to seek to continually improve whole pathways of care including specialised services and to design and implement effective and efficient integration,

2.2.4 to act at all times in accordance with the scope of their statutory powers,

2.2.5 to have regard to each other's needs and views, irrespective of the relative contributions of the Partners to the commissioning of any services and, as far as is reasonably practicable, take such needs and views into account,

2.2.6 to acknowledge shared responsibility and accountability, balancing joint decisions making with organisational sovereignty,

2.2.7 to share information and best practice, and work collaboratively to identify solutions, eliminate duplication of effort, mitigate risks and reduce cost.

2.2.8 to act in a timely manner,

2.2.9 to share information and best practice, and work collaboratively to identify solutions, eliminate duplication of effort, mitigate risks and reduce cost,

2.2.10 to act at all times to ensure the Partners comply with the requirements of the Delegation Agreements,

2.2.11 to act at all times in accordance with the scope of their statutory powers, and

2.2.12 to have regard to each other's needs and views, irrespective of the relative contributions of the Partners to the commissioning of any Delegated Services and, as far as is reasonably practicable, take such needs and views into account.

2.3 The Partners' aims are:

2.3.1 To maximise the benefits to patients of integrating the Delegated Functions with the ICBs' Commissioning Functions through designing and commissioning Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim,

2.3.2 Improving access to treatment, especially for those with the worst health outcomes (e.g. relating to inequalities others who currently struggle to access treatment).

2.3.3 Services commissioned more locally as part of a whole pathway of care that will be more sensitive to local need.

2.3.4 Potential to shift resource towards more early intervention and prevention and facilitate transformational changes generating efficiencies.

2.3.5 Ability to attract staff to providers and other organisations in the East of England.

2.3.6 Build closer relationships and alliances with commissioners and providers of services outside the East of England who service our population.

2.3.7 To enable partners to review and discuss NHSE's Reserved Functions and Retained Services.

3 SCOPE OF THE ARRANGEMENTS

3.1 This Agreement sets out the arrangements through which the ICBs will work together to commission Services in accordance with the Delegation Agreement This includes the following.

3.1.1 Delegation by NHS England of the Delegated Functions to each individual ICB in accordance with the relevant Delegation Agreement.

3.1.2 Development of a Specialised Commissioning Team through which these Specialised Services will be commissioned as set out in Schedule 6 (Commissioning Team Arrangements).

3.1.3 Establishment of a Joint Commissioning Consortium as described in part 2 of Schedule 2 (Governance Arrangements).

3.1.4 The designation of NHS Bedfordshire, Luton and Milton Keynes ICB to act as 'host' on behalf of the other ICBs.

3.1.5 Establishment of the following arrangements in line with the national guidance NHS England Specialised and Direct Commissioning Contracting Process 24-25 (NHS Standard Contract Model Collaborative Commissioning Agreement – Multiple Contract Option).

(a) Collaborative commissioning agreements (for individual contracts)

(b) Collaborative forums (for individual contracts)

4 FUNCTIONS

4.1 The purpose of this Agreement is to establish a framework through which the ICBs can secure the commissioning of health services in accordance with the terms of this Agreement.

4.2 This Agreement shall include such functions as shall be agreed from time to time by the ICBs and set out in this Agreement.

4.3 The ICBs shall work in cooperation and shall endeavour to ensure that Services in fulfilment of the Delegated Functions are commissioned with all due skill, care and attention irrespective of the Flexibilities utilised.

4.4 On behalf of the ICBs in the East of England, BLMK as Host ICB will oversee the functions carried out by the SCT as set out Schedule 6, Appendix 4.

5 SPECIALISED COMMISSIONING TEAM

5.1 The Partners agree to utilise the existing Specialised Commissioning Team as set out in Schedule 6 (Commissioning Team Arrangements).

6 STAFFING

6.1 The staffing arrangements shall be as set out in Schedule 6 (Commissioning Team Arrangements).

7 JOINT COMMISSIONING CONSORTIUM

7.1 The Partners have formed a Joint Commissioning Consortium and the arrangements for this are set out in Schedule 2 (Governance Arrangements) and the terms of reference.

8 GOVERNANCE

8.1 Overall strategic oversight of partnership working between the Partners shall be as set out in Schedule 2 (Governance Arrangements).

8.2 Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

8.3 ICBs shall provide overall approval of variations to each commissioned service through the Joint Commissioning Consortium.

9 RISK SHARING

9.1 The ICBs have agreed Risk Sharing in accordance with Schedule 4 (Financial Arrangements).

10 REVIEW

10.1 Save where the ICBs agree alternative arrangements (including alternative frequencies) the ICBs shall undertake a review after six months of the operation of this Agreement and the provision of the Specialised Services.

10.2 Reviews shall be conducted in good faith.

11 COMPLAINTS

11.1 Complaints received in relation to the delegated Specialised Services shall be processed in accordance with the Local Authority, Social Services and National Health Service Complaints Regulations 2009 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and reported back to the respective ICB, and as set out within the Delegation Agreement. This shall be set out in Schedule 6 (Commissioning Team Arrangements).

12 FINANCES

12.1 The financial arrangements shall be as agreed between the ICBs in Schedule 4 (Financial Arrangements).

12.2 Unless expressly provided otherwise in this Agreement or otherwise agreed in advance in writing by the Partners, each Partner shall bear its own costs as they are incurred.

13 VARIATION

13.1 The Partners acknowledge that the scope of the Arrangements may be reviewed and amended from time to time.

13.2 This Agreement may be varied by the agreement of the Partners at any time in writing in accordance with the Partners' internal decision-making processes.

13.3 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

13.4 The following approach shall, unless otherwise agreed, be followed by the ICBs.

13.4.1 On receipt of a request from one of the ICBs to vary the Agreement , the ICBs will first undertake an impact assessment and identify the likely impact of the variation. Unless the ICBs agree otherwise, the onus will be on the ICB(s) proposing the variation to carry out the impact assessment,

13.4.2 The ICBs will agree any action to be taken as a result of the proposed variation. This shall include consideration of:

(a) whether any Service Contracts affected by the proposed variation should continue, be varied or terminated, taking note of the Service Contract terms and conditions and ensuring that the ICBs holding the Service Contract/s is not put in breach of contract, its statutory obligations or financially disadvantaged, and/or

(b) whether the proposed variation could have an impact on the Specialised Commissioning Team and/or any Staff,

13.4.3 Wherever possible agreement will be reached to reduce the level of funding in the Service Contract(s) in line with any reduction in budget, and

13.4.4 Should this not be possible and one ICB is left financially disadvantaged as a result of the proposed variation, then the financial risk will, unless otherwise agreed, be shared equitably between the ICBs.

14 DATA PROTECTION

14.1 The Partners must ensure that all Personal Data processed by or on behalf of them in the course of carrying out the Joint Working Arrangements is processed in accordance with the relevant Partner's obligations under Data Protection Legislation and Data Guidance, and the

Partners must assist each other as necessary to enable each other to comply with these obligations.

14.2 Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need to Know basis.

14.3 If any Partner becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable or becomes aware of any security breach, in respect of the Relevant Information, it shall promptly notify the Joint Commissioning Consortium and NHS England. The Partners shall fully cooperate with one another to remedy the issue as soon as reasonably practicable.

14.4 In processing any Relevant Information further to this Agreement, each Partner shall at all times comply with their own policies and any NHS England policies and guidance on the handling of data.

14.5 Any information governance breach must be responded to in accordance with Data Security and the Protection Incident Reporting tool. If any Partner is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach, then, as soon as reasonably practical and in any event on or before the first such notification is made, the relevant Partner must fully inform NHS England and the Joint Commissioning Consortium of the information governance breach. This Clause does not require the relevant Partner to provide information which identifies any individual affected by the information governance breach where doing so would breach Data Protection Legislation.

14.6 Whether or not a Partner is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The Partners acknowledge that a Partner may act as both a Data Controller and a Data Processor.

14.7 The Partners will share information to enable joint service planning, commissioning, and financial management subject to the requirements of law, including in particular the Data Protection Legislation in respect of any Personal Data.

14.8 Other than in compliance with judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise required by any Law, no information will be shared with any third parties save as agreed by the Partners in writing.

14.9 Schedule 5 makes further provision about information sharing and information governance.

15 IT INTER-OPERABILITY

15.1 The Partners will work together to ensure, wherever possible, that all relevant IT systems operated by the Partners in respect of the Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

15.2 The Partners will use their respective reasonable endeavours to help develop initiatives to further this aim.

16 FURTHER ARRANGEMENTS

16.1 The ICBs must give due consideration to whether any of the Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act. The Partners must comply with any Guidance around the commissioning of Joint Specialised Services by means of arrangements under section 65Z5 or 75 of the NHS Act.

17 FREEDOM OF INFORMATION

17.1 Each Partner acknowledges that the others are a public authority for the purposes of the Freedom of Information Act 2000 ("FOIA") and the Environmental Information Regulations 2004 ("EIR").

17.2 Each Partner may be statutorily required to disclose further information about the Agreement and the Relevant Information in response to a specific request under FOIA or EIR, in which case:

17.2.1 each Partner shall provide the other with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR,

17.2.2 each Partner shall consult the other regarding the possible application of exemptions in relation to the information requested, and

17.2.3 each Partner acknowledges that the final decision as to the form or content of the response to any request is a matter for the Partner to whom the request is addressed.

18 CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

18.1 The ICBs must ensure that, in delivering the Delegated Functions, all Staff comply with Law, with Managing Conflicts of Interest in the NHS and other Guidance, and with Good Practice, in relation to gifts, hospitality and other inducements and actual or potential conflicts of interest.

18.2 A register of interests in respect of all persons involved in decisions concerning the Delegated Functions will be maintained.

19 CONFIDENTIALITY

19.1 Except as this Agreement otherwise provides, Confidential Information is owned by the disclosing Partner and the receiving Partner has no right to use it.

19.2 Subject to Clause 19.3, the receiving Partner agrees,

19.2.1 to use the disclosing Partner's Confidential Information only in connection with the receiving Partner's performance under this Agreement,

19.2.2 not to disclose the disclosing Partner's Confidential Information to any third party or to use it to the detriment of the disclosing Partner, and

19.2.3 to maintain the confidentiality of the disclosing Partner's Confidential Information.

19.3 The receiving Partner may disclose the disclosing Partner's Confidential Information:

19.3.1 in connection with any dispute resolution procedure,

19.3.2 to comply with the law,

19.3.3 to any appropriate regulatory or supervisory body,

19.3.4 to its staff, who in respect of that Confidential Information will be under a duty no less onerous than the receiving Partner's duty under Clause 19.2,

19.3.5 to NHS Bodies for the purposes of carrying out their functions,

19.3.6 as permitted under any other express arrangement or other provision of this Agreement.

19.4 The obligations in Clause 19 will not apply to any Confidential Information which,

19.4.1 is in or comes into the public domain other than by breach of this Agreement,

19.4.2 the receiving Partner can show by its records that it was in its possession before it received it from the disclosing Party, or

19.4.3 the receiving Partner can prove it obtained or was able to obtain the Confidential Information from a source other than the disclosing Partner without breaching any obligation of confidence.

19.5 This Clause 19 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by an ICB where necessary for the purposes of exercising its functions in relation to that ICB.

19.6 This Clause 19 will survive the termination of this Agreement for any reason for a period of five years.

19.7 This Clause 19 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

20 LIABILITIES

20.1 Subject to Clauses 20.2, and 20.3, if an ICB(s) ("First ICB(s)") incurs a Loss arising out of or in connection with this Agreement as a consequence of any act or omission of another ICB(s) ("Other ICB(s)") which constitutes negligence, fraud or a breach of contract in relation to this Agreement then the Other ICB(s) shall be liable to the First ICB(s) for that Loss.

20.2 Clause 20.1 shall only apply to the extent that the acts or omissions of the Other ICB(s) contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other ICB(s) acting in accordance with the instructions or requests of the First ICB(s) or the Joint Commissioning Consortium.

20.3 If any third party makes a claim or intimates an intention to make a claim against any ICB, which may reasonably be considered as likely to give rise to liability under this Clause 20, the ICB(s) that may claim against the Other ICB(s) will:

20.3.1 as soon as reasonably practicable give written notice of that matter to the Other ICB(s) specifying in reasonable detail the nature of the relevant claim,

20.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other ICB(s) (such consent not to be unreasonably conditioned, withheld or delayed),

20.3.3 give the Other ICB(s) and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Other ICB(s) and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

20.4 Each ICB shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

20.5 Unless expressly agreed otherwise, nothing in this Agreement shall affect,

20.5.1 the liability of NHS England to any person in respect of NHS England's functions, or

20.5.2 the liability of any of the ICBs to any person in respect of that ICB's Commissioning Functions.

20.6 Each ICB must comply with any requirements set out in the Clause 17 of the Delegation Agreements and any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims or the pro-active management of Claims.

21 DISPUTE RESOLUTION

21.1 Where any dispute arises between the Partners in connection with this Agreement, the Partners must use their best endeavours to resolve that dispute

21.2 Where any dispute is not resolved under Clause 21.1 on an informal basis, the matter will be referred to a meeting of the chief executives of the six ICBs as necessary to attempt to resolve the dispute.

21.3 If the dispute is not resolved in accordance with Clause 21.2 then any ICB may refer the matter to the East of England Regional Leadership Team for resolution.

22 BREACHES OF THE AGREEMENT

22.1 If any ICB ("Relevant ICB") fails to meet any of its obligations under this Agreement, the other ICBs (acting jointly) may by notice require the Relevant ICB to take such reasonable action within a reasonable timescale as the other ICBs may specify to rectify such failure. Should the Relevant ICB fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 21 ("Dispute Resolution").

22.2 Without prejudice to Clause 22.1, if any ICB does not comply with the terms of this Agreement (including if any ICB exceeds its authority under this Agreement), the other ICBs may at their discretion agree to;

22.2.1 waive their rights in relation to such non-compliance,

22.2.2 terminate this Agreement in accordance with Clause 23 (Termination and Default) below,

22.2.3 exercise the dispute resolution procedure in accordance with Clause 21 (Dispute Resolution),

22.2.4 Agree to enact a variation under Clause 13.

22.3 For the avoidance of doubt, there is no provision in this Clause 22 that enables the agreement to be terminated upon breach by any ICB.

23 TERMINATION AND DEFAULT

23.1 If an ICB wishes to end its participation in this Agreement, the relevant ICB must provide at least six months' notice to the other ICBs of its intention to end its participation in this Agreement and must have prior agreement by NHS England. Such notification shall only take effect from the end of 31 March in any calendar year and shall only take effect where alternative arrangements for the provision of the Delegated Services and effective exercise of the Delegated Functions are in place for the period immediately following termination.

23.2 An ICB considering ending, or intending to end, its participation in this Agreement will ensure that the ICBs are aware of this intention before formal notice is provided of termination. This will enable the ICBs and NHSE to work together to ensure that there are suitable alternative arrangements in place in relation to the exercise of the Delegated Functions.

23.3 Upon termination of this Agreement (in whole or in part), for any reason whatsoever, the Partners agree that they will work together and co-operate to ensure that the winding down of

these arrangements is carried out smoothly and with as little disruption as possible to patients, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so.

23.4 The provisions of Clauses 14 (Data Protection), 17 (Freedom of Information), 19 (Confidentiality), and 20 (Liabilities) shall survive termination or expiry of this Agreement.

24 PUBLICITY

24.1 The Partners shall use reasonable endeavours to consult one another before making any public announcements concerning the subject matter of this Agreement.

25 EXCLUSION OF PARTNERSHIP OR AGENCY

25.1 Nothing in this Agreement shall create or be deemed to create a legal partnership under the Partnership Act 1890 or the relationship of employer and employee between the Partners, or render any Partner directly liable to any third party for the debts, liabilities or obligations of any Partner.

25.2 Save as specifically authorised under the terms of this Agreement, no Partner shall hold itself out as the agent of any other Partner.

26 THIRD PARTY RIGHTS

26.1 The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly the Partners to this Agreement do not intend that any third party should have any rights in respect of this Agreement by virtue of that Act.

27 NOTICES

27.1 Any notices given under this Agreement must be sent by e-mail to the relevant Authorised Officers or their nominated deputies.

27.2 Notices by e-mail will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

28 ASSIGNMENT AND SUBCONTRACTING

28.1 This Agreement, and any right and conditions contained in it, may not be assigned or transferred by an ICB, without the prior written consent of the other ICBs, except to any statutory successor to the relevant function.

29 SEVERABILITY

29.1 If any term, condition or provision contained in this Agreement shall be held to be invalid, unlawful or unenforceable to any extent, such term, condition or provision shall not affect the validity, legality or enforceability of the remaining parts of this Agreement.

30 WAIVER

30.1 No failure or delay by an ICB to exercise any right or remedy provided under this Agreement or by law shall constitute a waiver of that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy. No single or partial exercise of such right or remedy shall prevent or restrict the further exercise of that or any other right or remedy.

31 STATUS

31.1 The Partners acknowledge that they are health service bodies for the purposes of section 9 of the NHS Act. Accordingly, this Agreement shall be treated as an NHS contract and shall not be legally enforceable.

32 ENTIRE AGREEMENT

32.1 This Agreement constitutes the entire agreement and understanding of the Partners and supersedes any previous agreement between the Partners relating to the subject matter of this Agreement.

33 GOVERNING LAW AND JURISDICTION

33.1 Subject to the provisions of Clause 21 (Dispute Resolution) and Clause 31 (Status), this Agreement shall be governed by and construed in accordance with English Law, and the Partners irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement.

34 FAIR DEALINGS

34.1 The Partners recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of any of them and that, if in the course of the performance of this Agreement, unfairness to either of them does or may result, then the others shall use their reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

35 COUNTERPARTS

35.1 This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

This Agreement has been entered into on the date stated at the beginning of it.

SIGNED by	.....	Signature	.....
for and on behalf of Bedfordshire, Luton and Milton Keynes Integrated Care Board		Date	.....
SIGNED by	.....	Signature	.....
for and on behalf of Cambridgeshire and Peterborough Integrated Care Board		Date	.....
SIGNED by	.....	Signature	.....
for and on behalf of Hertfordshire and West Essex Integrated Care Board		Date	.....
SIGNED by	.....	Signature	.....
for and on behalf of Mid and South Essex Integrated Care Board		Date	.....
SIGNED by	.....	Signature	.....
for and on behalf of Norfolk and Waveney Integrated Care Board		Date	.....
SIGNED by	.....	Signature	.....
for and on behalf of Suffolk and North East Essex Integrated Care Board		Date	.....
SIGNED by	.....	Signature	.....
for and on behalf of NHS England		Date	.....

SCHEDULE 1 DEFINITIONS AND INTERPRETATIONS

1. In this Agreement, unless the context otherwise requires, the following words and expressions shall have the following meanings:

Agreement	This agreement between the Partners comprising these terms and conditions together with all schedules attached to it.
Area	Means the geographical area covered by the ICBs.
Authorised Officer	The individual(s) appointed as Authorised Officer by the respective organisation in relation to specialised commissioning.
Claim	For, or in, relation to the Commissioning Functions, (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by any governmental, regulatory or similar body or agency.
Collaboration Agreement	This relates to this agreement, the Collaboration Agreement for the Commissioning of Delegated Specialised Services in the East of England, except for specific areas in Schedule 6 Commissioning Teams Arrangements, where this phrase may relate to other types of collaboration agreements.
Collaborative Commissioning Agreement	An agreement under which NHS commissioners set out collaboration arrangements in respect of commissioning Specialised Services Contracts.
Commencement Date	1 April 2024
Commissioning Functions	The respective statutory functions of the ICBs in arranging for the provision of services as part of the health service.
Commissioning Team Arrangements	The arrangements through which the services of the Specialised Commissioning Team are made available to other ICBs as set out in Schedule 6.
Confidential Information	Information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement or arrangements made pursuant to it and, (a) which comprises Personal Data or which relates to any patient or his treatment or medical history, (b) the release of which is likely to prejudice the commercial interests of a Partner or (c) which is a trade secret.
Data Controller	The natural or legal person, public authority, agency or other body which, alone or jointly with others, determines the purposes and means of the processing of personal data.

Data Guidance	Any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency and the Information Commissioner.
Data Processor	A natural or legal person, public authority, agency or other body which processes personal data on behalf of the controller.
Data Protection Legislation	Means the UK General Data Protection Regulation, the Data Protection Act 2018, the Regulation of Investigatory Powers Act 2000, the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (SI 2000/2699), the Privacy and Electronic Communications (EC Directive) Regulations 2003 (SI 2426/2003), the common law duty of confidentiality and all applicable laws and regulations relating to the processing of personal data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner.
Data Protection Officer	Shall have the same meaning as set out in the Data Protection Legislation.
Data Security and Protection Incident Reporting tool	The incident reporting tool for data security and protection incidents, which forms part of the Data Security and Protection Toolkit available at https://www.dsptoolkit.nhs.uk/
Data Subject	The identified or identifiable living individual to whom personal data relates.
Delegated Commissioning Group (DCG)	Means a group hosted by NHS England whose terms shall include providing an assurance role in compliance with the Assurance Processes
Delegation Agreement(s)	The Delegation Agreements under which NHS England delegates some of its Commissioning Functions to each ICB.
Delegated Functions	Commissioning Functions of NHS England delegated to each ICB under a Delegation Agreement.
Delegated Services	Those services commissioned in exercise of the Delegated Functions.
Dispute Resolution Procedure	The procedure set out in Clause 21 (Dispute Resolution).
Flexibilities	The flexibilities that the ICBs may use to work in a co-ordinated manner as set out at Clause 3 (Scope of the Arrangements).
FOIA	The Freedom of Information Act 2000 and any subordinate legislation made under it from time to time, together with any guidance or codes of practice issued by the Information Commissioner or relevant government department concerning this legislation.

Guidance	Any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the ICBs have a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified by any relevant Regulatory or Supervisory Body.
Governance Arrangements	The governance arrangements in respect of the Arrangements agreed by the Partners and as set out in Schedule 2 (Governance Arrangements).
Host ICB	NHS Bedfordshire, Luton and Milton Keynes ICB (BLMK) is the host for the Specialised Commissioning Team. Further details can be found under section 4 of Schedule 6 (Commissioning Team Arrangements).
High Cost Drugs	Medicines not reimbursed though national prices and identified on the NHS England high cost drugs list.
ICB Functions	The Commissioning Functions of an ICB.
Information	As defined under section 84 of FOIA.
Indemnity Arrangement	Either (a) a policy of insurance, (b) an arrangement made for the purposes of indemnifying a person or organisation or (c) a combination of (a) and (b).
Information Sharing Agreement	Any information sharing agreement entered into in accordance with Schedule 5 (Further Information Governance and Sharing Provisions).
Joint Commissioning Consortium	The meeting established under this Agreement on the terms set out in the Terms of Reference to oversee this Collaboration Agreement.
Law	(a) Any statute or proclamation or any delegated or subordinate legislation, (b) Any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable), (c) any judgment of a relevant court of law which is a binding precedent in England.
Need to Know	Has the meaning set out in Schedule 5
NHS Act	The National Health Service Act 2006.
Non-Personal Data	Means data which is not Personal Data.
Partners	The parties to this Agreement. This Agreement shall not be interpreted or construed to create a partnership between the parties (within the meaning of the Partnership Act 1890).

Personal Data	As defined in the Data Protection Legislation.
Population	The population for which an ICB or all of the ICBs have the responsibility for commissioning health services.
Regional Leadership Team (RLT)	A regular meeting of senior leaders from the East of England Regional Office of NHS England and ICBs.
Regulatory or Supervisory Body	Any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including, (i) CQC, (ii) NHS England, (iii) the Department of Health and Social Care' (iv) NICE, (v) Healthwatch England and Local Healthwatch, (vi) the General Medical Council, (vii) the General Dental Council, (viii) the General Optical Council, (ix) the General Pharmaceutical Council, (x) the Healthcare Safety Investigation Branch and (xi) the Information Commissioner.
Relevant Information	Personal Data and Non-Personal Data processed under this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*).
Request for Information	As defined in the Freedom of Information Act 2000.
Reserved Functions	The Specialised Services for which NHS England still retains commissioning responsibility or the Specialised Services delegated to ICBs for which they retain responsibility.
Retained Services	Those Specialised Services for which NHS England shall retain commissioning responsibility, as set out the Delegation Agreement.
Risk Sharing	An agreed arrangement for risk and benefit sharing between the ICBs.
Schedule of Payments	The schedule agreed with each ICB which sets out the payments that will be made on a monthly basis to providers for the provision of specialised services.

Special Category Personal Data	Has the meaning set out in the Data Protection Legislation.
Specialised Commissioning Functions	The statutory functions conferred on NHS England under Section 3B of the NHS Act 2006 and Regulation 11 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996 (as amended or replaced).
Specialised Commissioning Team (SCT)	Means those Specialised Service Staff within NHS England that carry out a role in respect of commissioning the Delegated Services.
Specialised Services	The services commissioned in exercise of the Specialised Commissioning Functions as defined as defined in Schedule 3 (Delegated Services).
Specialised Services and Health and Justice Operational Group (SSHJOG)	Operational group reporting to the Joint Commissioning Consortium.
Specialised Services Contract	A contract for the provision of Specialised Services entered into in the exercise of the Specialised Commissioning Functions.
Specialised Services Provider	A provider party to a Specialised Services Contract.
Staff	The Partners' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of any Partner in respect of specialised commissioning (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel.
Terms of Reference	The Terms of Reference for the Joint Commissioning Consortium agreed between the Partners at the first meeting of the Joint Commissioning Consortium.
Triple Aim	Relates to the duty on each of the ICBs in making decisions about the exercise of their functions, to have regard to all likely effects of the decision in relation to, (a) the health and well-being of the people of England, (b) the quality of services provided to individuals by the NHS, (c) efficiency and sustainability in relation to the use of resources by the NHS.
UK GDPR	Means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018.

2. References to statutory provisions shall be construed as references to those provisions as respectively amended or re-enacted (whether before or after the Commencement Date) from time to time.

3. The headings of the Clauses in this Agreement are for reference purposes only and shall not be construed as part of this Agreement or deemed to indicate the meaning of the relevant Clauses to which they relate. Reference to Clauses are clauses in this Agreement.

4. References to Schedules are references to the schedules to this Agreement and a reference to a Paragraph is a reference to the paragraph in the Schedule containing such reference.

5. References to a person or body shall not be restricted to natural persons and shall include a company, corporation or organisation.

6. Words importing the singular number only shall include the plural.

7. Use of the masculine includes the feminine and all other genders.

8. Where anything in this Agreement requires the mutual agreement of the Partners, then unless the context otherwise provides, such agreement must be in writing.

9. Any reference to the Partners shall include their respective statutory successors, employees and agents.

10. In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

11. Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

SCHEDULE 2 GOVERNANCE ARRANGEMENTS

1 GENERAL

1.1 The ICBs have established a Joint Commissioning Consortium (the Consortium) to oversee and take decisions in relation to the delegated Specialised Services. NHS England is a Partner in the Consortium to enable NHS England to advise ICBs on delegated specialised and to enable the Consortium to advise NHS England on its retained commissioning activity. Terms of Reference for the Consortium have been agreed as a separate document.

1.2 The Joint Commissioning Consortium is not a formal committee of the board for any of the Partner ICBs or a formal committee of NHS England. The Consortium has the authority to make decisions relating to the powers delegated to the Authorised Officer from each Partner as set out in their respective Schemes of Reservation and Delegation. Where decisions fall outside of those delegations, then the Authorised Officer will ensure that they have sufficient authority from their organisation for decision making, for example, obtaining approval from the relevant committees or board.

1.3 It is the responsibility of each Partner to determine the route by which it receives assurance from, and contributes to, the decision making of the Consortium. It is the responsibility of each Authorised Officer of the Consortium to operate within the governance structure of their organisation in order to provide such assurance using the route agreed by their organisation.

1.4 It is acknowledged that each Partner remains a sovereign organisation for decision making.

2 JOINT COMMISSIONING CONSORTIUM

2.1 The Consortium (and each member of the Consortium) will act at all times in accordance with the Terms of Reference.

2.2 The Partners shall nominate one Authorised Officer and substitutes/deputies to the Consortium in accordance with the Terms of Reference.

2.3 The Partners may establish sub-groups of the Consortium with such terms of reference as may be agreed between them from time to time, such group(s) shall have no delegated authority from the Partners other than by virtue of the officers represented at the group(s).

2.4 The Partners shall ensure that their Authorised Officer and substitutes/deputies have appropriate delegated authority, in accordance with their organisational governance arrangements, to represent the interests of their organisation on the Consortium and any other sub-groups established by the Consortium.

2.5 The Partners recognise the need to ensure that any potential conflicts of interest on the part of any Partner, including its representatives, in respect of this Agreement and the establishment or operation of the Consortium and any sub-group of the Consortium must be appropriately identified, recorded and managed.

2.6 The Consortium must establish effective, safe, efficient and economic arrangements for the discharge of ICB functions.

2.7 The members of the Consortium must act in accordance with:

the terms of this Agreement,

all applicable Law,

guidance,

the Schemes of Reservation and Delegation of Partners

the Terms of Reference, and

good practice.

the Delegation Agreement signed by each ICB and NHS England

2.8 NHS England East of England will be formal members of the Consortium in respect of those specialised services it is retaining. Where the Consortium addresses business relating to the delegated specialised services, then NHSE will be observers.

SCHEDULE 3 DELEGATED SERVICES

The following table shows the 59 services that have been delegated from NHS England as of the Commencement Date. Service specifications will be as set out on the NHS England website.

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
2	Adult congenital heart disease services	13X	Adult congenital heart disease services (non-surgical)
		13Y	Adult congenital heart disease services (surgical)
3	Adult specialist pain management services	31Z	Adult specialist pain management services
4	Adult specialist respiratory services	29M	Interstitial lung disease (adults)
		29S	Severe asthma (adults)
		29L	Lung volume reduction (adults)
5	Adult specialist rheumatology services	26Z	Adult specialist rheumatology services
7	Adult Specialist Cardiac Services	13A	Complex device therapy
		13B	Cardiac electrophysiology & ablation
		13C	Inherited cardiac conditions
		13E	Cardiac surgery (inpatient)
		13F	PPCI for ST- elevation myocardial infarction
		13H	Cardiac magnetic resonance imaging
		13T	Complex interventional cardiology (adults)
		13Z	Cardiac surgery (outpatient)
9	Adult specialist endocrinology services	27E	Adrenal Cancer (adults)
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08O	Neurology (adults)
		08P	Neurophysiology (adults)
		08R	Neuroradiology (adults)
		08S	Neurosurgery (adults)
		08T	Mechanical Thrombectomy
		58A	Neurosurgery LVHC national: surgical removal of clival chordoma and chondrosarcoma
		58B	Neurosurgery LVHC national: EC-IC bypass (complex/high flow)
		58C	Neurosurgery LVHC national: transoral excision of dens
		58D	Neurosurgery LVHC regional: anterior skull based tumours
		58E	Neurosurgery LVHC regional: lateral skull based tumours
		58F	Neurosurgery LVHC regional: surgical removal of brainstem lesions
		58G	Neurosurgery LVHC regional: deep brain stimulation
		58H	Neurosurgery LVHC regional: pineal tumour surgeries - resection
		58I	Neurosurgery LVHC regional: removal of arteriovenous malformations of the nervous system
		58J	Neurosurgery LVHC regional: epilepsy
		58K	Neurosurgery LVHC regional: insula glioma's/ complex low grade glioma's
		58L	Neurosurgery LVHC local: anterior lumbar fusion
	Adult specialist neurosciences services (continued)	58M	Neurosurgery LVHC local: removal of intramedullary spinal tumours
		58N	Neurosurgery LVHC local: intraventricular tumours resection
		58O	Neurosurgery LVHC local: surgical repair of aneurysms (surgical clipping)
		58P	Neurosurgery LVHC local: thoracic discectomy
		58Q	Neurosurgery LVHC local: microvascular decompression for trigeminal neuralgia
		58R	Neurosurgery LVHC local: awake surgery for removal of brain tumours

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
		58S	Neurosurgery LVHC local: removal of pituitary tumours including for Cushing's and acromegaly
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery (adults)
		34R	Orthopaedic revision (adults)
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis
16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery (adults)
		29Z	Adult thoracic surgery services: outpatients
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services (adults and children)
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services (adults and children)
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services (adults and children)
		08Z	Complex neuro-spinal surgery services (adults and children)
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services (adults and adolescents)
58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis
		04D	Complex urinary incontinence and genital prolapse
58A	Specialist adult urological surgery services for men	41P	Penile implants
		41S	Surgical sperm removal
		41U	Urethral reconstruction
59	Specialist allergy services (adults and children)	17Z	Specialist allergy services (adults and children)
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services (adults and children)
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services (adults and children)
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases
		18E	Specialist Bone and Joint Infection (adults)
72	Major trauma services (adults and children)	34T	Major trauma services (adults and children)
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services (adults and children)
83	Paediatric cardiac services	23B	Paediatric cardiac services
94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
		51R	Radiotherapy services (Children)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
		01S	Stereotactic Radiosurgery / radiotherapy
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer (adults)
		01K	Malignant mesothelioma (adults)
		01M	Head and neck cancer (adults)
		01N	Kidney, bladder and prostate cancer (adults)
		01Q	Rare brain and CNS cancer (adults)
		01U	Oesophageal and gastric cancer (adults)
		01V	Biliary tract cancer (adults)
		01W	Liver cancer (adults)
		01Y	Cancer Outpatients (adults)
		01Z	Testicular cancer (adults)
		04F	Gynaecological cancer (adults)
		19V	Pancreatic cancer (adults)
		24Y	Skin cancer (adults)
		19C	Biliary tract cancer surgery (adults)
		19M	Liver cancer surgery (adults)
		19Q	Pancreatic cancer surgery (adults)
		51A	Interventional oncology (adults)
		51B	Brachytherapy (adults)
		51C	Molecular oncology (adults)
		61M	Head and neck cancer surgery (adults)
		61Q	Ophthalmic cancer surgery (adults)
		61U	Oesophageal and gastric cancer surgery (adults)
		61Z	Testicular cancer surgery (adults)
		33C	Transanal endoscopic microsurgery (adults)
		33D	Distal sacrectomy for advanced and recurrent rectal cancer (adults)
106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer
		23A	Children's cancer
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence (adults)
		33B	Complex inflammatory bowel disease (adults)
107	Specialist dentistry services for children	23P	Specialist dentistry services for children
108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children
109	Specialist endocrinology services for children	23E	Specialist endocrinology and diabetes services for children
110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children
112	Specialist gynaecology services for children	73X	Specialist paediatric surgery services - gynaecology
113	Specialist haematology services for children	23H	Specialist haematology services for children
115B	Specialist maternity care for adults diagnosed with abnormally invasive placenta	04G	Specialist maternity care for women diagnosed with abnormally invasive placenta
118	Neonatal critical care services	NIC	Specialist neonatal care services
119	Specialist neuroscience services for children	23M	Specialist neuroscience services for children
		07Y	Paediatric neurorehabilitation
		08J	Selective dorsal rhizotomy
120	Specialist ophthalmology services for children	23N	Specialist ophthalmology services for children

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children
122	Paediatric critical care services	PIC	Specialist paediatric intensive care services
125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children
126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs (adults and children)
127	Specialist renal services for children	23S	Specialist renal services for children
128	Specialist respiratory services for children	23T	Specialist respiratory services for children
129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children
130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults
		19P	Specialist services for complex pancreatic diseases in adults
		19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults
		19B	Specialist services for complex biliary diseases in adults
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)
		03Y	Specialist services for haemophilia and other related bleeding disorders (Children)
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05P	Prosthetics (adults and children)
135	Specialist paediatric surgery services	23X	Specialist paediatric surgery services - general surgery
136	Specialist paediatric urology services	23Z	Specialist paediatric urology services
139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital
ACC	Adult Critical Care	ACC	Adult critical care

SCHEDULE 4 FINANCIAL ARRANGEMENTS

1 ESTABLISHMENT OF A MULTI-LEDGER HUB

1.1 The ICBs have agreed not to establish and maintain pooled funds for revenue expenditure. Instead, they have agreed to establish multi ledger access hub for 2024/25 which will be operated by the current specialised commissioning finance team. All transactions will be posted into ICB ledgers in accordance with the agreed annual plan and will reflect the authorisation and authority to pay requirements as delegated by NHSE. Until agreed, a default payment based on the previous financial year will be paid, followed by an in year reconciliation following final contract agreements Chart of accounts and detailed cost centres will be established in each ICB's area of the ledger for the delegated specialised commissioning allocation and spend.

1.2 ICBs will individually receive the notified allocation from NHSE, and this will include the calculated share of the national specialised commissioning position for that ICB based on the recurrent 2023/24 allocation and will also include growth resources as directed by the expected planning guidance. It is assumed that this will reflect a base level increase for all ICBs and then additional resources determined in accordance with calculated distance from target.

1.3 Monthly transactions will be processed on the 15th of each month in accordance with the ICBs' agreed Schedule of Payments. Quarterly and annual reconciliations will be undertaken with the nominated ICB finance staff. The specialised commissioning finance team will communicate regularly with ICB staff.

2 FINANCIAL ALLOCATIONS

2.1 The financial allocation for 2024/25 shall be as set out by the NHSE national specialised team in the agreed schedules with each ICB. Growth funding will be applied in accordance with national guidance for baseline levels. Any discretionary growth funding allocated nationally will be agreed by ICBs for consistent application into risk and investment reserves held by each ICB.

2.2 A running costs allowance (RCA) adjustment to individual ICB allocations is expected in 2025/26 financial year. This RCA adjustment to support specialised commissioning delegation will be ringfenced to resource the Specialised Commissioning Team.

2.3 Unless otherwise agreed, no provision of this Agreement shall preclude the ICBs from making additional contributions of Non-Recurrent Payments from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in the budget statement as a separate item.

3 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

3.1 The ICBs have agreed risk share arrangements described in 3.2 and 3.3, arising within the commissioning of services as set out in National Guidance.

3.2 A risk share for 2024/25 has been agreed by ICB Chief Finance Officers. This will meet the known risks for the 59 services to be delegated from 1 April 2024. The material risk has been quantified and relates to chemotherapy and non-mental health independent sector activity. The risk share agreement is based on each ICB holding 1% variable risk reserve and funding any ICB specific overspend from this reserve. If an ICB overspend exceeds the reserve, then the additional impact will be funded from other ICB reserves pro-rata to their allocation. Any distribution of reserves will be agreed at the Finance and Contracting sub-group of the Joint Commissioning Consortium.

3.3 In addition, ICB Directors of Finance have agreed to recognise the need to develop and transform patient care services which may require specific financial support and have agreed to hold a further 0.5% of allocation as an investment reserve, pending negotiations with providers, which will be deployed following a collective decision, supported by clear plans, by the Joint Commissioning Consortium.

4 CAPITAL EXPENDITURE

4.1 Unless agreed by the ICBs, no funds shall normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the ICBs. If a need for capital expenditure is identified this must be agreed by the ICBs.

SCHEDULE 5 FURTHER INFORMATION GOVERNANCE AND SHARING PROVISIONS

1 INTRODUCTION

1.1 This Schedule sets out the scope for the secure and confidential sharing of information between the Partners on a Need To Know basis, in order to enable the Partners to exercise their functions in pursuance of this Agreement.

1.2 References in this Schedule *(Further Information Governance and Sharing Provisions)* to the Need to Know basis or requirement (as the context requires) should be taken to mean that the Data Controllers' Staff will only have access to Personal Data or Special Category Personal Data if it is lawful for such Staff to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.

1.3 This Schedule and the Data Sharing Agreements entered into under this Schedule are designed to:

1.3.1 provide information about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the Partners,

1.3.2 describe the purposes for which the Partners have agreed to share Relevant Information,

1.3.3 set out the lawful basis for the sharing of information between the Partners, and the principles that underpin the exchange of Relevant Information,

1.3.4 describe roles and structures to support the exchange of Relevant Information between the Partners,

1.3.5 apply to the sharing of Relevant Information relating to Specialised Services Providers and their Staff,

1.3.6 apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted,

1.3.7 ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed,

1.3.8 apply to the activities of the Partners' Staff, and

1.3.9 describe how complaints relating to Personal Data sharing between the Partners will be investigated and resolved, and how the information sharing will be monitored and reviewed.

2 PURPOSE

2.1 The Specified Purpose of the data sharing is to facilitate the exercise of the Delegated Functions and NHS England's Reserved Functions.

2.2 Each Partner must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received from any third party organisations from which the Partners must obtain data in order to achieve the Specified Purpose. Where necessary specific and detailed

purposes must be set out in a Data Sharing Agreement that complies with all relevant Legislation and Guidance.

3 BENEFITS OF INFORMATION SHARING

3.1 The benefits of sharing information are the achievement of the Specified Purpose, with benefits for service users and other stakeholders in terms of the improved delivery of the Joint Specialised Services.

4 LAWFUL BASIS FOR SHARING

4.1 The Partners shall comply with all relevant Data Protection Legislation requirements and good practice in relation to the processing of Relevant Information shared further to this Agreement.

4.2 The Partners shall ensure that there is a Data Protection Impact Assessment ("DPIA") that covers processing undertaken in pursuance of the Specified Purpose. The DPIA shall identify the lawful basis for sharing Relevant Information for each purpose and data flow.

4.3 Where appropriate, the Relevant Information to be shared shall be set out in a Data Sharing Agreement.

5 RESTRICTIONS ON USE OF THE SHARED INFORMATION

5.1 Each Partner shall only process the Relevant Information as is necessary to achieve the Specified Purpose and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.

5.2 Access to, and processing of, the Relevant Information provided by a Partner must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be handled at all times on a restricted basis, in compliance with Data Protection Legislation requirements, and the Partners' Staff should only have access to Personal Data on a justifiable Need to Know basis.

5.3 Neither the provisions of this Schedule nor any associated Data Sharing Agreements should be taken to permit unrestricted access to data held by any of the Partners.

5.4 Neither Partner shall subcontract any processing of the Relevant Information without the prior consent of the other Partner. Where a Partner subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on the Data Controllers under this Agreement.

5.5 The Partners shall not cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.

5.6 Any particular restrictions on use of certain Relevant Information should be included in a Personal Data Agreement.

6 ENSURING FAIRNESS TO THE DATA SUBJECT

6.1 In addition to having a lawful basis for sharing information, the UK GDPR generally requires that the sharing must be fair and transparent. In order to achieve fairness and transparency to the Data Subjects, the Partners will take the following measures as reasonably required:

6.1.1 amendment of internal guidance to improve awareness and understanding among Staff,

6.1.2 amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects,

6.1.3 ensuring that information and communications relating to the processing of data is clear and easily accessible, and

6.1.4 giving consideration to carrying out activities to promote public understanding of how data is processed where appropriate.

6.2 Each Partner shall procure that its notification to the Information Commissioner's Office, and record of processing maintained for the purposes of Article 30 UK GDPR, reflects the flows of information under this Agreement.

6.3 The Partners shall reasonably cooperate in undertaking any DPIA associated with the processing of data further to this Agreement, and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.

6.4 Further provision in relation to specific data flows may be included in a Personal Data Agreement between the Partners.

7 GOVERNANCE: STAFF

7.1 The Partners must take reasonable steps to ensure the suitability, reliability, training and competence, of any Staff who have access to Personal Data, and Special Category Personal Data, including ensuring reasonable background checks and evidence of completeness are available on request.

7.2 The Partners agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where any of the Partners' Staff are not healthcare professionals (for the purposes of the Data Protection Act 2018) the employing Partners must procure that Staff operate under a duty of confidentiality which is equivalent to that which would arise if that person were a healthcare professional.

7.3 The Partners shall ensure that all Staff required to access Personal Data (including Special Category Personal Data are informed of the confidential nature of the Personal Data. The Partners shall include appropriate confidentiality clauses in employment/service contracts of all Staff that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Data Protection Legislation requirements, or cause damage to or loss of the Relevant Information.

7.4 Each Party shall provide evidence (further to any reasonable request) that all personnel that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Data Protection Legislation and this Agreement.

7.5 The Partners shall ensure that:

7.5.1 only those Staff involved in delivery of the Agreement use or have access to the Relevant Information, and

7.5.2 that such access is granted on a strict Need to Know basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited.

Evidence of audit should be made freely available on request by the originating Data Controller, and

7.5.3 specific limitations on the Staff who may have access to the Information are set out in any Data Sharing Agreement entered into in accordance with this Schedule.

8 GOVERNANCE: PROTECTION OF PERSONAL DATA

8.1 At all times, the Partners shall have regard to the requirements of Data Protection Legislation and the rights of Data Subjects.

8.2 Wherever possible (in descending order of preference), only anonymised information, or, strongly or weakly pseudonymised information will be shared and processed by the Partners. The Partners shall cooperate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data or Special Category Personal Data.

8.3 Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need to Know basis.

8.4 If any Partner

8.4.1 becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable, or

8.4.2 becomes aware of any security vulnerability or breach in respect of the Relevant Information,

it shall promptly, within 48 hours, notify the other Partners. The Partners shall fully cooperate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Data Protection Legislation.

8.5 In processing any Relevant Information further to this Agreement, the Partners shall process the Personal Data and Special Category Personal Data only:

8.5.1 in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information,

8.5.2 to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body,

8.5.3 in accordance with Data Protection Legislation requirements, in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR, and not in such a way as to cause any other Data Controller to breach any of their applicable obligations under Data Protection Legislation.

8.6 The Partners shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection Legislation, and in particular to protected the Personal Data (and Special Category Personal Data) against unauthorised or unlawful

processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

8.6.1 take account of the nature, scope, context and purposes of processing as well as the risks, of varying likelihood and severity for the rights and freedoms of Data Subjects, and

8.6.2 be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data and Special Category Personal Data, and having the nature of the Personal Data (and Special Category Personal Data) which is to be protected.

8.7 In particular, each Partner shall:

8.7.1 ensure that only Staff as provided under this Schedule have access to the Personal Data and Special Category Personal Data,

8.7.2 ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information,

8.7.3 obtain prior written consent from the originating Partner in order to transfer the Relevant Information to any third party,

8.7.4 permit any other Partner or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable each Partner to verify and/or procure that the other is in full compliance with its obligations under this Agreement, and

8.7.5 if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

The Partners shall adhere to the specific requirements as to information security set out in any Data Sharing Agreement entered into in accordance with this Schedule.

8.8 The Partners shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

8.9 The Partners' Single Points of Contact set out in paragraph 13 will be the persons who, in the first instance, will have oversight of third party security measures.

9 GOVERNANCE: TRANSMISSION OF INFORMATION BETWEEN THE PARTNERS

9.1 This paragraph supplements paragraph 8 of this Schedule.

9.2 Transfer of Personal Data between the Partners shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net or gcsx) e-mail.

9.3 Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information

governance and clinical safety practice, so as to ensure that the correct patient record / data is identified.

9.4 Any other special measures relating to security of transfer should be specified in a Data Sharing Agreement entered into in accordance with this Schedule.

9.5 Each Partner shall keep an audit log of Relevant Information transmitted and received in the course of this Agreement.

9.6 The Partners' Single Point of Contact notified pursuant to paragraph 13 will be the persons who, in the first instance, will have oversight of the transmission of information between the Partners.

10 GOVERNANCE: QUALITY OF INFORMATION

10.1 The Partners will take steps to ensure the quality of the Relevant Information and to comply with the principles set out in Article 5 UK GDPR.

11 GOVERNANCE: RETENTION AND DISPOSAL OF SHARED INFORMATION

11.1 A non-originating Partner shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically, the Relevant Information will be deleted and formal notice of the deletion sent to the that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Partner they came from.

11.2 Each Partner shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, upon request and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

11.3 If a Partner is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy in accordance with this Schedule, it shall notify the other Partners in writing of that retention, giving details of the documents or materials that it must retain.

11.4 Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all good practice including the Records Management NHS Code of Practice, as updated or amended from time to time.

11.5 The Partners shall set out any special retention periods in a Data Sharing Agreement where appropriate.

11.6 The Partners shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a cross cut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.

11.7 Each Partner shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.

11.8 Electronic records will be considered for deletion once the relevant retention period has ended.

11.9 In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Partner shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

12 GOVERNANCE: COMPLAINTS AND ACCESS TO PERSONAL DATA

12.1 The Partners shall assist each other in responding to any requests made under Data Protection Legislation made by persons who wish to access copies of information held about them ("Subject Access Requests"), as well as any other exercise of a Data Subject's rights under Data Protection Legislation or complaint to or investigation undertaken by the Information Commissioner.

12.2 Complaints about information sharing shall be reported to the Single Points of Contact and the Joint Commissioning Consortium. Complaints about information sharing shall be routed through each Partners' own complaints procedure unless otherwise provided for in the Joint Working Arrangements or determined by the Joint Commissioning Consortium.

12.3 The Partners shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Schedule or any data processing carried out further to it.

12.4 Basic details of the Agreement shall be included in the appropriate log under each Partner's Publication Scheme.

13 GOVERNANCE: SINGLE POINTS OF CONTACT

13.1 The Partners each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance.

14 MONITORING AND REVIEW

14.1 The Partners shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Data Protection Legislation and best practice. Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.

SCHEDULE 6 COMMISSIONING TEAM ARRANGEMENTS

1 SCOPE OF THE ARRANGEMENTS

1.1 In accordance with the Delegation Agreements, NHS England agrees to provide to the ICBs the Administrative and Management Services as set out in this Agreement.

1.2 The Partners agree that the costs associated with the provision of the Administrative and Management Services by the Specialised Commissioning Team (SCT) shall not be included within the Delegated Funds allocated or transferred to the ICBs for the Period and that NHS England shall meet those costs.

1.3 The Commissioning Team Arrangements are intended to be for one year, covering the 2024/25 financial year and the specific arrangements required (i.e. NHS England providing administration and management services to ICBs). It is envisaged that from 1 April 2025, The Specialised Commissioning Team will transfer to the host ICB and therefore the arrangements described in this appendix will either no longer be required or will require revision to support those arrangements.

1.4 The table at Appendix 5 describes the functions and services covered by the Schedule and allocates accountability and responsibility accordingly.

2 ADMINISTRATIVE AND MANAGEMENT SERVICES

2.1 NHS England, through the Specialised Commissioning Team, shall provide the Administrative and Management Services as set out in Appendix 1 or as otherwise agreed in writing between the Partners.

3 STAFFING

3.1 The provisions of Appendix 2 shall apply in respect of the NHS England Staff providing Administrative and Management Services.

4 HOST ICB

4.1 NHS Bedfordshire, Luton and Milton Keynes (BLMK) ICB is the host for the regional Specialised Commissioning Team and will fulfil the following functions.

4.1.1 Line manage the Managing Director, to whom the SCT will report.

4.1.2 Ensure the SCT effectively delivers the commissioning functions on behalf of the six ICBs in the East of England and NHS England (NHSE).

4.1.3 Ensure professional leadership is provided to senior managers and commissioning functions within the team.

4.1.4 Provide leadership for specialised commissioning in external fora (both within the East of England and across regional boundaries) on behalf of the six ICBs. Leadership in these fora may also be provided by other East of England ICBs directors and senior managers.

4.1.5 Employ and manage the SCT following the transfer of staff.

APPENDIX 1 ADMINISTRATIVE AND MANAGEMENT SERVICES

1 GENERAL

1.1 NHS England will provide such Services as it agrees with the ICBs as required for the ICBs to exercise the Statutory Functions as set out in Schedule 3 to the Delegation Agreement which shall include, but is not limited, to the Administrative and Management Services set out below.

2 CONTRACT MANAGEMENT

2.1 The Specialised Commissioning Team shall provide contract management and support in respect of the Delegated Services in order to facilitate the ICBs to meet the Delegated Functions set out in Schedule 3 of the Delegation Agreement (Delegated Functions). Such support shall be in compliance with the agreed regional contracting strategy and Standard Operating Procedures.

3 FINANCE

3.1 The financial arrangements in respect of the provision of the Administrative and Management Services by NHS England to the ICBs shall be as set out in Appendix 4 (Financial Arrangements).

4 DATA MANAGEMENT AND ANALYTICS

4.1 The Specialised Commissioning Team shall provide such data management and analytic services as NHS England considers necessary to ensure that the ICB meets its obligations under Schedule 3 of the Delegation Agreement (Delegated Functions).

5 FREEDOM OF INFORMATION AND PARLIAMENTARY REQUESTS

5.1 The Specialised Commissioning Team shall provide such reasonable support as required by an ICB to ensure the appropriate handling, management and response to all freedom of information and parliamentary correspondence relating to Delegated Specialised Services.

6 INCIDENT RESPONSE AND MANAGEMENT

6.1 The Specialised Commissioning Team shall provide such reasonable support as required by an ICB in relation to local incident management for Delegated Specialised Services

7 PROVIDER SELECTION AND PROCUREMENT

7.1 The Specialised Commissioning Team shall act on instructions from the ICBs in relation to provider selection and procurement processes for the Delegated Specialised Services.

8 QUALITY

8.1 The Specialised Commissioning Team shall ensure appropriate arrangements for quality oversight are in place in respect of the provision of the Administrative and Management Services.

9 AUDIT

9.1 During 2024/25, it is anticipated that an audit will be conducted by NHS England's auditors on the administrative and management services provided to the ICBs by the Specialised

Commissioning Team. The scope of the audit is to be determined. The ICBs will be asked by NHS England to provide input to the audit.

10 STRATEGY, PLANNING AND TRANSFORMATION

10.1 The Specialised Commissioning Team will support the development of strategies and plans for Specialised Services, liaising and coordinating with ICB staff who are leading on the development of strategies and plans for non-specialised services. This will include development of a joint resource prioritisation approach and work programmes for both Delegated and Retained Services. The transformation team will provide transformation project, programme, and portfolio management support for Specialised Services on a multi-ICB footprint.

APPENDIX 2 STAFFING MODEL

1 SPECIALISED COMMISSIONING TEAM STAFF MODEL

1.1 NHS England will ensure such resource as it considers reasonably required is allocated to the provision of the Administrative and Management Services.

1.2 Under this Agreement NHS England shall be providing the Administration and Management Services to the ICB to assist the ICB in meeting its obligations in respect of the Delegated Functions under the Delegation Agreement for Specialised Services.

1.3 There is no delegation of the accountability for statutory functions under this Agreement but the responsibility for the Delegated Specialised Services, along with the decision-making responsibility, rests with the ICBs.

2 AVAILABILITY OF NHS ENGLAND STAFF

2.1 In addition to any Staff deployed in any communicated arrangement, NHS England may deploy additional Staff to the Specialised Commissioning Team to perform Management Services.

2.2 NHS England will take all reasonable steps to ensure that the NHS England Staff deployed for the purposes of carrying out the Delegated Functions shall:

(a) faithfully and diligently perform duties and exercise such powers as may from time to time be reasonably assigned to or vested in them, and

(b) perform all duties assigned to them pursuant to this Schedule 6 (Commissioning Team Arrangements).

2.3 The host ICB shall notify NHS England if the host ICB becomes aware of any act or omission by any NHS England staff which may have a material adverse impact on the provision of the Services or constitute a material breach of the terms and conditions of employment of the NHS England staff.

2.4 NHS England shall use all reasonable efforts to make its services available whilst the NHS England staff are absent:

(a) by reason of industrial action,

(b) as a result of the suspension or exclusion of employment or secondment of any Staff by NHS England,

(c) in accordance with the NHS England Staff's respective terms and conditions of employment and policies, including, but not limited to, by reason of training, holidays, sickness, injury, trade union duties, paternity leave or maternity or where absence is permitted or required by Law,

(d) if making the NHS England Staff available would breach or contravene any Law,

(e) as a result of the cessation of employment of any individual NHS England Staff, and/or

(f) at such other times as may be agreed between NHS England and the ICB.

3 EMPLOYMENT OF THE NHS ENGLAND STAFF

3.1 NHS England shall employ its Staff and shall be responsible for the employment of its Staff at all times on whatever terms and conditions as NHS England and its Staff may agree from time to time.

3.2 NHS England shall pay its Staff their salaries and benefits and make any deductions for income tax liability and national insurance or similar contributions it is required to make from salaries and other payments.

3.3 NHS England shall not hold out its Staff as employees of the ICBs, and shall ensure that its Staff do not hold themselves out as employees of the ICB.

4 MANAGEMENT OF NHS ENGLAND STAFF

4.1 NHS England where appropriate, shall in consultation with the ICBs, make arrangements to ensure the day-to-day control of the activities of their Staff is shared with the ICBs and deal with any relevant management issues concerning their Staff including, without limitation, performance appraisal, discipline and leave requests.

4.2 The ICBs agree to provide all such assistance and co-operation that NHS England may reasonably request from time to time to resolve grievances raised by NHS England Staff and to deal with any disciplinary allegations made against NHS England Staff arising out of or in connection with the provision of the Services which shall include, without limitation, supplying NHS England with all information and the provision of access to all documentation and NHS England Staff as NHS England requires for the purposes of considering and dealing with such issues and participating promptly in any action which may be necessary.

5 CONDUCT OF CLAIMS

5.1 If an ICB becomes aware of any matter that may give rise to a claim by or against a member of NHS England Staff, notice of that fact shall be given as soon as possible to NHS England. NHS England and the ICB shall co-operate in relation to the investigation and resolution of any such claims or potential claims.

5.2 No admission of liability shall be made by or on behalf of an ICB and any such claim shall not be compromised, disposed of or settled without the consent of NHS England.

APPENDIX 3 FINANCIAL ARRANGEMENTS

1 SPECIALISED COMMISIONING TEAM

1.1 Staff in the Specialised Commissioning Finance Team will have access to each of the ICBs' ledgers in order to process transactions in line with the agreed ICB Schedule of Payments.

1.2 The Specialised Commissioning Team will have discretion relating to finances in accordance with the agreed ICB Schedule of Payments.

1.3 Where decisions are needed outside of the agreed ICB Schedule of Payments or to operate a risk and investment reserve (if agreed), then approval will be sought from the ICB(s) through the Joint Commissioning Consortium.

1.4 Regular payments in line with the agreed ICB Schedule of Payments. will be made on the 15th day of each month.

1.5 The Specialised Commissioning Finance Team will produce monthly financial reports for each ICB.

1.6 Where queries or disputes arise, then these should be dealt with between the specialised commissioning finance team and the relevant ICB finance team, in the first instance. Where this does not resolve the issue, then the dispute resolution process as set out in Clause 21 (Dispute Resolution) of the Collaboration Agreement will be followed.

1.7 The Managing Director and the Finance Director for the Specialised Commissioning Team (SCT) have the authority to make decisions within the limits as agreed by the Joint Commissioning Consortium and in line with Schemes of Reservation and Delegation.

- SCT can make financial decisions on expenditure within the agreed annual budgets to ensure there is a balanced position across the region or to improve existing services.
- SCT will need to consult and obtain agreement from the JCC on:
    - Use of agreed reserve and/or investment funds.
    - Recurrent financial commitments to developments of new services.
- Financial arrangements are set out in Schedule 4.

1.8 A financial plan will be submitted to the JCC for approval.

1.9 The budget within which the SCT will operate and can make decisions on will be agreed by the JCC at the beginning of each financial year in line with ICB Schemes of Reservation and Delegation.

1.10 If there is a dispute relating to finance or the activities undertaken by the NHSE Specialised Commissioning Team, this will be escalated to the JCC.

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APPENDIX 4 RESPONSIBILITIES

1 INTRODUCTION

1.1 The following table shows the responsibilities covered by this Schedule 6 (Commissioning Team Arrangements) and allocates them accordingly.

Function	Primary Responsibility for development	Responsibility outside the SCT	Key relationships outside the SCT	Formal Meetings	Reports produced
• Develop a strategic plan and supporting financial plan. • Develop an annual operating plan/work plan. • Allocate financial budgets to services that will be commissioned to secure the delivery of the annual operating plan. • Operate within financial thresholds for decisions. • Procure services in line with workplan.	• Specialised Commissioning Team (SCT)	• JCC approval • ICB service leads to contribute to strategy development	• ICB executive leads for Specialised Services, strategy, finance and/or quality. • Relevant leads within wider ICB/ICS teams • Service leads • Clinical leads • Finance • National SCT • RCC • Regional Leadership Team/Regional Executive Team	• JCC • DCG • NHS England	• Monthly integrated performance reports covering: o Finance o Activity o Quality o KPIs • Reports for ICB Boards • Contribution to ICB Forward and Annual Plans
• Exercise statutory duties and functions for the delivery of the commissioned services to ICB populations and patients.		• ICB Boards			
• Review of services o Finance o Performance	• SCT	• JCC review			

Function	Primary Responsibility for development	Responsibility outside the SCT	Key relationships outside the SCT	Formal Meetings	Reports produced
○ Quality and safety • Agreed interventions • Implement service standards					
• Commissioning Specialised Services at providers outside the East of England (EoE)	• SCT	• JCC review	• Contract leads whether NHSE or ICBs		• As above
• Commissioning of specialised commissioning funded networks	• SCT	• JCC review	• ICB and NHSE service leads • Liaison with networks for EoE populations that are managed within other regions	• Specialised Services and Health and Justice Operational Group • JCC by exception	• Annual work plan • Regular updates of progress against plans
• Draw up and agree contracts • Review and initiate recovery or improvement plans with providers. • Carry out service reviews • Lead on service procurements	• Acute SCT (including wider matrix team from functional areas)	•	• ICB executive leads for commissioning and/or finance • ICB contract leads • ICB/ICS service leads • Provider commissioning leads	• National SC contract leads • Provider contract meetings	• Service reports as required

Function	Primary Responsibility for development	Responsibility outside the SCT	Key relationships outside the SCT	Formal Meetings	Reports produced
			• Provider service leads • Programme of care (PoC) & clinical reference group (CRG) leads • NHSE national commissioning teams • Cancer Alliance • Regional service leads		
Draw up and agree contracts. Review and initiate recovery or improvement plans with providers. Lead on service procurements Carry out service reviews.	• Mental Health SCT (including wider matrix team from functional areas)		• ICB executive leads for commissioning and/or finance • Provider collaboratives • Provider service leads • ICB/ICS service leads • PoC/CRG leads	• National SC service leads • Provider contract review meetings • National/Regional Heads of Specialised Mental Health • Lead Provider Business meetings • NHSE/Provider Collaborative Assurance meetings	• Service reports as required

Function	Primary Responsibility for development	Responsibility outside the SCT	Key relationships outside the SCT	Formal Meetings	Reports produced
			• NHSE national commissioning leads • Regional MH/LDA team		
Manage budgets on Specialised Services by ICB, Provider and Service. Keep track of costs attributable to individual ICBs. Transact costs for individual ICBs (invoices/transfers).	• SCT finance	• ICB FD review and approval	• ICB FDs • ICB finance teams	• NHSE Specialised Service Finance Leadership Group (SSFLG)	• Budget position and accounts for each ICB • ICB financial performance reports
Ensure providers are submitting quality, timely data. Ensure data is accessible to SCT and ICB B BI teams. Provide analytical service.	• SCT business intelligence		• ICB BI leads • ICB service leads • National BI leads		• Monthly reports by ICB, provider & service
Manage work plan. Lead on and contribute to service transformation projects. Develop Strategy and work plan.	• SCT transformation	• JCC review	• ICB Service development/ transformation leads		• Monthly work plan progress report
Work with providers to implement national, regional and local schemes for improved cost and quality effectiveness in use of medicines.	• SCT Medicines Management	• JCC review	• ICB medicine management leads • Provider pharmacy leads		• Monthly report on high cost drugs

Function	Primary Responsibility for development	Responsibility outside the SCT	Key relationships outside the SCT	Formal Meetings	Reports produced
			• National pharmacy leads		
Review services against service standards Support peer reviews and visits. Lead on any quality/patient safety issues that require SCT oversight. Escalate to national, regional or system quality groups.	• SCT Quality	• JCC review	• ICB quality leads • NHSE-EoE quality leads • Service providers	• National SC quality. • Regional Director of Nursing. • System quality Groups. • National/regional specialised mental health meetings	• NHSE Specialised Services Quality Dashboard (SSQD)
Lead on engagement with patients and the public. Seek and report provider and patient feedback. Advise and support commissioning teams with engagement with patients and the public. Work with providers, ICBs and other stakeholders to ensure patient feedback is considered in commissioning activity. Provide assurance to NHSE as required concerning legal duties..	• SCT partnerships and engagement		• ICB and provider patient and public engagement leads	• Regional forum	• Annual report
Public Health leadership Public Health review	• SCT public health (PH)		• ICB PH leads	• Regional forum	

Function	Primary Responsibility for development	Responsibility outside the SCT	Key relationships outside the SCT	Formal Meetings	Reports produced
Representation on PoC					
Clinical leadership Clinical review	• SCT Medical		• ICB Medical Directors • Provider Medical Directors	• Regional forum	
Specification development Policy development National Strategies Information Standards	• National SCT		• JCC representative • SCT	• Delegated Commissioning Group (DCG)	• Monthly report on devices
Complaints	• SCT investigates and drafts response	• ICBs' complaints teams receive and assign complaints • ICBs sign off complaint response	• National SCT • Providers		
FOI	• SCT, where SCT holds the information or a common regional response is required for all ICBs. • Where a single national response is required NHSE will provide the response.	• ICB to respond where the information is held by the ICB outside the SCT	• Providers		

Function	Primary Responsibility for development	Responsibility outside the SCT	Key relationships outside the SCT	Formal Meetings	Reports produced
IG incident reporting	• Relevant organisation responsible for the IG incident				

Strategic Risks to 31st March 2024

Appendix C

Risk Type	Risks	Leading To	Probability	Impact	Score	Mitigations
Financial	• **Insufficient allocation to meet current commissioning commitments and volatile nature of demand for specialised services in 24/25**	Financial risks to ICBs and / or demand for services not met	1	4	4	Allocations to be confirmed as part of the expected planning guidance for 24/25 ICBs to manage within resources available
	• **Lack of visibility of historic cost and activity to assess financial risk and of service and quality related issues**	Financial risks to ICBs and / or demand for services not met	1	3	3	Detailed packs have been produced which identify and assure concerning historic finance and activity details
	• **Timescale for moving to target allocation is too long**	Delay in realising benefits for patients	2	4	8	Allocations and movement to target to be determined nationally as part of the planning guidance expected
	• **Inability of ICBs to agree effective risk-share arrangements for 24/25**	Financial risks to ICBs and inequality of access for different ICB populations	1	3	3	ICBs have agreed on risk share (contingency) arrangement principles and have agreed on consistent application.
	• **Following delegation to 6 ICBs there will be an increase in transactions**	Leading to more work and costs for providers	3	2	6	TBC
	• **Delay to National Guidance**	Unable to complete financial sections of SDC	3	3	9	Escalate to NHSE
Governance	• **Lack of engagement from all partners at the appropriate seniority and with authority to act for their organisations**	Delay in agreeing Delegation Agreements and meeting delegation deadline of 31st March 2024	1	4	4	JCC TORs tbc 31/1 ICB leads have confirmed ICB leads for each working group and dates for ICB approval of delegation agreements
	• **Complexity of commissioning arrangements as other regions move at different pace**	Mixed economy of provision for our populations	2	2	4	Relationships to be maintained and developed with neighbouring regions and ICBs. Providers to be informed of and supported to understand technical changes required
Organisational	• **Uncertainty and change**	Poor retention of staff and loss of expert knowledge and experience in Specialised Commissioning team	2	4	8	Organisational risks will be mitigated through: • robust plans and dialogue with NHSE and ICBs to identify sufficient leadership capacity and recruitment plan. • engagement with national and regional NHSE teams to clarify funding for overheads, retained/delegated teams and process for retaining critical staff.
	• **Insufficient staffing resources in 24/25**	Lack of capacity to undertake functions	2	4	8	
	• **Insufficient leadership capacity within Host ICB in 24/25**	Low staff moral and loss of staff from team	2	4	8	

Risks to be reviewed and updated quarterly to reflect evolving nature of delegation

Risk RAG	High 12-16	Medium 6-9	Low 1- 4

Norfolk and Waveney
Integrated Care Board

Agenda item: 09

Subject:	**5-year Joint Forward Plan (JFP) refresh for 2024/25 to 2028/29**
Presented by:	**Andrew Palmer, Executive Director of Performance, Transformation and Strategy and Deputy Chief Executive**
Prepared by:	**Liz Joyce, Head of System Transformation**
Submitted to:	**ICB Board**
Date:	**26 March 2024**

Purpose of paper:

This paper presents the refreshed 5-year JFP for 2024/25 to 2028/29, for approval by the ICB Board, subject to any minor drafting corrections.

Executive Summary:

Producing the JFP is a statutory duty for ICB's, NHS Trusts and NHS Foundation Trusts and each partner will take the 2024/25 to 2028/29 JFP through their own governance as required.

This FP is a refresh of the previous version. The eight Ambitions remain unchanged, but the 21 Objectives have been updated to reflect progress made over the past nine months. All the sections have been reviewed and updated with partners, programme boards and local delivery groups, but the format and broad content are similar to the previous year. This is consistent with the published NHSE JFP Guidance and the existing Norfolk and Suffolk HWB strategies and Integrated Care Strategies.

The final 2024/25 NHSE operational planning assumptions have not yet been published so we are working to the interim guidance. This particularly impacts Ambitions 6 (UEC) and 7 (Elective Recovery) but does not preclude re-publication of the updated JFP.

The 2024/25 to 2028/29 JFP will be published by 31 March on the ICS website, using the same design features as last year with infographics and case studies. The JFP will be accompanied by a refreshed easy read version and glossary.

It will be presented to the Suffolk and Norfolk Joint Health and Wellbeing Boards in May and June 2024, with their opinion published retrospectively.

A copy of the refreshed 5-year JFP is attached at Appendix A.

1.0 Introduction

The National Health Service Act (2006) as amended by the Health and Care Act (2022) requires ICB's and their partner NHS Trusts and Foundation Trusts to prepare a plan setting out how they propose to exercise their functions in the next five years. These should be reviewed and/or revised before the start of each financial year. This plan is known as the Joint Forward Plan or JFP.

The Guidance on updating the JFP for 2024/25 was published in December 2023 and a link is provided as a reference document in the table at the end of this report.

The Guidance explains the relationship between the JFP and NHSE planning which are separate processes but should align. However, the 2024/25 NHSE planning guidance has not been published yet, so we are working to interim and draft planning assumptions.

Norfolk and Waveney published its first JFP in 2023 and a link to the web-site is here: https://improvinglivesnw.org.uk/norfolk-and-waveney-5-year-joint-forward-plan/

As a recap, our JFP is in two parts:

1) Part one is the main body of the JFP which sets out our Ambitions and Objectives i.e. the why, what and how we are going to deliver. There is considerable flexibility within the guidance as to how systems write this up; and
2) Part two which describes how we meet the Legal Duties, which is more prescribed in what we have to evidence.

The first JFP publication was mandated by 30th June 2023 but subsequent refreshes are required by 31 March of each year.

Progress against the first JFP will be published separately in spring 2024 once we have reached year-end 31 March. This will report on the initial nine-months of delivery and is separate to the refreshed JFP.

2.0 JFP 2024/25 refresh

In line with the Guidance on updating the JFP, our revised plan reflects a continuation of the priorities agreed in the previous year.

The eight JFP Ambitions therefore remain our focus for 2024/25 and this approach was supported by the Transformation Board in January 2024. Each Ambition has a clear logo / branding and we have built on these in-year, using them for communications and engagement activity that relates to JFP delivery.

Our eight ambitions for improvement

1. Population Health Management, Reducing Inequalities and Supporting Prevention

2. Primary Care Resilience and Transformation

3. Improving services for Babies, Children and Young People (BCYP) and developing our Local Maternity and Neonatal System (LMNS)

4. Transforming Mental Health services

5. Transforming care in later life

6. Improving Urgent and Emergency Care

7. Elective Recovery and Improvement

8. Improving Productivity and Efficiency

The JFP is encouraged to be a local delivery mechanism for the Norfolk Health and Wellbeing strategy (which is also the Integrated Care Strategy for Norfolk and Waveney) and the Suffolk Health and Wellbeing strategy. These strategies have not been re-published since the first JFP was published in June 2023 and is therefore consistent with continuation of the current Ambitions.

3.0 Summary of the content changes

Part 1 JFP:

1. As noted above the eight Ambitions have been retained but the 21 Objectives have been refreshed in line with the progress made in 2023/24. The one exception is Ambition 3 (Babies, Children & Young People) where we have replaced Objective d) Children's Occupational Therapy offer, with an objective that focuses on Neurodiversity (NDD). This is a new Objective 3d). The expected deliverables for 2023/24 were met in respect of the Children's Occupational Therapy objective and outstanding tasks can be picked up with business-as-usual activity.
2. The JFP is a rolling five-year plan, so 2023/24 year one has been deleted and subsequent years have been refreshed and renumbered, including a new year five if appropriate objectives exist. Trajectories and milestones have been updated. Some of the objectives will finish in years three or four now and further work will be needed to look further ahead.
3. Several strategies, frameworks and plans in the first iteration of the JFP have been published recently or are due to be published imminently. The associated objectives focus on delivery and implementation.
4. Where we have started projects that are implementing an upstream prevention such as Targeted Lung Checks, cardiovascular disease detection, smoking in pregnancy and managing asthma in children, the focus is on accelerating the pace of delivery, expanding coverage, monitoring and evaluation.

5. The Ambitions have been aligned to delivery of the Medium-Term Financial Plan and do not introduce new cost pressures.
6. Wrapped around the Ambitions are the introductory chapters which set the scene about our population and the rationale for why we are going to take action. The Life Course infographic has been updated.
7. The Chapters that explain the role of our partners i.e. providers, five Places and eight Health & Well-Being Partnerships and the VCSE sector, set out how we are going to work together, and have been refreshed by them.
8. Where new strategies, frameworks and plans have been published in-year they have been included as a new hyperlink. Alignment and doing things once is a key message within the JFP.
9. There is some new content about the delegation of the 59 specialised services to ICB's from NHSE on 1 April 2024.
10. The Community Services Review work has also been referenced.

Part 2 JFP:

There are 17 Legal Duties and 7 other areas of recommended content, and these have all been reviewed to ensure we have demonstrated our compliance with the duty. This is a more prescribed section, but we have cross-referenced their enabling capability to the Ambitions.

Copies of the near final draft of both Part 1 and Part 2 of the JFP are included in Appendix A. Subject to any final minor drafting corrections and a few refreshed case studies this is proposed to be the final copy. Providers, Norfolk and Suffolk County Councils and Norfolk Healthwatch and Suffolk Healthwatch have been invited to comment on the refreshed Norfolk and Waveney 5-year JFP for 2024/25 to 2028/29.

4.0 Next steps

Subject to ICB Board approval the 2024/25 to 2028/29 JFP will be published on the ICS web-site on 31 March 2024.

The Guidance stipulates that a draft of the JFP must be sent to each relevant Health and Wellbeing Board (HWB) when undertaking significant revisions or updates. Whilst the 2024/25 updates are not significant, we will still formally present the JFP to the Suffolk HWB on 16 May and to the Norfolk HWB on 12 June and their opinions will be retrospectively published within the JFP on the ICS website. The timing of the release of the JFP Guidance and the scheduled dates of these meetings do not line up optimally this year, hence a pragmatic approach to meet the refresh date of 31 March. This approach has been agreed with the Suffolk and North-East Essex system for consistency.

Progress made in 2023/24 will be published on the ICS web-site in Spring 2024, at the ICB Patients & Communities Committee and the Health and Wellbeing Board / ICP meetings.

Engagement will continue within the objectives and there are a number of examples where this has happened e.g. the Health Inequalities Framework for Action and the Short Term Dentistry Plan.

For the 2025/26 to 2029/30 JFP we plan to commence that work in the autumn of 2024 in anticipation of needing to undertake a more comprehensive refresh, but this will be subject to Guidance.

Recommendation to the Board:

1. That the Board of the ICB approves the refreshed 5-year JFP for 2024/25 to 2028/29, subject to any minor drafting corrections.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	The JFP content has been triangulated with the developing Medium Term Financial Plan and this is a key requirement prior to submission.
Impact Assessment (environmental and equalities):	Each objective within the JFP is assessed.
Reputation:	It is important that this plan is realistic, achievable and deliverable.
Legal:	This is a statutory requirement for the ICB and NHS Trusts and Foundation Trusts.
Information Governance:	N/A
Resource Required:	The JFP will be delivered within existing resources.
Reference document(s):	Go to England.nhs.uk to read the guidance on developing the joint forward plan.
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	Patients and Communities Committee supported the approach to refreshing the JFP on 22/01/2024 Also discussed and supported at the Transformation Board on 18/01 and 22/02 2024

Appendix A

Part 1 and Part 2 JFP – Dated 19th March 2024

Improving lives **together**

Norfolk and Waveney Integrated Care System

Norfolk and Waveney Integrated Care System

Part 1: Joint Forward Plan 2024-2029

Contents

Foreword

Foreword

TO BE ADDED

Norfolk Health & Well-Being Board opinion on the JFP

TO BE ADDED

Suffolk Health & Well-Being Board opinion on the JFP

TO BE ADDED

Executive Summary

Executive Summary

Introduction

The 2024/25 to 2028/29 Norfolk and Waveney Joint Forward Plan is our rolling plan for the next five years setting out what we will do, and where and how we are going to improve health and care services for our local population, their families and carers. Our local communities are at the heart of our plan, and people have previously told us that they want to feel safe when they use local services, they do not want to be passed between different organisations so they have to retell their story each time, and they expect services to be accessible, tailored to their needs and of good quality.

This plan is a refresh of the first version which was published in June 2023. It is updated each year to ensure it remains 'live' and addresses current needs, and is a shared plan, developed with and supported by the partners in our local system. The plan is to two parts:

Part one draws together our public health data and learning from engagement with the people who use our services to set out the case for why we need to make changes to the way we provide services. This informed our eight ambitions for improvement and the objectives that underpin them. Within all the objectives we have been clear about what people will see improve and by when, and how partners in our ICS will work together on our commitment to making a difference to peoples' lives.

Part two provides a summary of how we will meet our legal duties and these have been reviewed and updated. Taken together, these parts form the Norfolk and Waveney Joint Forward Plan.

We will deliver our plan through collaboration with our partners and local communities. Where services are being developed, this will involve the people that plan, provide and use our services, using a range of methods to help people participate. District, city and borough councils and the Voluntary, Community, & Social Enterprise (VCSE) sector are key partners in their local areas within Places and Health and Wellbeing Partnerships. How all parts of the system will work together to deliver this plan is equally as important as what we are going to do. There is an emerging and critical role for Integrated Neighbourhood Teams, and we are undertaking a review of community services to look at how we can further support partnership working in our local communities.

The Life Course infographic on page 24 presents a picture of whether certain aspects of health in Norfolk and Waveney are getting better or are declining. This plan aims to address a number of these challenges through our ambitions and objectives. There are known challenges across Norfolk and Waveney as our population is ageing and there are inequalities that must be addressed. Where people live can also be a major factor affecting both the length and quality of peoples' lives.

Our eight ambitions for improvement

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

Our eight ambitions are unchanged this year, but we have changed objective 3d) within Ambition 3, which is about Improving Services for Babies, Children and Young People. The new objective is in section 4.2, which is focused on neurodiversity, and replaces the previous objective which was about children's occupational therapy services, which has become business as usual. Expected outcomes and milestones for delivering each of the 21 objectives have been refreshed.

Prevention and self-care
The eight ambitions are of equal importance, with prevention, self-care and early intervention being integral to them all. The public health data highlights where we have room to improve, and the key message is that outcomes can improve if preventative action is taken now. This is against the backdrop of emerging national strategy on major conditions with a focus on early diagnosis, early intervention and quality treatment.

This plan continues to signal a clear shift towards prevention through education and direct intervention, looking ahead and being proactive about what can be done now and enabling and supporting those people in our local population identified as most at risk. At the same time, we will ensure we tackle some of our most pressing system challenges, such as reducing waiting times for treatment, , increasing the availability of dental provision, our primary care workforce and ensuring people receive the right care in the right place at the right time. All of this is within the context of some significant financial challenges.

Alignment with partners' plans and other strategies
This plan is aligned to the Norfolk and the Suffolk Joint Health and Wellbeing Strategies and key ICS strategies in areas including Clinical, Research and Innovation, Quality, Digital, Workforce and Estates. Ensuring all our strategies are aligned and complement each other will better enable us to make the improvements we are committed to. The three acute hospitals have published their joint acute clinical strategy since the 2023-24 JFP was published and more information can be found on this in section 6.3. Both the Queen Elizabeth Hospital and the James Paget Hospital are part of the New Hospital Programme which brings an opportunity to re-size and re-configure service delivery in partnership with others. On 1 April 2024 the ICBs in the East of England become the commissioners for 59 specialised services, which brings an opportunity to join up pathways of care. There is more about this in section 6.0.

Affordability
The ambitions and objectives in the JFP are consistent with the current medium term financial planning for our system, but our financial position as a system across our NHS partners is challenging and there will be some difficult choices to make. We have to live within our means and so we must ensure we enhance productivity and efficiency within everything we do. By designing and transforming services to ensure the best value for money, we will be more able to provide high quality, responsive and sustainable services for our population in the future. This will not be easy and we will need to be agile with our change programme, balancing this with the requirements for existing commitments and significant future developments such as our new Hospital build programmes and the Electronic Patient Record.

1.0 Scope of the JFP

1.0 Scope of the JFP

1.1 Introducing the JFP

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

The JFP describes how we will deliver national NHS commitments such as recovering core services after the COVID-19 pandemic and improving productivity, as well as transforming care across our eight areas of ambition. The JFP also describes how we will meet our key legal duties, and these are set out in Part 2. A number of these are also referred to within the JFP in relevant sections because they will help support our improvement and the delivery of our eight ambitions which we set out in this plan.

This plan is predominantly about improvements in NHS services but has been developed in collaboration with partners where services are provided together. This is our second JFP, and we refresh it each year so we have a rolling five year prorgramme of improvement. Progress against the plan will be publicly visible in each NHS partner's annual report, and in the annual report of the ICB.

Our ICS partners are shown in the stakeholder map.

We will work together in partnership across the Norfolk & Waveney Integrated Care System (ICS) to deliver our eight ambitions.

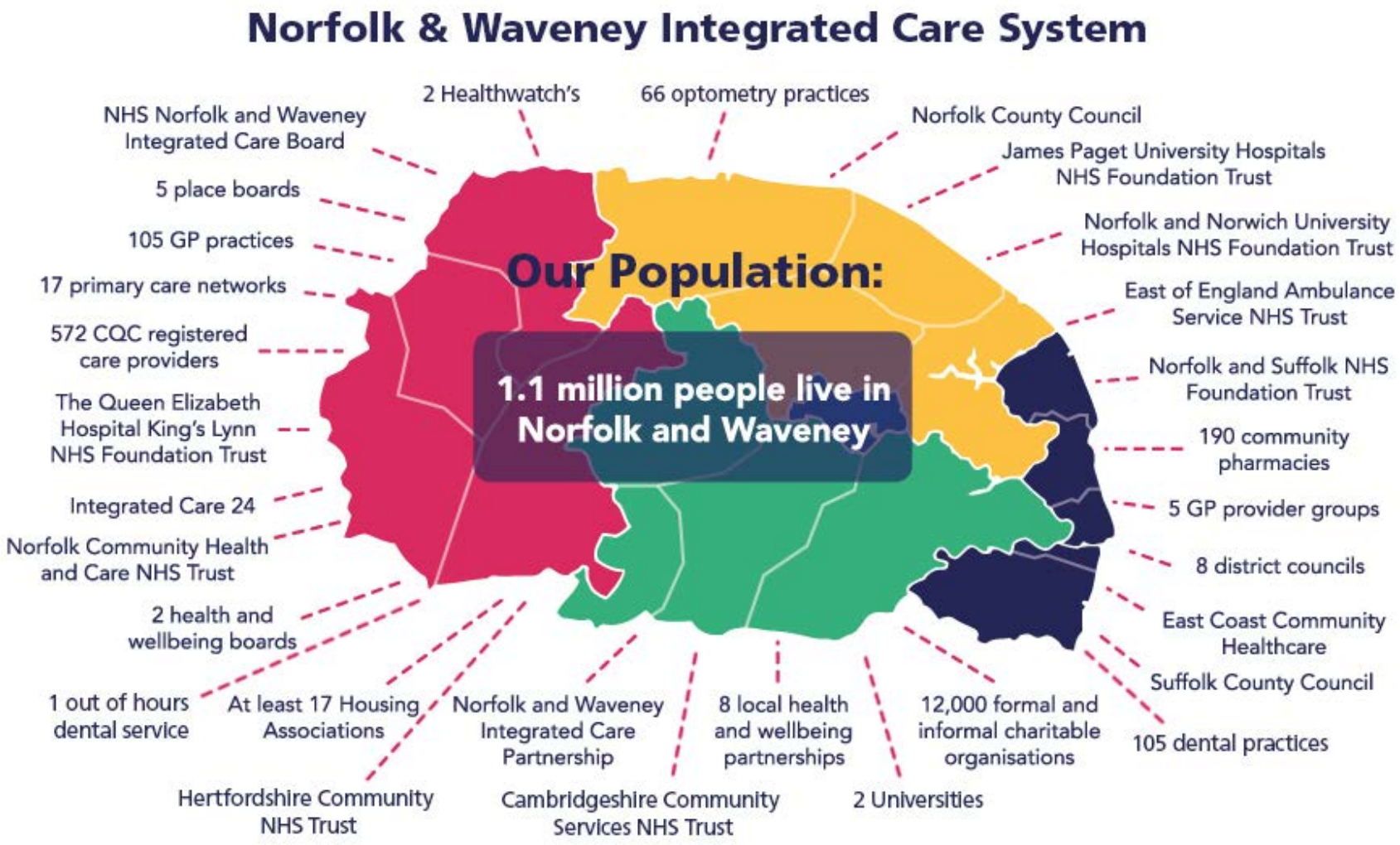


Figure 1 - Stakeholder map

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

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

1.3 Link to the core purposes of an ICS

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

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

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

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

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

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

Case Study

Providing multi-agency support to ensure people can live in warm, comfortable homes, reducing the impact on their health

Cold homes and Chronic respiratory illness is an issue for many areas across the country. In Great Yarmouth and Waveney, the local health and wellbeing partnerships are building on the approach developed in Gloucestershire, which focused on the direct correlation between cold, damp living conditions, exacerbation of respiratory illness and increased risk of hospital admission. These partnerships are made up of Local Authorities, VCSE and NHS organisations, primary care and others who are truly working together to wrap services around our people and communities.

Clinically led by Dr Sarah Flindall, East Norfolk Medical Practice, the project has been supported through ringfenced funding agreed between Great Yarmouth Borough Council and East Suffolk Council and has supported approximately 750 people this winter.

The project is reducing respiratory ill health caused by cold homes, by seeking out vulnerable people with chronic respiratory conditions who are living with fuel poverty, providing them with financial support from the national Household Support Fund.

The project is also linking individuals with other support services for their wider health and wellbeing needs, with the intention of helping people to lead longer, healthier and happier lives. This project has a big focus on prevention, helping to reduce the number of related hospital admissions and supporting people to help prevent respiratory illness from starting or indeed getting worse.

2.0 Framework for Change

2.0 Framework for change

2.1 Five-point approach to developing our JFP

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

1. **Why** we are doing this – using our ICS Transitional Integrated Care Strategy and the Suffolk Health and Wellbeing Strategy we have set out the needs of our population using evidence, data and public engagement to compile an overall case for change to improve the health and outcomes for the people of Norfolk and Waveney. This is section 3.0.

2. **What** are our ambitions for improvement– these are our eight ambitions, with initial objectives identified. This is section 4.0.

3. **When** we expect to deliver – we have created a summary roadmap that illustrates when there will be activity happening on each ambition. This is in section 5.0. Within each objective there are detailed trajectories and milestones for implementation.

4. **How** we are going to work together differently to deliver this – these are the seven ways of working that we have agreed and are set out in section 6.0. This is a really important journey for us to go on as a system, these are our enablers, and we have some key areas to focus on – these are equally as vital as the ambitions and objectives themselves.

5. **Commitment** to achievable, measurable and impactful improvements – this is how we will know we are achieving our objectives in our first JFP. Our objectives are consistent with the Medium-Term Financial Plan, recognising capacity constraints and competing priorities. This is section 7.0.

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

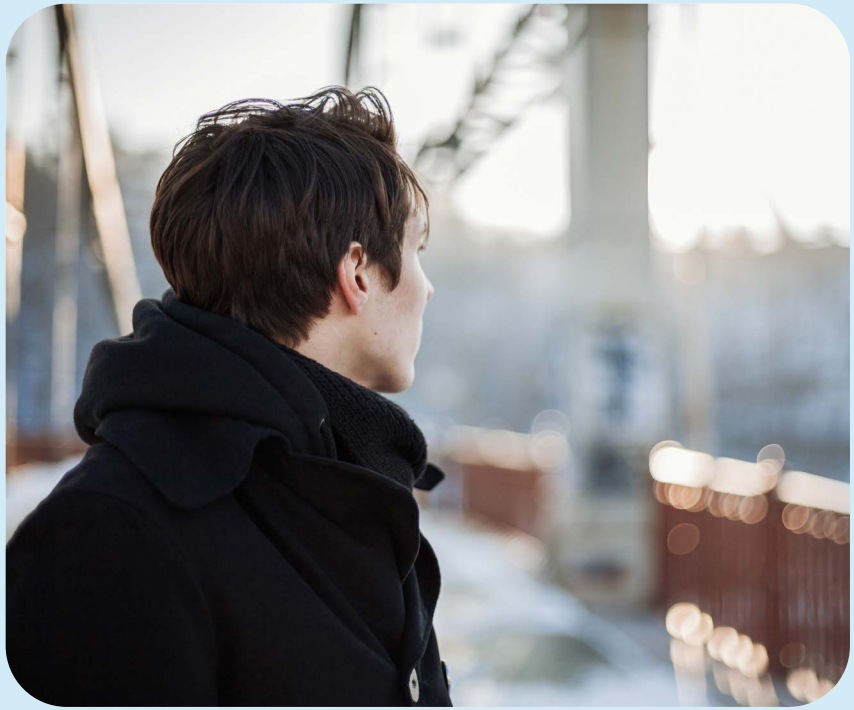
Case Study

Working together to reduce re-offending, substance misuse and supporting better mental health

As a result of working together, a new clinical psychologist role has been rolled out across the Norfolk and Waveney ICS, commissioned by Norfolk County Council, employed by Norfolk and Suffolk NHS Foundation Trust, and deployed into the Project ADDER team within our VCSE-provided local drug and alcohol service (Change Grow Live).

Project ADDER aims to reduce re-offending, reduce substance misuse and promote mental health in service users with complex emotional needs, substance misuse and a history of contact with the criminal justice system. In this role, the psychologist works directly with individuals to provide intervention and indirectly with staff to increase the provision of brief psychologically informed treatments.

This reduces barriers to access as service users with high levels of complexity can be seen in a setting they are familiar with where they are used to engaging with support. The role also forms a bridge for service users to access more specialist mental health treatment within the mental health trust as needed, and a channel for specialist resources and training from within the mental health trust to be made available to project ADDER and CGL staff.



3.0 Why we are doing this – the case for change

3.0 Why we are doing this – the case for change

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

Prevention - 3 levels

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

For more information – Prevention | local government Association

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

NHS England > What are Health Care Inequalities?

Populations Health Management is a way of working, using joined-up local data and information to better understand the health and care needs of our local people and proactively put in place new models of care to deliver improvements in health and well-being.

For more information NHS England Population Health and the Population Health Management Programme

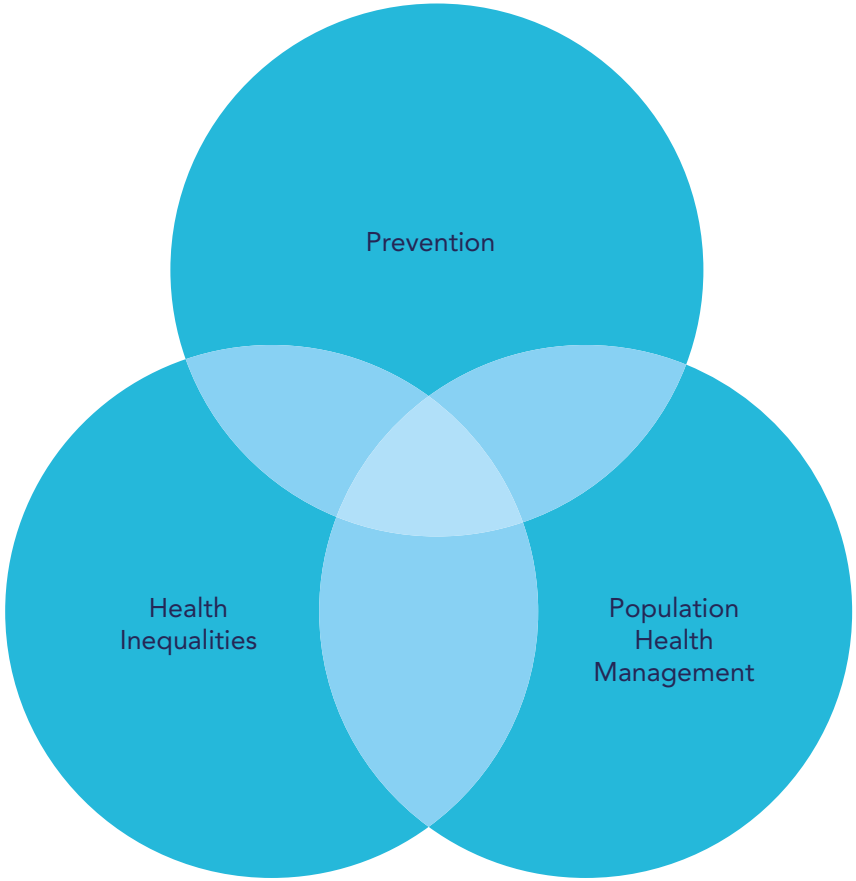


Figure 2 - PHM, Health Inequalities and Prevention

3.1 Summary of health need for Norfolk and Waveney population

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

In 2021 there were **8,750** births and **12,860** deaths

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 6 appointments), and **75.6%** of people have a positive experience of their GP practice

In June 2022 **75,000** children had visited an NHS dentist in the previous 12 months and **309,000** adults visited an NHS dentist in the previous two years

During 2021/2022

57,000 people in Norfolk and Waveney were in contact with Mental Health, Learning Difficulties or Autism services and **16,000** of these were under 18. This is over 5% of the total population and over 8% of the population under 18

A&E departments saw **298,500** attendances with **101,105** Norfolk and Waveney patients admitted as an emergency.

There were **1,285,000** hospital outpatient appointments and **165,700** hospital operations – of which **111,650** were operations for people on the waiting list

165,000 people in Norfolk and Waveney live in the 20% most deprived communities in England (known as the core20 population)

As of January 2023, **126,700** people in Norfolk and Waveney have 4 or more diagnosed long term health conditions (LTC's) (physical health and/or mental health conditions)

In terms of physical health, in 2021/2022 the number of people diagnosed with LTC's include **176,900** with high blood pressure, **70,400** with diabetes, **39,600** with heart disease, **30,200** with atrial fibrillation or a common abnormal heart rhythm, **24,400** with Chronic Obstructive Pulmonary Disease (COPD) which is a lung condition that causes breathing difficulties and **78,900** with asthma.

In terms of mental health, **10,400** people are diagnosed with a serious mental illness and **111,500** are diagnosed with depression

9,800 people are diagnosed with dementia

In 2020 across Norfolk and Waveney there were **6,580** cancers diagnosed

We know there are opportunities for longer term prevention. For example, there are estimated to be:

- more than **120,000** smokers, more than **500,000** people overweight or obese and more than **180,000** who do not exercise
- more than **89,000** people with high blood pressure that has not yet been diagnosed and managed

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

3.2 The growing population – our older population

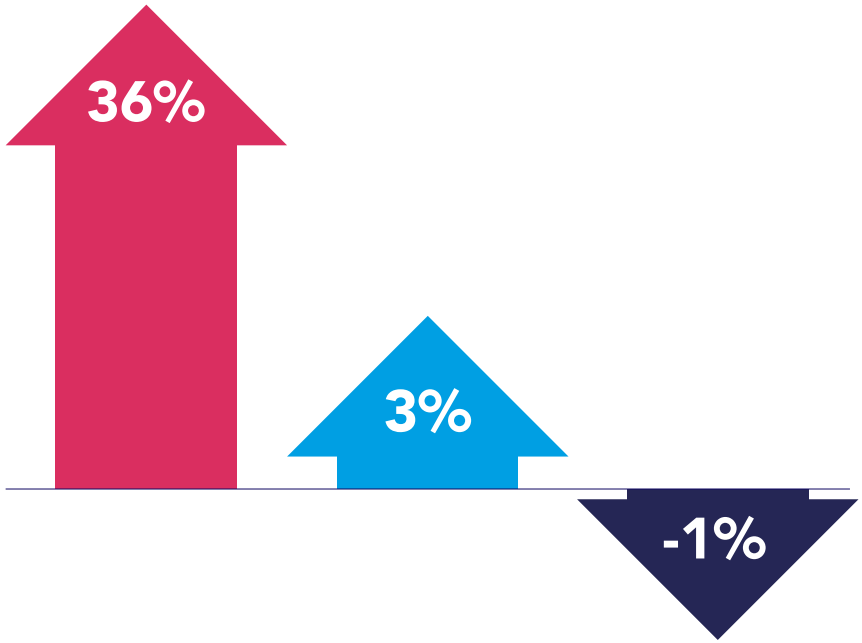
Norfolk and Waveney generally has an older population, projected to increase at a greater rate than the England average. This creates a key challenge for our health and care system and is why we have an ambition of transforming care in later life.

From 2020 to 2040 there will be an estimated:

36% increase in people aged over 65, mostly in those aged 75+

3% increase in people of working age

1% decrease in children and young people under the age of 16



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

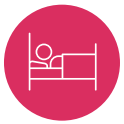
Over the next five years the population is expected to grow by more than 25,000 people, and about 20,000 will be those aged 65+. We anticipate this to continue, and by 2040 the population is likely to have increased by about 110,000 people, this is about the same as the current population of North Norfolk.

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

The demand for appointments with a GP is likely to have increased by more than a **1,000 per day**

The number of people with 4 or more LTC's which need ongoing management is likely to have increase by about **1,800 per year**

The number of people going to A&E is likely to have increased by about **900 per month**



The number of people who have to stay in hospital having arrived as an emergency is likely to have increased by about **500 per month**

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

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

3.3 We can make a change

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

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

However, there are some poor outcomes for some people at different stages along their life course (Figure 3) and we want to tackle those. For example, for children and young people a higher proportion of pregnant females smoke, and in people of working age we are seeing a reduction in the percentage of patients who have had a review for their COPD and asthma. When developing our ambitions and objectives we have carefully considered what this outcomes life course is telling us and focussed on where we need to make improvements based on the evidence.

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

Outcomes along the life course for people in Norfolk and Waveney
Source: Insight and Analytics at Norfolk County Council

Arrows represent the trend (if available)
- Green arrows represent getting better
- Yellow arrows represent staying the same
- Red arrows represent getting worse

Icon colours show how the indicator compared to the national average (if available)

Worse **No significant difference** **Better**

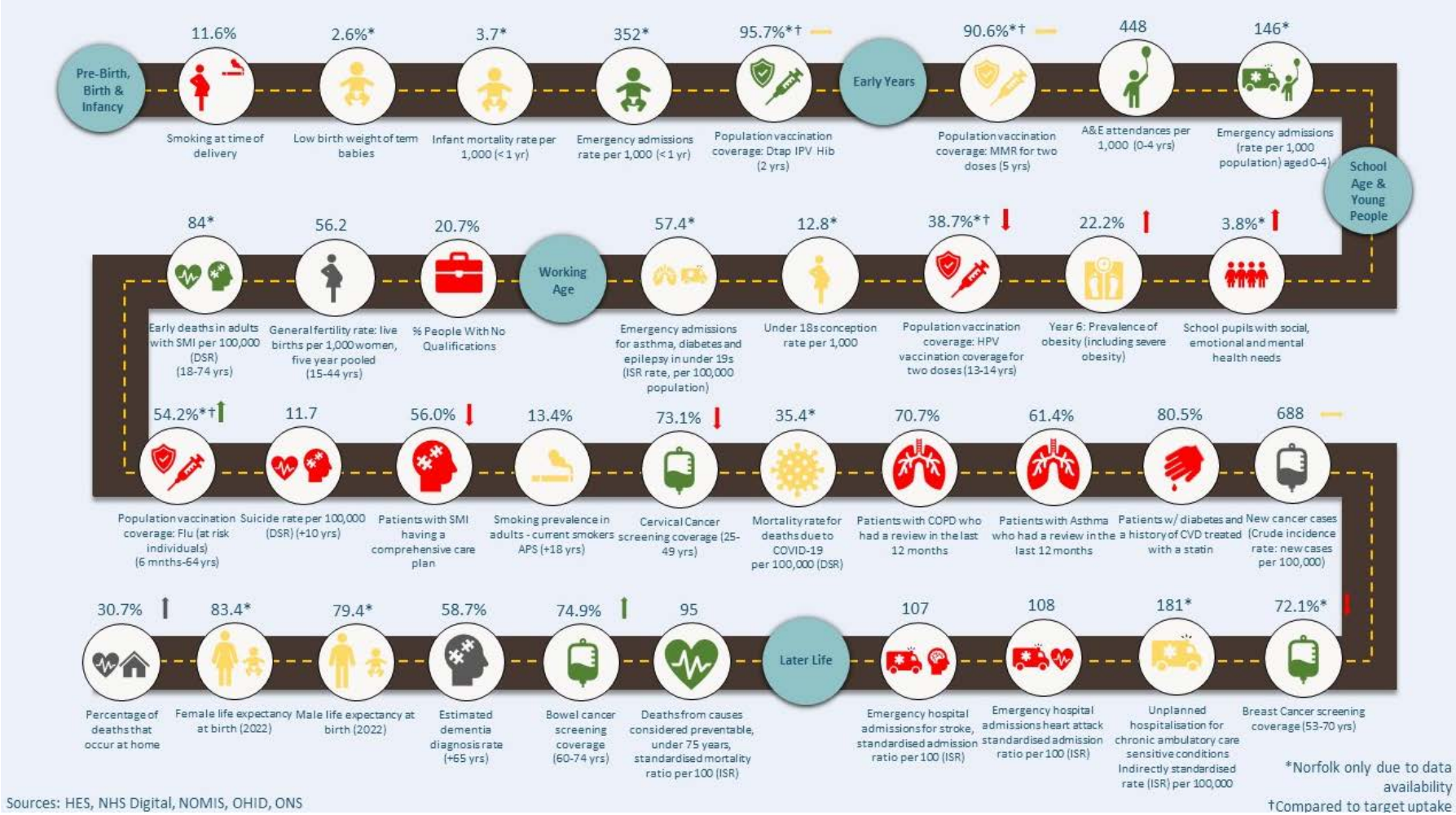


Figure 3 – Outcomes along the life course for people in Norfolk and Waveney

3.4 Health Inequalities

Aside from the conditions that people die from, the amount of disability or illness that people have varies according to where you live – that is a fact. In Norfolk and Waveney many health outcomes for people are as good or better than in England overall as a comparison, and males and females generally live longer lives in Norfolk and Waveney than the England average.

However, there are stark inequalities in outcomes for people in the 20% most deprived communities (known as "core 20"), that then accumulate over the life course. These result in poorer health outcomes and ultimately a shorter life expectancy.

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

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

(Core20 and Core20PLUS5 are explained in more detail in the legal duty to reduce health inequalities in Part 2 of the JFP, and through this link: NHS England » Core20PLUS5 – an approach to reducing healthcare inequalities).

The core 20 populations in Norfolk and Waveney are shown on the map in Figure 4 and we know that the health outcomes for the populations in our most deprived communities could be improved further. This is one of our objectives in ambition one, Population Health Management, Reducing Inequalities and Supporting Prevention.

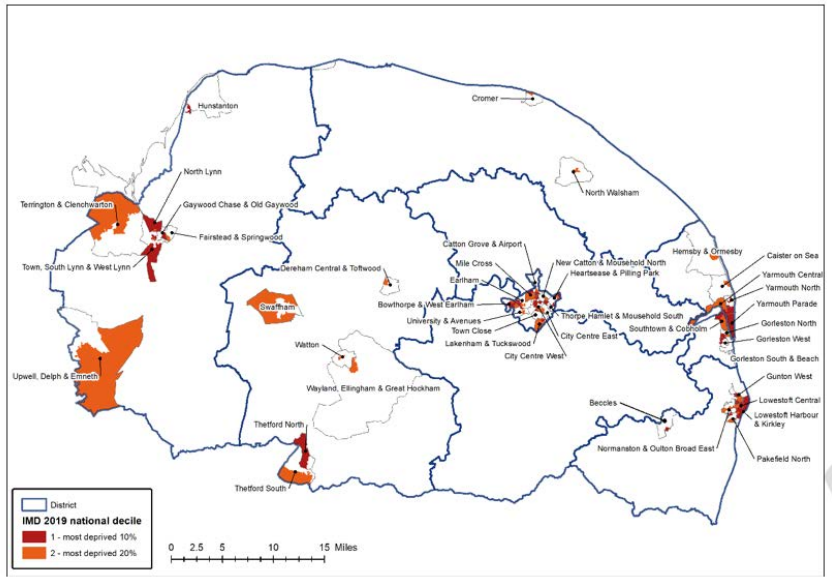


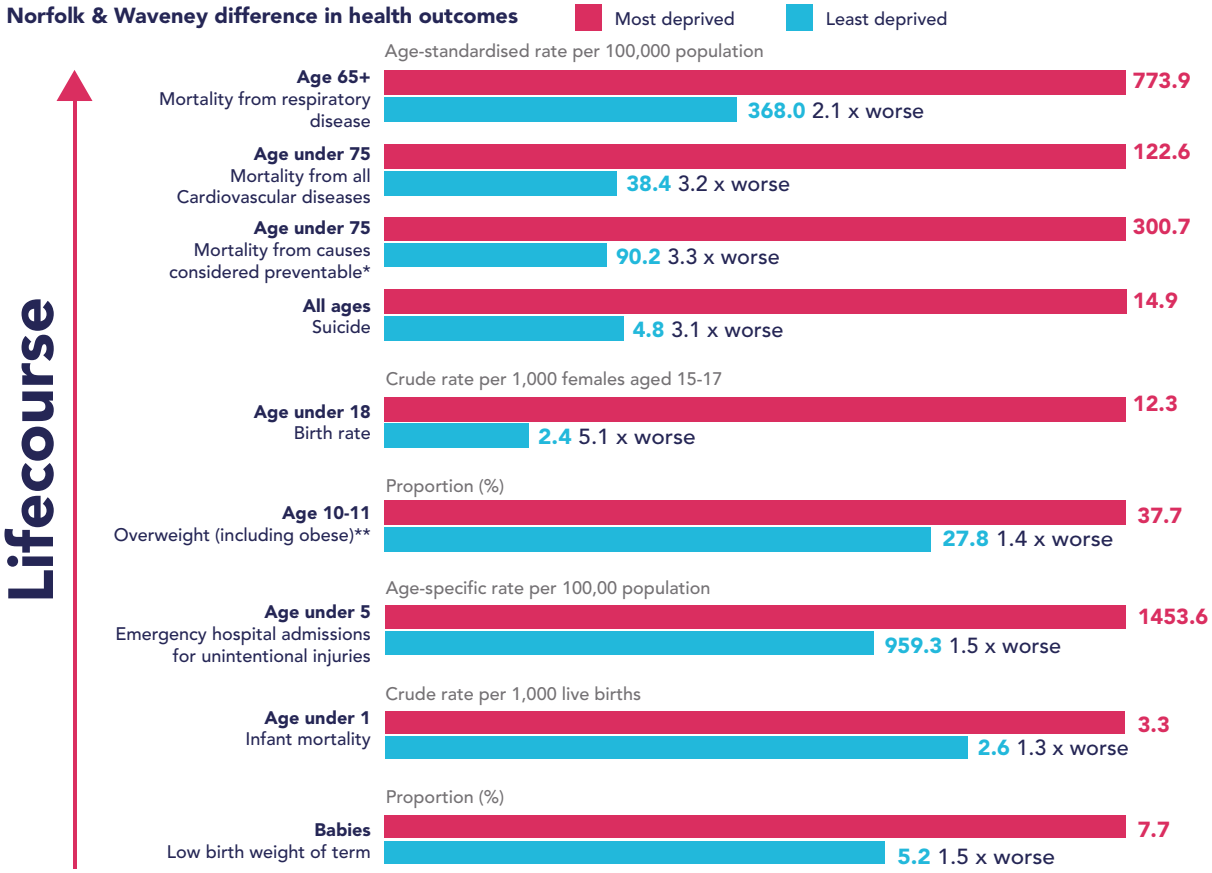
Figure 4 – "Core20" communities across Norfolk and Waveney where some or all of the residents live in the 20% most deprived areas in England according to IMD2019

Other population groups in addition to those that live in the most deprived communities are also more likely to have poor health outcomes and to die early. For example, children and young people with learning difficulties or autism and those that are looked after are more likely to experience mental health issues. According to the Norfolk Joint Strategic Needs Assessment undertaken in 2022 there is a predicted population of over 16,500 adults in Norfolk who have a learning disability, and who have an average lifespan that is over 10 years shorter than the wider population.

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

For example, Figure 5 compares the least deprived communities with the most deprived "Core20" communities:

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



Comparison between the most and least deprived 20% (quintiles) of the population Norfolk & Waveney. *Pre-2019 definition for preventable mortality. **'Age 10-11, Overweight (including obese)' compares areas within Norfolk and excludes Waveney.

Figure 5 - Inequalities in health outcomes between the least deprived and the most deprived Core20 communities in Norfolk and Waveney

The accumulation of inequalities over the life course for those in the more deprived Core20 communities has an impact on the number of years a person is likely to live.

Across Norfolk and Waveney in 2020-2021 the gap in life expectancy between the most deprived Core20 communities and the least deprived communities was 6 years and 9 months for males and 5 years and 4 months for females.

This gap is due to more deaths in the Core20 communities from heart attacks, strokes, cancer, respiratory disease and COVID-19 (Figure 6).

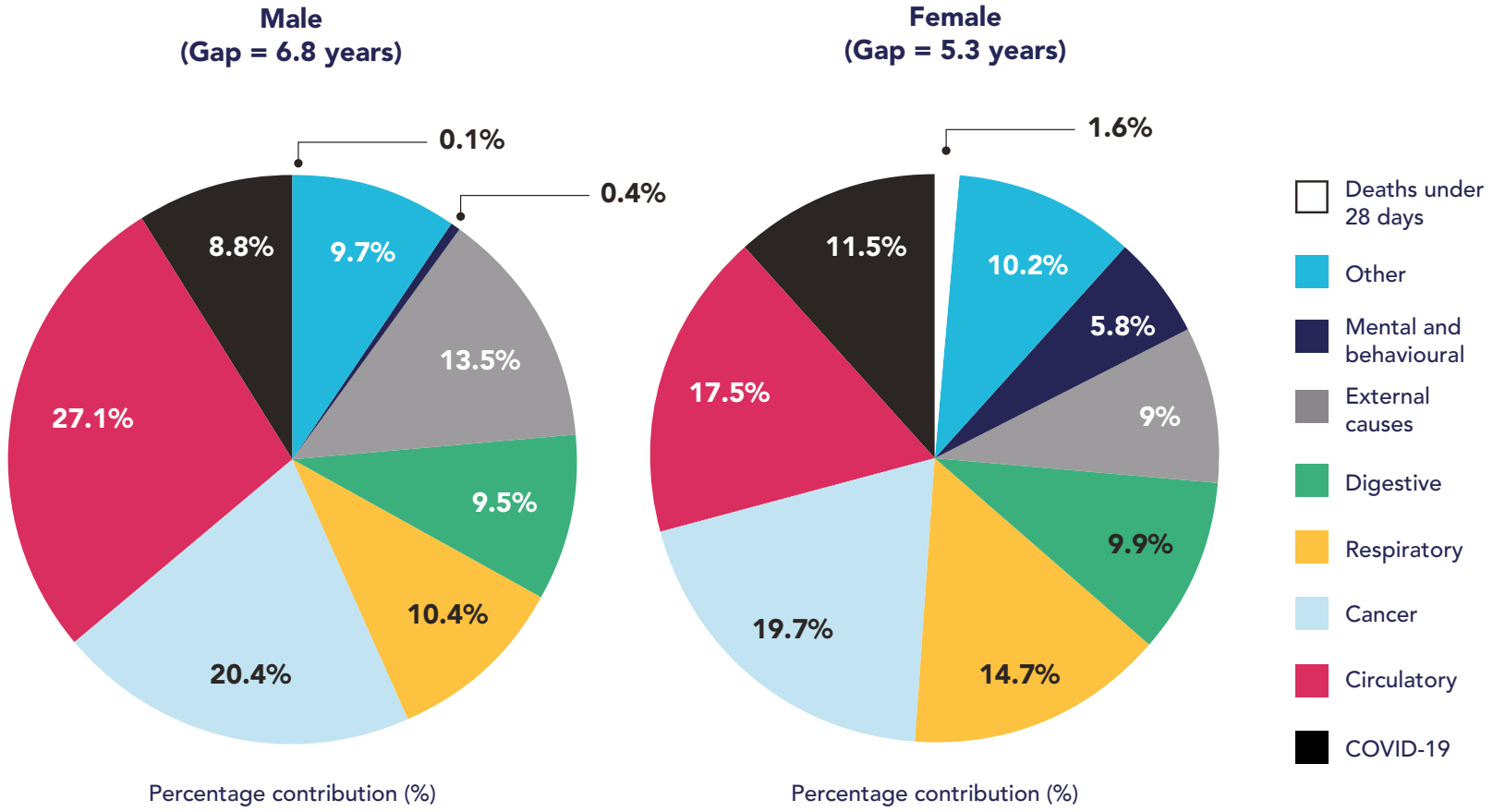


Figure 6 Breakdown of the life expectancy gap between the most and least deprived quintiles of NHS Norfolk and Waveney by cause of death, 2020 to 2021 (https://analytics.phe.gov.uk/apps/segment-tool/)

3.5 Opportunities to improve outcomes

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

Across Norfolk and Waveney just over half of all cancers are diagnosed early and while overall screening uptake is good (and this helps with earlier diagnosis), people from the core20 most deprived communities are less likely to be screened for cancer. For example, there are 46 GP practices in Norfolk and Waveney where the proportion of people screened for bowel cancer is less than the Norfolk and Waveney average. If all these practices screened at least the Norfolk and Waveney average then an additional 3,500 people would be screened for cancer. For the Core20 most deprived GP practices this is an additional 1,300 people, which is more than a third of the total.

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

There are also opportunities to improve outcomes for people with respiratory and circulatory conditions through changing health behaviours and reducing unwarranted variation in clinical care. For example, Norfolk and Waveney has a higher prevalence of COPD than England (2.3% vs. 1.9%) but has a lower proportion of COPD patients that receive a 12-month review (55% vs 60%). And there is variation across Norfolk and Waveney from practices with 10% of patients with a 12-month review to practices with over 90% of patients with a review. For circulatory conditions the Cardiovascular Disease (CVD) prevent work shows that if we were to detect and better manage 17,000 the hidden cases of high blood pressure then we would save more than 100 heart attacks and more than 150 strokes over the next three years.

Due to inequality in health behaviours, the opportunities for improving outcomes are likely to be greater in the Core20 most deprived communities. As deprivation increases the proportion of people with risky health behaviour also increases. Over the long term if we are to reduce inequality in life expectancy due to cancer, circulatory and respiratory conditions, then we will have to address health behaviours such as smoking, physical activity, obesity and diet.

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

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

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

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

There are opportunities through:

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

3.6 Public engagement on the JFP so far

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

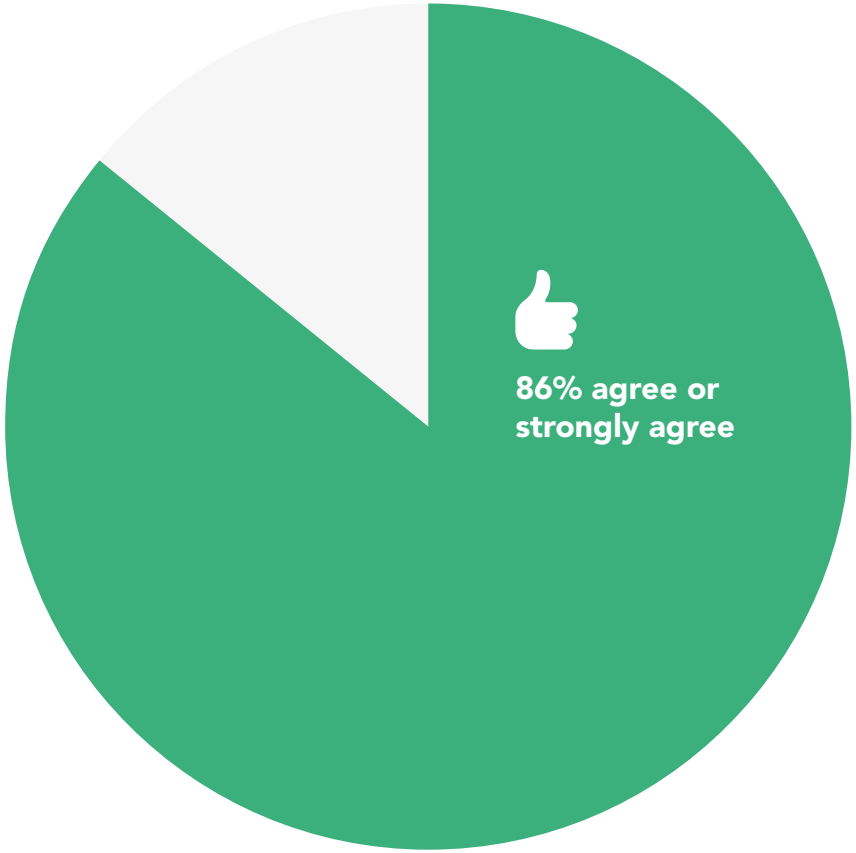
- Transforming Mental Health services
- Improving Urgent and Emergency Care
- Elective Recovery and Improvement
- Primary Care Resilience and Transformation
- Improving Productivity and Efficiency

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

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

Our online survey received 700 responses in total.

505 people out of 585 who responded (just over 86%) strongly agree or agree that we have chosen the right priorities.

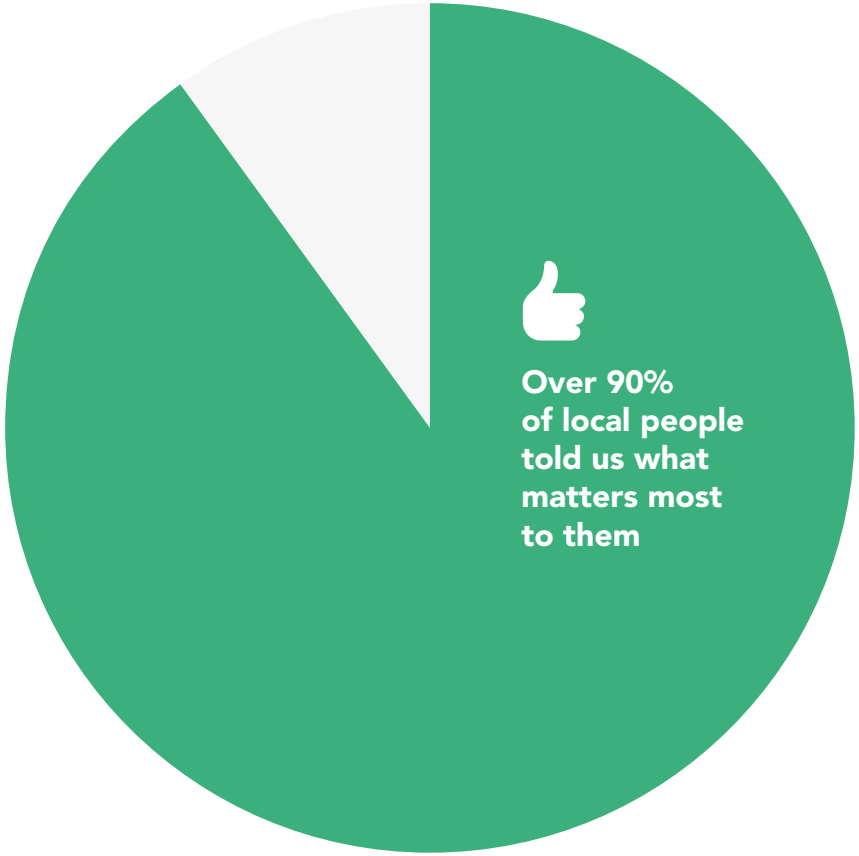


249 people also left free text comments

For example:

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

537 people out of 592 who completed surveys (just over 90%) responded to What matters most to you?



Many of the points were made again, but other issues raised include:

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

You can read the full report, including examples of the comments people made, on our dedicated webpage: Joint Forward Plan

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

Case Study

I-statements – working with our experts by experience

Through a series of workshops and discussions with Experts by Experience, facilitated by Rethink Mental Illness and NHS Norfolk and Waveney's Mental Health programme team, a set of I-Statements, tailored to Community Transformation (CT) were developed during 2022-23.

We are now taking steps to ensure service provision is aligned with the I-Statements. A project is now being planned to develop an outcomes-based commissioning approach, building on this work.

An expert by experience said: "Working with NHS Norfolk and Waveney and the wider Norfolk and Waveney ICS has really helped bring the views and experiences of people who have experienced mental ill health.

"This is a fresh, new innovative approach which is valuing the views and experiences of people with lived experience."

4.0 Our ambitions for improvement

4.0 **Our ambitions for improvement**

4.1 2024/2025 immediate priorities

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

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

Each year the NHS is asked to produce an operational plan detailing the activity levels, performance standards, workforce numbers and financial plans for the next 12 months. Each of these elements are triangulated to ensure consistency, for example that an increase in activity is supported by an increase in staffing, which in turn is included in the financial projections. These plans are developed together as a system, working in partnership to achieve the required aims and ambitions expected in the awaited Operational Planning Guidance 2024/25.

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

- Improving the flow of urgent and emergency care patients in to and out of our services. We have said we would improve our discharge pathways through increasing the number of virtual ward services for example. This in turn will reduce the length of stay in hospital, bed occupancy, and enable the emergency department to see at least 77% of patients within 4 hours; allowing ambulances to be released to respond to category 2 calls in the community.
- Continue to reduce the number of people waiting for diagnostics and elective care. During the year the plan is to reduce the number of people waiting over 65 weeks for elective care by over 8,000. This and future reductions in waiting times will be achieved by working more closely together, reducing waiting times for diagnostics using technology. The system is working together to improve faster diagnostic times for cancer patients towards meeting the 77% target by March 2025. For those requiring treatment, the ambition is for 70% of patients to receive treatment within 62 days.
- Increased capacity for people of all ages to access mental health services earlier, such as Psychological Therapies and specialist community perinatal services. To manage care closer to home by reducing out of area placements.
- Continue to address health inequalities and improve prevention services. For adults this is maternity continuity of care, severe mental health checks, respiratory conditions, early cancer diagnosis and case finding and treating high blood pressure. For children and young people, the focus will be on asthma, diabetes, epilepsy, oral health and mental health.
- Continue to support people living with learning disabilities and/or autism through the number of annual health checks and health action plans being delivered by Primary Care for people with a learning disability. Improve the adult autism diagnostic offer and reduce waiting times. Provide timely support for neurodiverse children and young people. Build alternative care and support community models across the system to help prevent avoidable admissions to inpatient hospital services.

Commissioning of Specialised Services

From April 2024 the six ICB's in the east of England are coming together to commission what are called 'specialised services', legally taking on the delegated responsibility for these from NHS England with support from the existing staff. The rationale for delegating the commissioning is to enable population based, end-to-end commissioning of services with decisions made closer to communities, and care provision is better joined up for the benefit of the local population.

Specialised services are typically (but not exclusively) those that fewer numbers of the population need to access as they are for more complex care. Some of them are provided locally but some are in specialist hospitals such as Great Ormond Street, Papworth or Moorfields for example. The ICB took on responsibility for commissioning pharmaceutical, ophthalmic and dentistry services in 2023 and these additional 59 specialised services follow the roadmap of delegation, with more services expected to follow in future years. 2024/25 will be a transition year but the six ICB's and partners are working together to develop a work plan and longer term strategy for the eastern region which is consistent with the JFP's that each ICB has published. Clinical input into the re-design of services within the existing available budgets will be key.

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

4.2 Our eight longer-term ambitions for improvement

The 2024/2025 immediate priorities are not quick fixes and so feed into the longer-term ambitions. Our eight ambitions are evidence based and consistent with what we heard from our public engagement, with a clear focus on planning ahead to make improvements and to get ahead of the curve with prevention. We have also looked at our local population across the course of an entire lifetime, from conception to end of life, to examine outcomes to inform where improvements could be made.

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

As system partners we all want to use this plan because it identifies common ambitions that we can all support and will help us to drive forward improvements together. This is why we have purposely selected and made a commitment to a number of achievable, measurable and impactful improvements, presented in this section as objectives, linked to each of the eight ambitions.

These objectives have been developed in response to what our data tells us, and they require a collaborative system-wide approach to successfully deliver them. Some of the objectives commit to doing more work to develop key strategies, such as for Population Health Management (PHM), Health Inequalities and for people in later life. Others are much more specific projects with defined and measurable outcomes in the shorter term.

We will refresh this JFP annually, with the next version ready for April 2025, and ensure our objectives remain current and focused on what we need to deliver. A summary of the eight ambitions and 21 underpinning objectives is set out in Figure 7.

Joint Forward Plan eight Ambitions and underpinning objectives

Ambition	Ambition Objective
1	**PHM, Reducing Inequalities & Supporting Prevention**
1a	Development and delivery of two strategic pieces of work: A Norfolk and Waveney Health Inequalities Strategic Framework for Action; and a Population Health Management Strategy
1b	Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people
1c	Early Cancer Diagnosis – Targeted Lung Health Check Programme
1d	Cardiovascular disease Prevention – develop a programme of population health management interventions targeting High Blood Pressure and Cholesterol
2	**Primary Care Resilience & Transformation**
2a	Developing our vision for providing accessible enhanced primary care services, improving patient outcomes and experience
2b	Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years.
3	**Improving Services for Babies, Children, Young People (BCYP) and developing our Local Maternity and Neonatal System (LMNS)**
3a	Successful implementation of Norfolk's Start for Life (SfL) and Family Hubs (FH) approach
3b	Continued development of our Local Maternity and Neonatal System (LMNS), including the Three Year Maternity Delivery Plan
3c	Implementation of asthma and epilepsy recommendations, for Children and Young People
3d	Develop an improved and appropriate offer for Children's Occupational Therapy
4	**Transforming Mental Health Services**
4a	We will work together to increase awareness of mental health; enable our population to develop skills and knowledge to support wellbeing and improve mental health; and deliver a refreshed suicide prevention strategy. This will prompt early intervention and prevention for people of all ages, including those who experience inequalities or challenges to their mental health and wellbeing.
4b	Mobilise an adult mental health collaborative and a children and young people's collaborative so that partners work as one to deliver better health outcomes for our people and communities
4c	Establish a Children and Young People's (0-25 years) Emotional Wellbeing and Mental Health 'integrated front door' so all requests for advice, guidance and help are accepted, and the appropriate level of support is given to ensure that needs are met.
4d	We will see the whole person for who they are, developing pathways that support engagement, treatment and promote recovery for people living with multiple and complex needs, with a focus on dual diagnosis and Complex Emotional Needs (CEN).
5	**Transforming Care In later life**
5a	To have health, carer and support services that are fit for our ageing population - supporting people as they age, to lead longer, healthier, happier lives
6	**Improving UEC**
6a	Improve emergency ambulance repsonse times and ensure patients are seen more quickly in the Emergency Departments
6b	Expand virtual ward services as an alternative to an inpatient stay
6c	Delivery of the RightCareNoW programme to reduce length of stay (LoS) in hospitals
7	**Elective Recovery & Improvement**
7a	Effectively utilise capacity across all Health System Partners
7b	Implement digital technology to enable elective recovery
8	**Improving Productivity and Efficiency**
8a	Improve the services we provide by enhancing productivity and value for money, and delivering services together where it makes sense to do so.

Figure 7 – summary of the eight ambitions and 21 underpinning objectives

Case Study

Wellbeing hubs putting mental health front and centre of the community

Wellbeing hubs across Norfolk and Waveney are breaking down barriers and putting mental health front and centre of the community.

Dr Ardyn Ross, Mental Health Clinical Lead for NHS Norfolk and Waveney said: "Having community wellbeing hubs where people can drop in, without an appointment, to discuss their health and wellbeing and any issues that are affecting their mental health is invaluable in removing the stigma around mental health.
"After all we all have mental health – sometimes it's good and sometimes we need support with it to stay well."

The fifth NHS-funded hub - REST Aylsham opened in July 2022 – joining REST Norwich and Kings Lynn and Steam House Café Gorleston and Kings Lynn.

The wellbeing hubs may be branded differently but they all have one thing in common – they're a safe space for people to get support for their mental health and wellbeing in their community. Including people experiencing significant mental distress.

With a focus on wellness, not illness, there's always a warm welcome and supportive staff to offer help, advice, or a listening ear.

The Steam House Café in Gorleston – run by Access Community Trust has been a lifesaver for Lynn White. She says: "I have a mental health problem and the staff here are absolutely brilliant. I come every day and they listen, and they are so kind and helpful. If you come in and just want to chat, you can.

"If it wasn't for this place, I'm not sure I would have coped with my health. I have dissociative disorder and I do have bad attacks and they know what to do if I have one. It's so relaxed and a perfect place to come."

Ambition 1: Population Health Management (PHM), Reducing Inequalities and Supporting Prevention

Ambition 1: Population Health Management (PHM), Reducing Inequalities and Supporting Prevention

Tracy Williams
Queens Nurse
Honorary Fellow Faculty Homeless and Inclusion Health
Norfolk and Waveney ICB Clinical Lead for:
Health Inequalities & Inclusion Health
Norwich locality Adviser

Suzanne Meredith
Associate Director Population Health Management
Deputy Director of Public Health, Norfolk County Council

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

Our objectives

a) Development and delivery of two strategic pieces of work:

- A Norfolk and Waveney Health Inequalities Strategic Framework for Action; and
- A Population Health Management Strategy

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

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

c) Early Cancer Diagnosis – Targeted Lung Health Check Programme

d) Cardiovascular disease (CVD) Prevention

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

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

Why we chose these objectives
We will be aspiring to a reduction in the differences in outcomes we currently experience. We have identified initial Population Health Management priorities at a system level to address health inequalities and meet the Core20PLUS5 priorities, which will have the greatest impact and where we know there are opportunities to improve. These are smoking, especially smoking in Pregnancy, Serious Mental Illness, Cardiovascular disease, diabetes and respiratory, early cancer diagnosis and children and young people. We will also be seeking to prioritise prevention activities, particularly relating to smoking, alcohol, diet and physical activity and uptake of cancer screening and immunisations.

Objective 1a Development and delivery of two strategic pieces of work to support prevention: A Norfolk and Waveney Health Inequalities (HI) Strategic Framework for Action and a Population Health Management (PHM) Strategy

What are we going to do?
Last year, we developed a Health inequalities strategic framework for action and a population health management strategy. This year we will deliver against these two strategic pieces of work. These will ensure we are clear on our priorities for targeting resources and that we are working on agreed priorities for Health Inequalities and PHM together, across the Integrated Care System. The action we have planned to reduce Health Inequalities is in the form of an overarching framework for Norfolk and Waveney, and PHM is a way of working or enabler that will support the delivery of all our plans in Norfolk and Waveney, not just Health Inequalities.

Deliver a Health Inequalities strategic framework for Action, as a first step towards a whole system approach to reducing inequalities. The framework is focussed around three key building blocks and work to create a strong foundation in the form of conditions for success. These include wider factors that impact on health and well-being such as housing and the environment we live in, lifestyle and healthcare.

Deliver a Population Health Management strategy, to proactively use joined up data and to put in place targeted support to deliver improvements in health and wellbeing. The strategy identifies five initial PHM priorities and includes plans for how we will be using data, building a PHM cycle of improvement into our work. Our approach to delivering the improvement will be at both system and at place / neighbourhood level.

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

How are we going to do it?
By working together and getting behind the priorities that have been collectively agreed by system partners and our local communities for Health Inequalities and PHM. We will be using joined up data to proactively identify prevention opportunities and groups of people who would benefit most from targeted health and care interventions.

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

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

How are we going to afford to do this?
Resources may be needed to support ongoing projects, on an invest to save basis – each project to be considered on its own merits and evaluated. Some national funding is allocated to the ICS to support the delivery of the Core 20 plus 5 priorities.

What are the key dates for delivery?

Year 1 April 2024 – Sep 2024

- Action plans developed with SMART objectives, milestones and trajectories

Year 1 Oct 2024 – March 2025

- Implementation of the action plans, reflection and review, establish reporting and refresh for next year based on outcomes.

Year 2 April 2025 – March 2026

- Updated as required, and continue with delivery plans and monitoring of achievement against objectives. milestones and trajectories.

Year 3 April 2026 – March 2027

- Continued focus on reducing Health Inequalities based on the data and insights in respect of outcomes and population experiences, extending our PHM approach and a re-set of objectives, milestones and trajectories

Year 4 April 2027 – March 2028

- A continued and targeted focus on reducing Health Inequalities and reflection and continued focus on using PHM to drive improvement across the system and inform where we focus our effort.

Year 5 April 2028 – March 2029

- Review and refresh both strategic documents for the future, with refreshed objectives and trajectories.

How will we know we are achieving our objective?

Publication of action plans to reduce health inequalities and develop our PHM approach over the next 5-10 years and the improvement we expect to see.

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

Objective 1b Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people.

What are we going to do?
Stopping smoking is a preventative approach to improving health for all, especially in pregnancy.

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

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

How are we going to do it?

- The NHS will work together with local authorities, service users and others through our Tobacco Dependency Clinical Programme Board, Tobacco Control Alliances and the Health Improvement Transformation Group to plan how we can best make use of our shared resources and how support should be rolled out.

- We will focus on health inequalities ensuring that we understand access by population subgroups (such as age, ethnicity and deprivation) to ensure equity of access.

- We will work with the VCSE around wider issues like income, cost of living and mental wellbeing that could be linked to smoking choices.

How are we going to afford to do this?
National NHS funding has been provided to help us roll out NHS tobacco support in Norfolk and Waveney. We are expecting this funding to be made available every year, though this is yet to be formally confirmed by NHS England.

We are also working closely with local authority Public Health teams who are providing significant support to help with the delivery of NHS smoking in pregnancy services, including help with staff training, access to Nicotine Replacement Therapy and vapes, quit support for partners and other people living with service users, and the provision of incentive schemes.

What are the key dates for delivery?

Year 1 April 2024 – Sep 2024

- Ensure service is embedded and established and that the care offered is effective and meets the needs of the population
- Build on hearing the service users' voice - develop information resources for service users in line with results of the Maternity and Neonatal Voice Partnerships survey and the Community Voices smoking project, which has gathered learning from local people about things that help or hinder them from stopping smoking.
- Ensure information is being collected and reported to key stakeholders about how well the service is performing and to help make continuous improvement.

Year 1 Oct 2024 – March 2025

- Roll out smoking in pregnancy incentive scheme in line with learning from any previous pilots and in alignment of further announcements from the Department of Health and Social Care.
- Explore with Public Health opportunities for providing free vapes to service users through the national 'Swap to Stop' scheme and to promote smokefree homes by working with partners and family members

Year 2 April 2025 – Sep 2026

- Ensure service user voice informs a review of how the services are working
- Working with Public Health and other partners, review longer-term support available in the community after the baby is born.
- Work with local authority and VCSE through partnerships at local community level to ensure good access to wider community support e.g. social prescribers and peer support groups
- Explore opportunities for the use of technology to improve the support to pregnant smokers and their wider families.

Year 3 April 2026 – March 2027

- Explore opportunities to enhance joined up working e.g. between tobacco advisers, antenatal teams and mental health support for women with perinatal mental health conditions.

Years 4 and 5 April 2027 – March 2029

- This objective will be retired at the end of Year 3 as the maternity tobacco dependency service becomes fully established and will continue to be delivered as 'business as usual' and monitored along with other core maternity care, using the Maternity and Neonatal Safety Improvement Programme to ensure we continue to improve.

How will we know we are achieving our objective?

We will begin to see our approach is working because we will begin to be able to measure a reduction in the percentage of women in Norfolk and Waveney who are smoking at time of delivery.

Data for Norfolk and Waveney from December 2022 shows that 12% of mothers were smoking at time of delivery.

We aim to see this reduce over the next two years, by March 2026, towards the regional and national average of 9% and to reduce further to 6% by the end of March 2028.

Ultimately, the national ambition, which we share for Norfolk and Waveney, is to become 'smoke-free' by 2030 – achieved when adult smoking prevalence falls to 5% or less.

Objective 1c Early Cancer Diagnosis – Targeted Lung Health Check programme

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

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

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

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

How are we going to do it?

- As the programme is rolled out across Norfolk and Waveney, we will use a place-based local approach to support its promotion.
- Eligible individuals will be invited to a Lung Health Check appointment. At the Lung Heath Check a risk assessment will be undertaken which will identify if the patient is at a higher risk of Lung cancer. If the participant is considered to be at high risk of lung cancer, they will be referred for a Low Dose CT scan, provided as close as possible to home. If the scan results come back with signs of anything of concern, the participant will be contacted with further information and referred for further tests and treatment. Most of the time no issue is found, but if a cancer or other issue with participant's breathing or lungs is found early, treatment could be simpler and more successful.

How are we going to afford to do this?

- The TLHC programme is funded by the National Cancer Action Team, and this is expected to continue until the system achieves 100% roll out to the baseline population in March 2029. After this it is expected that the programme will become part of the recently announced National Lung cancer screening programme.

What are the key dates for delivery?

Year 1 April 2024 to March 2025

- Continue to deliver TLHC to the Great Yarmouth and Lowestoft populations.
- Commence 24-month follow-up scanning of the Great Yarmouth population from November 2024
- Develop an engagement plan working with Community Voices to improve uptake in the Great Yarmouth and Waveney area
- Finalise modelling/planning for roll out to Central Norfolk and West Norfolk. By April 2024 we will have confirmed who will be delivering TLHC to the rest of Norfolk and Waveney in 2024/25.
- Commence delivery to wider Norfolk and Waveney eligible population September 2024. The initial target will be our Core 20 areas of highest deprivation.

Year 2 April 2025 – March 2026

- We will finish delivering lung health checks to all individuals in Great Yarmouth and Waveney who are in the initial target audience for the programme.
- Continue with follow up scans for individuals at high risk of lung cancer, every 24 months until they reach the age of 75
- Subject to capacity, commence invites for patients who have reached the age of 55 and review the risk assessment of previously lower risk patients. Risk can change over time due to increased age and changes in an individual's life (e.g. start smoking again)
- Continue roll out to the remaining 'ever smoked' group across Norfolk and Waveney focusing initially on areas of higher deprivation.

Years 3, 4 and 5 April 2026 – March 2029

- Continue expansion to the remaining 'ever smoked' populations in Norfolk and Waveney, including invitation of patients who reach the age of 55, and continue with 24 month follow up scanning.
- The national target is to cover the whole eligible baseline population of approximately 136,000 individuals by the end of 2028/29.

How will we know we are achieving our objective?

Proposed % of Uptake of Lung Health Checks for 2024/25(*):

	Baseline Position	Q1	Q2	Q3	By Q4
Uptake (%) of Lung Health Checks	35% at the start of the programme	40%	40%	40%	45%

(*) the national target for 2024/5 is take-up of 53%, however the most recent uptake rate nationally is 44%, which is an increase of 3% in the previous 12 months.

For context against the national picture, Great Yarmouth and Waveney take-up is approximately 35%. We will be working with the local council and community organisations on targeted engagement strategies and wider communication to improve uptake.

Invitations and uptake will fluctuate between the quarters due to batch invitation processes and delays for some participants between invites and lung health checks. Uptake will also be impacted in Q3 when the roll out is mobilised because there will be a time lag between invitations being sent and Lung Health Checks taking place.

Objective 1d: Cardiovascular Disease (CVD) Prevention – develop a programme of population health management interventions targeting High Blood Pressure and Cholesterol

Early detection of cardiovascular disease forms a preventative approach to improving health of those at risk of developing the disease.

What are we going to do?
We will provide all Norfolk and Waveney Primary Care Networks (PCNs) with real time data on their patients who have:

1) A diagnosis of CVD; or at high risk of CVD, and

2) Risk-stratify these patients, to help Practices treat those at greatest need.

This will allow action to be taken early to prevent and reduce the negative outcomes of unmanaged CVD.

In addition, we will be running a PHM project and contacting patients identified through the above case finding tool, assisting Practices in promoting CVD Prevention, and helping to reach those patients who most need intervention.

How are we going to do it?
We will be using a national audit tool called "CVD PREVENT" to benchmark our system. The Eclipse platform will be utilised to risk-stratify and identify specific patients on practice systems. The Eclipse system has been updated to case find patients based on the same categories used in the national CVD PREVENT audits.

Our PHM Team will engage with practices identified as needing support and will contact patients to seek to get them to see their relevant health professional or point them to services that can help with lifestyle changes that promote better cardiovascular health.

Local engagement will be a key component of the CVD prevention objective. Each place has different demographics and challenges, and VCSE partners. Their engagement will be key in supporting PCNs to achieve our targets.

We will scope how Primary and Community Care services could work together to prevent CVD. Given that this objective focuses on the desire to prevent CVD before community services input is required, the greater scope will be for Primary care working with other ICS VCSE partners.

We will evaluate our findings using the audit tool and as part of our Population Health management programme evaluation. As CVD PREVENT is updated on a Quarterly basis, progress can be monitored very closely.

How are we going to afford to do this?
Funding has been secured via Health Innovation East to support the project. Further funding is available via Suffolk Public Health to promote lifestyle interventions in the GYW area. There are links with Primary Care funding and Quality Outcomes Framework funding.

What are the key dates for delivery?

Year 1 April 2024 – Sep 2024

- Delivery to commence through sharing of Eclipse monitoring tool for CVD with Primary Care. GP Practices enabled to commence real-time monitoring and risk-stratification of identified patients with a diagnosis of CVD or at higher risk of developing CVD.

Year 1 Oct 2024 – March 2025

- ICB PHM Team and Planned Care team to support GP Practices with patient contacts and signposting to support services. Year one evaluation to be undertaken.

Year 2 April 2025 – March 2026

- Metrics in CVD PREVENT domains should see Norfolk and Waveney in the top quartile for prevention and management of Atrial Fibrillation, Hypertension, and Cholesterol.

Year 3 April 2026 - March 2027

- Second evaluation and further PHM team support if required.

Year 4 April 2027 – March 2028

- Further evaluation or it may be that this objective can then be retired and moved into business as usual.

Year 5 April 2029 – March 2030

- Continued monitoring of progress and support for GP practices where need identified but this becomes business as usual.

How will we know we are achieving our objective?

In the first 6 months, we will gather all relevant baseline data and complete the creation of our patient-specific reporting tools for Primary Care. We expect to see more patients with high blood pressure identified and treated and those who would benefit treated on low intensity statins – This data will be readily available on the next quarterly CVD PREVENT Audit. We aim for a 5% improvement in each of these hypertension metrics 6 months after these reporting tools have gone live.

In the longer term we would expect to see reduction in inequalities in terms of early mortality, reduction in admissions related to CVD related events. Data will be available via CVD PREVENT and via the Model Health system for trajectory tracking. Tangible targets for reduction will follow national NHSE operational planning guidance which will be adopted once made available each year.

Ambition 2: Primary Care Resilience & Transformation

Ambition 2: Primary Care Resilience & Transformation

Dr Jeanine Smirl
N&W ICB clinical lead for primary care

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

Our objectives

a) Developing our vision for providing accessible enhanced primary care services, improving patient outcomes and experience.

b) Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years.

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

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

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

NHS England published the Delivery plan for recovering access to primary care in 2023 which focuses on the need to streamline access to care and advice, reducing the number of people struggling to contact their practice and so that patients know how their request will be managed, on the day they contact their practice. The plan also outlines the ambition for expanding community pharmacy services to make them the first port of call for minor common conditions, supporting better integration in line with the vision set out in the Fuller stocktake report. Objective 2a includes our plans to implement this, and it's called Pharmacy First.

Objective 2a Developing our vision for providing accessible enhanced primary care services, improving patient outcomes and experience

What are we going to do?
We will agree principles and develop an **overarching vision for those receiving, delivering or planning primary care services** across Norfolk and Waveney over the next five years.

Principles will reflect our commitments to using population health data and the goal of access to holistic and joined up care for all.

The shared vision will underpin **long-term plans for dentistry**, due to be published in April 2024 (there is more detail in Objective 2b), **community pharmacy and general practice** due to be published during 2024/25 **together with optometry (eye services)** during 2025/26

Long term plans will be developed, together with key stakeholders, and will describe our approach to supporting resilience and enabling transformation to make sure:

- those who need care understand how they can access what they need, when they need it within their local community
- those delivering care can respond to the ongoing challenges and demands they face, as part of a wider primary care family within their local communities
- those planning care do so in a way that enables everyone to play a meaningful role in accessing and providing sustainable services across primary care - the front door of our NHS

A **model of care framework** will be agreed to support partners who work locally at place level to consider and test new ways of organising and delivering healthcare together to meet the needs of their local population. The framework will be designed to highlight inter-dependencies and commitments within other strategies, and map activities across all primary care long term plans to support detailed, locally owned plans for achieving better outcomes through an **integrated approach at neighbourhood level.** Joining things up and doing them together so we do them once is a key opportunity.

The model of care framework will set out our approach to **Integrated Neighbourhood Working** and support a localised approach to building **integrated neighbourhood teams**. The framework will bring together key enablers for delivery, such as the use of digital tools, remote monitoring equipment, shared use of buildings, etc.

We will embed and grow **Pharmacy First Services** launched on 31st January 2024, the national initiative to enable community pharmacies to provide treatment, if required, **for seven common conditions** (sinusitis, sore throat, earache, infected insect bite, impetigo, shingles and uncomplicated urinary tract infections in women)

How are we going to do it?
We will engage with those who receive, provide and plan primary care to agree principles and develop an overarching vision for primary care by:

- Using existing data and research (including but not limited to patient feedback, workforce surveys, population health data)
- Engaging with key stakeholders for their views

The development of long term plans will reflect:

- the use of available data to understand and prioritise population need
- meaningful engagement with professionals and providers to understand the challenges they face and the enablers required to address them
- listening to service users about access and experience
- the views of wider partners on working with primary care to positively address the wider determinants of health and health inequalities
- opportunities for working at scale, workforce recruitment and retention, shared systems and processes and a collective approach to estates

We will take the learning from the **Community Services Review (CSR)** to develop of a model of care framework, to support local development of Integrated Neighbourhood Teams and the evolution of Primary Care Networks. A key part of the CSR includes looking at how we integrate the work of our community providers with social care, primary care, council services, public health and voluntary, community and social enterprise (VCSE) sector groups and also incorporates local initiatives designed to test how teams can work together more closely to deliver care on the ground.

A key pillar for primary care integration and improving access is the national Pharmacy First Scheme, introduced at the end of January 2024.

Through our Community Pharmacy Primary Care Network roles we will look to strengthen working relationships between community pharmacy and general practice and streamline processes to provide a better experience for people accessing Pharmacy First services.

How are we going to afford to do this?
We will use existing funding allocations to commission outcome-based services with flexibility to deliver against agreed priorities, including targeted support for identified population needs and working at scale.

What are the key dates for delivery?

- **Year 1 April 2024 – March 2025**
  - Agree principles for overarching primary care vision
  - Work with key stakeholders to agree and publish long term plans for community pharmacy, dentistry (see objective 2b for dentistry) and general practice
  - Agree strategic framework to support integrated working by Place Partners
  - Integrate and maximise Pharmacy First
- **Years 2 to 4 April 2025 – March 2028**
  - Start delivery against long term plan to improve access to dentistry services during April 2025 (see objective 2b)
  - Start delivery to achieve ambitions set out in long term plans for community pharmacy and general practice by April 2026
  - Agree and publish a long term plan for optometry by March 2026
  - Start delivery against plans to achieve agreed optometry ambitions by April 2026

This objective will be refreshed for Year 5 or sooner, and may be retired or replaced based on current priorities at that time.

How will we know we are achieving our objective?
We will have a rolling programme of targeted actions to respond to people's experience of poor access to primary care services

We will use feedback to understand any increased awareness and confidence in use of digital tools across primary care and our communities (e.g. NHS App)

We will have a roadmap for protecting the provision of core primary care services locally as they are now, whilst supporting a transition to a more sustainable integrated neighbourhood model of care

Objective 2b Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years

What are we going to do?
Publication of our Norfolk and Waveney Short Term Dental plan in September 2023 was about addressing immediate priorities such as being able to access an Urgent Treatment Service, and stabilising services through workforce recruitment and retention schemes. You can read the Short Term Plan here. We are now well on the way to developing a follow-on Long Term Dental Plan and taking steps to make improvements, but there is much to do and this will take a number of years.

The Long-Term Plan will set out what we plan to prioritise over the next two years from April 2024 onwards, and then outline our aims and a more strategic piece of work over the next three years. This will enable us to develop a dental strategy, as part of the wider primary care strategy which is referenced in Objective 2a.

The Long-Term Plan has some key programmes of work:

1. Develop capacity in our dental teams through our workforce
2. Improve access for everyone, but with an initial priority on children and young people and those individuals and patient groups with greatest need
3. Promote good oral health, in our population overall but especially in children and young people

NHS England published the national Dental Recovery Plan in February 2024 setting out key proposals for implementation during 2024/2025. We will implement the Plan for our local population, working with system partners.

The Long-Term Plan and the national Dental Recovery Plan work will be co-ordinated and undertaken together where it makes sense to do so. We will develop measurable outputs and milestones to track the outcomes we want to achieve for our local population as a result of these plans.

How are we going to do this?
By working with key stakeholders and system partners to develop solutions for securing access to NHS dental care for the whole population.

We will develop a two-year plan for the near term to address immediate needs:

- We will use all available data to understand and prioritise the immediate dental need. This may be a clinical need or a geographical need.
- We will seek interest from current dental providers to increase the number appointments they are able to offer on a short-term basis.
- We will monitor the impact these actions have to improve access to dentistry and build this information into our next part of the objective – to develop a dental strategy for Norfolk and Waveney.

Next, we will extend this timeframe by another three years to develop a five-year dental strategy for Norfolk and Waveney.

We will:

- Continue to engage with the profession and the ICB's 'Dental Development Group' to hear to the challenges faced by the profession and work collaboratively with system partners and key stakeholders to find solutions to improve access to dental care.
- Listen to our patients and hear about their lived experiences, to ensure our local population has access to oral health prevention advice, working with local authorities and the voluntary sector in Norfolk and Suffolk.
- Use our population health data, Dental Data Review, and ensure our strategy is evidence based, balanced to meet the needs of residents, and reduces health inequalities.
- Identify steps to retain, grow and develop our local dental workforce to meet our patients' needs. We will work with our local providers to begin to build multi-skilled dental teams, including roles such as Dentists, Dental Nurses, Dental Hygienists and Dental Therapists.

How are we going to afford to do this?
We will utilise our existing dental funding allocation to commission services with flexibility to meet the needs from the Dental Data Review published in 2023/2024.

We will work with partners, such as NHS England, to ensure their funding is invested appropriately across Norfolk and Waveney and to meet our workforce development and training needs.

What are the key dates for delivery?

- **Year 1 April 2024 – March 2025**
  - Implement the first stage of the Long-Term Plan
  - Implement the national Dental Recovery Plan for Norfolk and Waveney
  - Determine the key metrics we are going to measure and develop trajectories for improvement for each of the key programmes of work.
- **Year 2 April 2025 – March 2026**
  - Implement the first stage of the Long-Term Plan
- **Years 3 to 5 April 2025 – March 2028**
  - Continue to implement the individual elements set out in the new long-term plan and wider primary care strategy with frequent monitoring of outcomes.

How will we know we are achieving our objective?
We will have published our Long-Term Plan for dentistry by Spring 2024, informed by strong public engagement and using data to meet the needs of our population.

Improved access for our population to urgent treatment services, and reduced impact on Emergency Departments and other system partners.

Improving access for our local population through management of health inequalities and for children and young people.

Case Study

Working in the Voluntary, community and social enterprises (VCSE) sector there is so much to be gained. Meet Joe.

Joe Worsley is on a Health Leadership, Graduate Management Scheme with an interest in the charity sector and was pleased to take a flexi opportunity and work at Access Community Trust. Joe helped to develop and roll out their Customer Relationship Management system which hopes to measure the social value of the work that Access do.

The Access Community Trust's vision is to promote social inclusion for the community benefit by preventing people from becoming socially excluded, relieving the needs of those who are socially excluded and assisting them to integrate into society. Aimed at young people and adults they provide a range of services from house related support, learning, development, employment and providing support with mental health and wellbeing. With social enterprises such as the STEAM house cafes offering a safe space for those in mental health crisis day and night.

Joe says "that it is important that Access can measure the social value of the work they do, so they can demonstrate the value their work provides the Community which often goes far beyond their initial remit. This will help to secure further government funding and enable them to self-evaluate where they need to further focus their efforts, continuing to reduce health inequalities by providing essential services to customers at risk of social exclusion.

The work of Access is vital as it supports complex customers who otherwise might fall through the gaps between health and social care and multiple providers. Access can support a customer's journey from sleeping rough to temporary accommodation, permanent accommodation, and employment.

Joe says, "this placement gave me a real insight into how much value the 'third sector' can bring and how much there is to be gained by integrating the Voluntary Sector and Social Enterprises such as Access, with all healthcare providers".

Ambition 3: Improving Services for Babies, Children, Young People (BCYP) and developing our Local Maternity and Neonatal System (LMNS)

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El Mayhew
Interim Executive Director Children & Families
Suffolk County Council

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"Our collective Ambition is that all babies, children and young people will have the best start in life, achieved through person and family centred, high quality support to enable them to 'Flourish'. We will focus on collaborative working with system partners to promote the importance of a strong start in life for children and young people. We will prioritise the voices, needs and ambitions of children and young people so they can live their happiest, most rewarding lives and meet their potential."

Our objectives

a) Successful implementation of Norfolk's Start for Life and Family Hubs approach

b) Continued development of our LMNS, including the 3-year Maternity Delivery Plan

c) Implementation of asthma and epilepsy recommendations, for Children and Young People

d) Develop an improved and appropriate offer for Children's Neurodiversity

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

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

Why we chose these objectives

The first 1001 days of a child's life are critical, and the NHS plays a crucial role in improving the health of babies, children and young people: from pregnancy, birth, and the early weeks of life; through supporting essential physical and cognitive development before starting school through to help in navigating the demanding transition to adulthood. We know the health of children and young people is determined by far more than healthcare. A stable and loving family life, healthy environment, education, safe housing, and income all significantly influence young people's health and life chances. The outcomes we seek to achieve for children will be consistent across Norfolk and Waveney so that regardless of postcode, families can expect to have access to appropriate services. We aim to provide holistic care through design and implementation of care models that are age appropriate, closer to home and bring together physical and mental health services to support development. We can improve outcomes and make a difference through working in partnership with other organisations.

Objective 3a Successful implementation of Norfolk's Start for Life (SfL) and Family Hubs (FH) approach

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

The emphasis will be on support for families in local areas, plus a designated family hub site in each of the seven district council areas. There will be sites in Norwich, King's Lynn, Great Yarmouth/Gorleston, and Thetford where 37% of Norfolk's overall population reside and include the most deprived areas in Norfolk.

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

How are we going to do it?
Through improved data sharing arrangements and a more joined up approach to 'whole family' needs whatever part of the system families' access.

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

Through prioritising prevention and early intervention by providing advice and guidance to families at the earliest opportunity when families engage with FHs. This will also include the signposting to self-care resources, and the opportunity to link with others for mutual support.

How are we going to afford to do this?
There is national Department of Health & Social Care funding for perinatal mental health and parent-infant relationship support, to be effectively utilised to deliver the programme's minimum expectations by March 2025.

The funding required to develop and implement a SfL and FH approach in Norfolk is secured through a grant to the host agency, Norfolk County Council. There is an added requirement for Partners (resource expertise) across the system to collaborate to ensure the most effective support is in place to benefit families.

What are the key dates for delivery?

Year 1 April 2024 – Sep 20234

- Families have access to information and advice about the service offer (physically within 7 newly established family hub sites and a dedicated virtual offer).
- Expanded the reach of services for those who need it most including those facing greatest inequalities and fathers and co-parents.

Year 1 Oct 2024 – March 2025

- Enhanced offer of perinatal mental health support through local NHS Talking Therapies service
- Pregnancy loss service is mobilised through local voluntary sector partner with counselling available to families experiencing loss.
- Embed father inclusive practice network and reflective practice drop-ins across system

Years 2 - 5 April 2025 – Sep 2029

- To be defined by local plans developed in collaboration with system partners and include sustaining the transformation programme beyond funding period.

How will we know we are achieving our objective?
The programme team is currently working with the DfE/DHSC to develop an evaluation process for the national FH and SfL programme.

In addition, at a local level a performance measurement dashboard will be developed to track the identified KPI's across the programme and for each individual work strand, for example:

1. Feedback from families on Start for Life and Family Hubs offer (e.g. inclusive, 90% accessible, co-ordinated approach, greater connection through services, easier to navigate access services)
2. 90% access integrated referral pathways tell story once and 90% of families access the advice, information and guidance they need feedback from parent and carer panel feedback
3. More Practitioners across agencies work in a whole family approach (data single view – data sharing agreements)
4. Recruitment of an additional 70 peer support volunteers recording families receiving support and recruitment numbers by 2025/26.
5. Aim 250 of families supported via Every Relationship Matters reduce parental conflict on children
6. Families receiving help to manage financial challenges (measured through Department of Work & Pensions advisors embedded in Family Hubs)
7. Families accessing non funded services
8. Parents accessing Start for Life and Family Hub services have improved understanding of the contribution to child's wellbeing, achievement and school attendance. Measured increase in number of families receiving support and increase in school attendance.
9. Families with SEND receive early support reducing escalation measured through reduction in Education Health and Care Plan (EHCP) and needing access alternative provision.
10. Improved health and development outcomes for babies and children with focus on most deprived 20% of Norfolk population (measured by aligned public health outcomes.

Objective 3b Continued development of our Local Maternity and Neonatal System (LMNS), including the Three-Year Maternity Delivery Plan

What are we going to do?
The LMNS brings together the NHS, local authorities and other local partners with the aim of ensuring women and their families receive seamless care, including when moving between maternity or neonatal services or to other services such as primary care or health visiting.

NHS England published a three-year delivery plan for maternity and neonatal services in Spring 2023: 3 year delivery plan which sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families.

Our LMNS equity and equality action plan Norfolk and Waveney Maternity Equity and Equality action plan is a five year plan that will be monitored, reviewed and updated to ensure:

- equity for mothers and babies from Black, Asian and Mixed Ethnic groups
- those living in the most economically deprived areas
- race equality for staff
- development of co-produced equity and equality action plans to support the Core20PLUS5 approach.

How are we going to do it?
The LMNS will align with the wider work to develop Family Hubs (implementation of Family Hubs is an objective within this ambition) to ensure that safe, healthy pregnancy and childbirth is embedded into the Start for Life approach.

We will:

- improve equity and equality in accessibility of services.
- offer a 'one stop shop' for care to all pregnant women and people.
- improve maternity safety and outcomes.
- improve maternal and staff satisfaction.
- reduce footfall through hospitals

We will develop a workforce improvement plan to reduce our vacancies for maternity staff. The plan will include:

- implementation of consistent job roles across the system,
- systemwide recruitment of midwifery students,
- deliver systemwide training and learning events,
- support our hospital trusts to have current and robust digital maternity strategies, forming the basis for digital integration in maternity services.

We will make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury.

LMNS will oversee the quality and safety of maternity services. We will share learning and development, informed by the experiences of people using maternity services. This will include access to postnatal physiotherapy and a focus on reducing in smoking during pregnancy, which is an objective within this ambition. We will ensure our Maternity and Neonatal Voices Partnerships (MNVPs) are representative of the population and the LMNS can evidence continued co-production with service users of service improvement.

How are we going to afford to do this?
6 March 2023 funding allocation letter received detailing available funding for delivery of the three year delivery plan across the system. There will also be an expectation that existing funding within the system is utilised to continue to deliver the quality, safety and transformation requirements that will be detailed in the three-year delivery plan.

What are the key dates for delivery?

- **Year 1 April 2024 – Sep 2024**
  - Revised MNVP approved and ready for implementation.
  - LMNS governance and reporting reviewed, refreshed and updated.
- **Year 1 Oct 2024 – March 2025**
  - Pelvic Health Prevention Service is embedded.
- **Year 2 April 2025 – Year 4 March 2028**
  - We will continue to embed the learning, upskill the workforce, continue to hear the service user voice and drive continued quality and safety measures as part of our usual business.
- **Year 5 April 2028 – March 2029**
  - We will review performance against the three year Delivery Plan and target actions to ensure we continue to make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families.

How will we know we are achieving our objective?

We will see the maternity workforce vacancies reduce and retention improve, with clear evidence of future leaders ready to drive forward maternity improvement. As at May 2023 the vacancy rate is 9% which will be our baseline position to measure improvement against.

Objective 3c Implementation of asthma and epilepsy recommendations, for Children and Young People

What are we going to do?
We will work alongside clinically led professional networks to implement the recommendations of two bundles of care – Asthma and Epilepsy.

Over the next two years, we will increase access to psychological support for those affected by asthma and epilepsy, raise awareness of the conditions, and improve support available to children and families.

This links to Core20PLUS5 which is explained in section 3.4. Asthma and Epilepsy are two of the '5' focus clinical areas.

How are we going to do it?
We will expand the collaboration achieved in year one and work alongside Place based leads to drive forward plans locally using local teams and expertise.

We will support children with epilepsy and asthma to access activities within their communities and remain well while doing so through delivery of better care across clinical and non-clinical services, including access to condition specific training.

We will support improved independence to self-manage conditions and access to skilled advice and support to keep children out of hospital.

How are we going to afford to do this?
In the absence of regional funding to support Norfolk and Waveney to progress plans, local systems can submit expressions of interest for linked innovation schemes.

What are the key dates for delivery?

- **Year 1 April 2024 – Sep 2024**
  - Work with proposed health inequalities leads to develop CYP strategy
  - Work with place leads to identify opportunities for local delivery of Asthma bundle – e.g., Promote community voices programme for CYP to ensure 20% of children from most deprived communities have a personalised action plan
  - Review Health weight offer for Norfolk and Waveney
- **Year 1 Oct 2024 – March 2025**
  - Seek to increase access to training from Community activity providers and extend new model of care with psychological support.
- **Year 2 April 2025 – March 2026**
  - Seek to increase specialist nursing capacity across trusts
  - Seek to implement agreed care pathways across epilepsy services
- **Years 3 and 4 April 2026 - March 2028**
  - To be defined by the local networks and progress against bundle of care
- **Year 5 April 2028 – March 2029**
  - To be defined by local plans developed in collaboration with system partners

How will we know we are achieving our objective?
- Decreased hospital admissions for asthma for young people aged 10-18
- Decreased hospital admissions for epilepsy for children and young people aged 0-19
- Link for indicators is here: https://fingertips.phe.org.uk/indicator-list/view/paGkBr8vy0#page/1/gid/1/pat/15/ati/167/are/E38000239/iid/93136/age/288/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

Objective 3d Develop an improved and appropriate offer for Neurodiversity

What are we going to do?

Through a collaborative of system leads responsible for children's services, we will formally review and improve the clinical and non-clinical offer of support for our neurodivergent population

This programme will:

- Improve data monitoring and intelligence
- Improve pathways to support for assessment, and treatment
- Identify and address skills gaps in the existing education, health and care workforce
- Improve quality of clinical pathways
- Improve access to evidenced based information and advice
- Increase access to support for mental health needs

How are we going to do it?
We will increase awareness of health inequalities for neurodivergent young people

We will work with the organisations who see the patients to improve data monitoring and reporting for autistic young people accessing their services

We will improve governance of this programme of transformation through the system collaborative for CYP

We will develop a joint plan for action to reduce waiting times

We will test the delivery of whole school approaches of support for neurodiversity and expand if proven to be effective

We will provide tools to self-manage conditions and provide access to skilled high-quality advice and support to reduce the need for specialist interventions.

We will work with parents and carers to ensure those with lived experience are involved in the co-production of the improved service.

Access to a digital offer of support and training will enable universal services to provide better support to children and young people.

How are we going to afford to do this?
Funded within existing resources and supported through a process of prioritisation.

What are the key dates for delivery?

- **Year 1 April 2024 – Sep 2024**
  - Work with education and parent carer forums to design a local pilot testing whole school approaches for neurodiversity
  - Implement new provider framework for clinical assessments
  - Publish a Norfolk and Waveney 'supporting your neurodiverse child' resource pack
- **Year 1 Oct 2024 – March 2025**
  - Commission specialist training for 40 primary schools across Norfolk and Waveney
  - Commence implementation of action plan for system collaborative
  - Publish a dedicated digital library for neurodivergent people
- **Year 2 April 20245 – March 2026**
  - Implement changes to commissioned pathways
  - Launch new pre-diagnostic offer for families
  - Launch new 0-5 age offer of support
  - Evaluate Mental Health offer pilot
- **Year 3 April 2026 – March 2027**
  - Use evaluation and learning to develop the future service.
- **Years 4 and 5 April 2027 – March 2029**
  - To be defined by local plans developed in collaboration with system partners

How will we know we are achieving our objective?

- Improved patient experience evidenced through feedback with families
- A reduction in waits to specialist services
- Increase in 'appropriate' referrals to services
- Reduction in complaints regarding barriers to accessing care
- Number of unique users of the digital library

Outcomes

- Improved experiences for children and young people of health and care pathways
- Improved attendance at school
- Improved access to digital resources online and accepted referrals for sensory needs
- Improved access to specialist advice and therapy through increased interventions
- Improved access to assessments of need
- Improved access to universal training for non-clinical professionals and parents/carers

Ambition 4: Transforming Mental Health Services

Ambition 4: Transforming Mental Health Services

"Our aim is to ensure that people of all ages can access timely and responsive support for all their emotional wellbeing and mental health needs. Working together with partners across health, care, VCSE and our experts with lived experience, we will offer person centred care at an earlier stage, and provide services that are compassionate, holistic, and responsive guiding people towards better mental health".

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

"We look forward to being equal partners in the implementation of the JFP, using lived experience insight to ensure better mental health outcomes for everyone. The JFP will be delivered alongside existing services and builds on current and ongoing improvement plans. We hope the JFP will lead to joined-up, timely, ongoing care and personalised support for the people in our communities. Including addressing mental health inequalities for people who have little or no support. We hope the JFP will mean more people, including unpaid carers and staff, are more connected to wellbeing support and the right care for them."

N&W ICS Mental Health Transformation Expert by Experience Reference Group, May 2023

Our objectives

a) We will work together to increase awareness of mental health; enable our population to develop skills and knowledge to support wellbeing and improve mental health; and deliver a refreshed suicide prevention strategy. This will prompt early intervention and prevention for people of all ages, including those who experience inequalities or challenges to their mental health and wellbeing.

b) Mobilise an adult mental health collaborative and a children and young people's collaborative so that partners work as one to deliver better health outcomes for our people and communities.

c) Establish a Children and Young People's (0-25 years) Emotional Wellbeing and Mental Health 'integrated front door' so all requests for advice, guidance and help are accepted, and the appropriate level of support is given to ensure that needs are met.

d) We will see the whole person for who they are, developing pathways that support engagement, treatment and promote recovery for people living with multiple and complex needs, with a focus on dual diagnosis and Complex Emotional Needs (CEN).

What would you like to see in our five-year plan for health and care services? What matters most to you?
People with experience of mental health services and others who responded to a recent survey said, 'We must put more focus on prevention and invest in this area, including de-stigmatising mental health - we must see looking after our mental health the same as eating 5 fruit and veg a day'. They also told us:

- They want to be empowered to access intervention and holistic wraparound care, which supports long-term recovery.
- They want to "experience person-centred care, and be treated as an individual, rather than as a diagnosis".
- They want choice in how care is delivered and a focus on "what matters to me", instead of "what's the matter with me".
- They want their diagnosis to be only one part of their health journey. Their other physical and/or mental health conditions, as well as life events, may impact on their current state, which needs to be considered.

Children and young people have developed a Mental Health Charter and have told us that what matters to them is that services will care, staff will support and be well supported themselves, the right help, right time, right way, treatment will be personalised to meet individual needs, communication will be effective and young people will have a voice.

Why we chose these objectives
Mental health conditions can have a substantial effect on all areas of life, such as school or work performance, relationships with family and friends and the ability to participate in the community. People with mental health conditions often experience human rights violations, discrimination, and stigma. Key vulnerable groups who may be affected by poor mental health include children, young people and families, people who experience long term conditions and men experiencing financial and economic constraints and/or relationship breakdown. Improving the offer of proactive and preventive support is a priority outcome for this ambition, where we aim to intervene quickly and broaden the range of specialist support offers to enhance recovery.

Objective 4a We will work together to increase awareness of mental health; enable our population to develop skills and knowledge to support wellbeing and improve mental health; and deliver a refreshed suicide prevention strategy. This will prompt early intervention and prevention for people of all ages, including those who experience inequalities or challenges to their mental health and wellbeing.

What are we going to do?

1. Develop a structure for mental health literacy, to enhance and expand skills and knowledge on emotional wellbeing and mental health
2. Co-produce, implement and promote tools and capacity to support good mental wellbeing
3. Co-develop a refreshed Norfolk and Waveney Suicide Prevention Strategy and action plan

How are we going to do it?
Building on the targeted grant programme for vulnerable groups and the health promotion campaign 'Take 5', we will develop two complementary workstreams that will empower our people and communities to look after and improve their wellbeing:

A community mental health literacy workstream will be developed to inform our workforce, people and communities about wellbeing and mental health. This will promote activities to keep people well and enable them to access services if needed. Training and resources will be aimed at:

- Increasing skills to recognise and address wellbeing concerns
- Enabling individuals to effectively manage their own wellbeing
- Building capacity across the wider system, including in the VCSE sector to manage wellbeing within the community.

This will build on existing approaches focussed on children and young people.

The development of a Resilience Framework will provide our workforce, people and communities with the tools to increase and maintain wellbeing. This framework will focus on wellbeing initiatives such as a targeted sleep campaign to provide practical solutions in managing mental health and wellbeing.

These commitments work with existing prevention initiatives such as digital wellbeing tools, support for schools and families, Family Hubs, Community Wellbeing Hubs and NHS Talking Therapies.

The Suicide Prevention Partnership will coproduce a refreshed five-year Suicide Prevention strategy, with anticipated key themes for action around Self Harm, Bereavement and Primary Care pathways for people with depression – as informed by audits. While this work is underway, we continue to raise awareness, deliver campaigns to reduce stigma, provide accessible training, and invest in community support for at-risk groups. There is commitment to continue monitoring outcomes through Suicide Prevention Audits, and real time surveillance on self-harm and suspected suicides.

How are we going to afford to do this?
We will explore opportunities to use existing resources to deliver this provision, which may impact on timescales. We will seek to identify what can be achieved through improved partnership working at no/low cost and scope where additional resource would improve delivery.

What are the key dates for delivery?

There are three priority activities with the following milestones:

Year 1 April 2024 – Sep 2024
- Secure resourcing for mental health literacy framework to the system.
- Finalise measures and trajectory for indicators of improvement
- Begin implementation of the targeted workstreams in the action plan of the refreshed suicide prevention strategy.
- Ensure monitoring is established.

Year 1 Oct 2024 – March 2025
- Co-produce and develop a system wide approach to a resilience framework for and with communities.
- Launch implementation of the mental health literacy framework (may be delayed if funding is not secured)

Years 2 and 3 April 2025 – March 2027
- Implement the resilience framework and deliver initiatives i.e., impact of sleep and tools to improve sleep quality and continue to deliver mental health literacy.

Year 4 April 2027 – March 2028
- Review the suicide prevention strategy.
- Evaluate the joint funded suicide prevention programme.

Year 5 April 2028 – March 2029
- Implement actions based on evaluation of joint funded initiatives.
- Continuous improvement of the Mental Health Literacy programme.

How will we know we are achieving our objective?

- There will be a measurable change in self-reported mental wellbeing – the number of people reporting high anxiety, low happiness and low worthwhile scores.
- Rates of suicide and self-harm will decrease.

Objective 4b Mobilise an adult mental health collaborative and a children and young people's collaborative so that partners work as one to deliver better health outcomes for our people and communities.

What are we going to do?
Establish an adult Mental Health (MH) system collaborative and a Children and Young People (CYP) system Collaborative and participate in the Suffolk Mental Health Collaborative to help plan services for CYP in Waveney.

Adult Mental Health System Collaborative:
Identify opportunities to work collaboratively, using available data, intelligence, and insights, which focus on improving mental health and wellbeing of adults and older people.

Children and Young People System Collaborative:
Implement the Thrive model through close working between the Norfolk and Suffolk MH CYP collaboratives, which are on a county council footprint. Making the structural, operational, and cultural changes required to deliver community based multi-disciplinary teams, working across organisations, to ensure collective support to meet the emotional wellbeing, mental and physical health needs of the child or young person and their family.

How are we going to do it?

Embedding a new approach that:

- focuses on early intervention and prevention – moving the resource and support further upstream, providing support to more people at an earlier stage and freeing up specialist support
- focuses on 'place' and the development of support within local communities – with less reliance on specialist settings, clinics, or institutions
- moves away from a focus on a clinical model to one which builds understanding and resilience of community-led early support, and which develops the skills and resources of people, families, and communities to help themselves.

How are we going to afford to do this?
We intend to make use of existing resources in a different way. For example, existing community-based teams would be upskilled to support people and families with early dementia, which will free up capacity within the specialist teams to support people with more complex needs and reducing the existing specialist waiting lists. This process will be repeated for other conditions and for children and young people too.

What are the key dates for delivery?

- **Year 1 April 2024 – March 2025**
  - Strengthening the Adult MH System Collaborative as it is integrated into the wider Adult MH programme of work and associated governance structure:
    - reviewing the membership and ToR of the MH Strategic Oversight Board, and potentially the sub-groups that feed into it.
    - incorporating the dementia programme of work into the wider Ageing Well programme. The majority of the dementia pathway is delivered by wider system partners represented on the Ageing Well Programme Board.
  - Continued checking back with adults with mental health needs, and children, young people and families with emotional wellbeing, mental and physical health needs that the transformed services are meeting their needs.
  - The CYP Mental Health Collaborative will continue to work towards providing:
    - Self-Care support, through digital resources and tools, including guided self-help, with a 'request for support' process that automatically leads to suitable resources.
    - Improved access to advice and guidance through a single telephone number, and offering timely, single session interventions where clinically appropriate.
    - Request for Support – One trusted pathway for children, families, and professionals to ask for emotional wellbeing and mental health support.

- **Year 2 April 2025 – March 2026**
  - Continued integration of services within mental health and wider system pathways, so that people have their wellbeing and mental health needs met seamlessly.
  - Embedding delivery of the adult mental health programme, through key examples outlined in JFP Objectives 4a and 4d, within the adult system collaborative.

This objective will be retired at the end of Year 2 and become business as usual within the Adult MH programme of work.

How will we know we are achieving our Objective?

Access to support is streamlined, responsive and coordinated for:

- Adults with mental health needs.
- Children or Young Person with emotional wellbeing, mental and physical health needs.

The impact will be measured by actively seeking feedback from our people and communities, families and carers, and workforce, before and after any change that is implemented.

Objective 4c Establish a Children and Young People's (0-25 years) Emotional Wellbeing and Mental Health 'integrated front door' so all requests for advice, guidance and help are accepted, and the appropriate level of support is given to ensure that needs are met.

What are we going to do?
We are launching an Integrated Front Door (IFD) to support Children and Young People (CYP) aged 0-25 with an emotional wellbeing or mental health need to access the right support at the right time. This will be a 'needs led' single integrated access point for all emotional wellbeing and mental health enquiries and requests for support. Following consultation with CYP and families this new service will be called "Norfolk & Waveney access to mental health advice and support 0-25yrs". The aim is that children and young people and their families will have immediate guidance and/or timely support based on an understanding of need, to allow them to flourish.

It will provide:

- **Self-Care** support, through digital resources and tools, including guided self-help, with a 'request for support' process that automatically leads to suitable resources
- **Improved access to advice and guidance** through a single telephone number, and offering timely, single session interventions where clinically appropriate
- **Request for Support** – One trusted pathway for children, families, and professionals to ask for emotional wellbeing and mental health support. The clinical team will assess every request for support and promptly allocate to the most appropriate service offer to meet the needs of children and young people if required.

How are we going to do it?
System partners work collaboratively within a strategic alliance, ensuring that services are committed to working together to provide the best possible care and support for CYP and their families. This is in line with the Thrive principles, with children and young people at the centre of delivery and resources wrapped around them, enabling them to Flourish.

How are we going to afford to do this?
This programme of work is fully resourced through identified mental health service development funding (SDF) and is factored into medium term financial plans. Any efficiencies gained through implementation will be re-invested into enhancing the range of emotional wellbeing and mental health service offers and capacity available.

What are the key dates for delivery?

- **Year 1 April 202 – Sep 2024**
  - Launch "N&W access to mental health advice and support 0-25yrs" to include a comprehensive range of community emotional wellbeing and mental health pathways (0-25yrs). Crisis support should continue to be accessed through 111 Mental Health Option.
  - Refine data and reporting processes (including reporting on system waits and coding) to ensure an improved experience for service users and professionals.
- **Year 1 Oct 2024 – March 2025**
  - Work with system partners to scope additional CYP and family support services that could be accessed via the IFD and plan for implementation, including primary care.
  - Refine digital referral engine and request for support form following feedback from CYP, families and professionals to continue to enhance service user experience.
- **Year 2 April 2025 – March 2026**
  - Continue to onboard system pathways, including "Early Help and Family Support" delivered by Local Authority partners.
  - Implement Single Session approaches to ensure CYP can have their needs met in the most efficient way.
- **Year 3 April 2026 – March 2027**
  - Develop and embed Artificial Intelligence (AI) and machine learning solutions to improve efficiencies across the IFD.
- **Year 4 April 2026 – March 2027**
  To be defined by local plans developed in collaboration with system partners.
- **Year 5 April 2028 – March 2029**
  To be defined by local plans developed in collaboration with system partners.

How will we know we are achieving our Objective?

We will be able to measure an increase in the number of children and young people accessing the right support to meet their emotional wellbeing and mental health needs. This will be evidenced through the CYP Mental Health access metric within the national Mental Health Services Data Set (MHSDS) and through patient reported outcome measures.

Objective 4d We will see the whole person for who they are, developing pathways that support engagement, treatment and promote recovery for people living with multiple and complex needs, with a focus on dual diagnosis and Complex Emotional Needs (CEN).

The term Dual Diagnosis in this Objective, is used to define the experience of those with Mental Illness and substance misuse.

What are we going to do?

Complex Emotional Needs*:

1. Implementation of Complex Emotional Needs (CEN) Strategy, including the development of a collaborative pathway.
2. Increasing access to psychological therapy for people with complex emotional needs, wherever they present.

Dual Diagnosis:

3. Develop a recognised dual diagnosis pathway - with consideration to other issues, social or physical that are commonly associated with experience of Mental Illness and substance misuse.

*We are using the term Complex Emotional Needs to encompass people who have previously been described as having a diagnosis of personality disorder or experience of complex Post Traumatic Stress Disorder (PTSD).

How are we going to do it?
Providers and stakeholders will engage those with lived experience at all stages, from design to delivery, to improve access and care for people with dual diagnosis and Complex Emotional Needs, inclusive of those with Neuro Diversity.

A "no wrong door" approach will be developed with system partners Make pathways inclusive, accessible and flexible to promote recovery and independence. Partners will work collaboratively to cover unmet needs.

We will continue to develop mental health provision in primary care, embed the CEN strategy and pathway, and assist system partners to work collaboratively to support people with dual diagnosis.

The Mental Health Integrated Community Interface (MHICI) will join system partners up in a new way of working to provide this function, helping to improve the experience of people with complex needs.

How are we going to afford to do this?
We will seek to identify what can be achieved through improved partnership working within existing resource, and/or scope where additional resource would improve delivery further.

What are the key dates for delivery?

Year 1 April 2024 – Sep 2024
Complex Emotional Needs:
- Provide a tiered offer of therapeutic interventions for those with Complex Emotional Needs (CEN) who fall in the gap between primary and secondary care

Dual Diagnosis:
- Agree an integrated mental and substance misuse pathway.
- Draft protocol for local data collection.
- Integrate Experts by Experience into working group.

Year 1 Oct 2024 – March 2025
Complex Emotional Needs:
- Implement the Norfolk and Suffolk Foundation Trust CEN Strategy to support a joined-up approach across Norfolk and Waveney.
- Review the offer for carers of people with Complex Emotional Needs, identifying gaps with a view to improve provision.

Dual Diagnosis:
- Draft a coproduced strategy.
- Develop principles to support partnership working.
- Begin to implement an integrated a mental health and substance misuse pathway to improve access and increase inclusion.

Year 2 April 2025 - March 2026

Complex Emotional Needs:

- Complete a review of patient experience and identify any unmet need.
- Strengthen integrated pathways and joint working between providers.

Dual Diagnosis:

- Review training needs to inform expansion of dual diagnosis training programme.
- Review the experience of people with Dual Diagnosis leaving prison, inpatient institutions and other out of system placements, to improve continuity of care.

Year 3 April 2026 – March 2027

Complex Emotional Needs:

- Coproduce a set of recommendations to improve inclusion and access for under-served groups and marginalised communities.
- Expand existing training offer to professionals and carers, helping them to identify and respond appropriately to people with co-occurring needs.

Dual Diagnosis:

- Complete a digital options appraisal to improve service access.
- Review pathway and protocol to inform practice and ensure a suitable offer for people of all ages.

Year 4 April 2027 - March 2028

Complex Emotional Needs and Dual Diagnosis::

- Evaluate service user and system outcomes to inform future planning and ensure continual quality improvement.

Year 5 April 2028 - March 2029

Complex Emotional Needs and Dual Diagnosis::

- Continue to implement improvements to quality of care and patient experience, addressing identified gaps.

How will we know we are achieving our Objective?

Complex Emotional Needs:

- 300 additional staff trained per year in Knowledge and Understanding Framework, Dialectical Behavioural Therapy, or psychologically informed approaches system-wide
- Increase in numbers of service users able to access a psychologically informed intervention outside of NHS Talking Therapies and secondary care offer
- A reduction in presentations to Emergency Departments for patients with Personality Disorder.

Dual Diagnosis

- Achieve an increased number of referrals (as per Y1 plans and trajectory) accepted via the dual diagnosis pathway
- A reduction in presentations to emergency departments for service users with mental health needs and drug or alcohol problems

Case Study

Working together to reduce unnecessary hospital admission

John is a 46-year-old man with cerebral palsy and epilepsy who called 999 with a head injury after a fall. John was assessed through the 999-triage process as requiring a category 3 response. This is a lower acuity response with a target response time of 2 hours.

Within the Ambulance Control Room, this case was discussed with partner organisations – 999, Community Teams and the Clinical Assessment Service (CAS) – to determine whether a 999 response would be best, or whether a different service could respond to John in the allocated time.

John lives with his mum and both John and his mum were testing positive for COVID-19 at the time of the call. The Community team had resources available in the area who could visit John and his mum at home. A Community Matron called John prior to visiting to explain it would be the community team who would visit, not an ambulance. John's mum was relieved by this as she said she hadn't wanted to call an ambulance but wasn't sure what she should do instead.

The Community Matron arrived at John's home within two hours and carried out an assessment. A clinical assessment was completed for the head injury, as well as wounds and bruises to the body that were caused during the fall. The Matron was able to dress the wounds and complete a chest examination and COVID-19 assessment. John was found to have no clinical red flags that would be a reason for a hospital admission. The cause of the fall was also assessed and found to be caused be COVID-19 symptoms exacerbating John's existing mobility difficulties. Mobility aids and equipment options were discussed, and equipment from community stores was collected and loaned. Medication advice was given to help with COVID-19 symptoms and some pain from the bruising.

Image kindly supplied by: Norfolk Community Health and Care

John was able to stay at home, which both he and his mum were relived about, as they were concerned about John having to go alone to hospital while his mum was also covid positive. The Matron have advice for what to do and who to contract if the situation deteriorated and a follow up later that week confirmed that John was back to his usual level of mobility, his wounds and bruising was healing and he had no further concerns.

Ambition 5: Transforming Care in Later Life

Ambition 5: Transforming Care in Later Life

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

Sheila Glenn
Director of Planned Care and Transformation
NHS Norfolk and Waveney

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

Our objectives

a) **To have health, carer and support services that are fit for our ageing population – supporting people as they age, to lead longer, healthier, happier lives**

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

Why we chose these objectives
Our population is older than in most systems, but a lot of our services have not been designed with older people in mind. Current services are often confusing or complicated to access meaning that people don't always get the help they need until far too late. So, we want to design our services with our older residents.

We want to make it easy for older people to access support as soon as they need it, whether that support is for social, care or health needs. We want to simplify and join up all of our different services, so they are wrapped around our residents, and delivered as close to home and as early as possible.

By making it easy to access support and by removing the barriers between the different types of support available, we will work together to support older people to maintain their independence and preserve their quality of life.

Objective 5a: To have health, carer and support services that are fit for our ageing population - supporting people as they age, to lead longer, healthier, happier lives

In our first year, our objective was to develop a shared vision and strategy with older people.

The Ageing Well Strategic Framework has now been published and you can read it here.

The next year will focus on implementation.

What are we going to do?
Our vision is that Norfolk and Waveney will be a place where people in later life and their carers:

- are helped to age well, living happier, healthier lives, living as independently as possible, for as long as possible;
- feel heard and respected, and know they will be treated as individuals;
- experience services that ask, 'what matters most to you' and proactively act upon their answer.

This year, we will work together with our NHS providers, VCSE partners, members of our community, and our Public Health teams in Norfolk and Suffolk to start delivering this framework.

How are we going to do it?
We will set up an Ageing Well Programme board and 4 priority workstreams:

1. Frailty focussed hospital care
2. Improved care and fewer unplanned admissions from care homes and supported accommodation
3. Prevention of frailty and extending healthy older life
4. Improved quality of life for people living with dementia

We will also ask all our providers and places to use the strategic framework to identify where we have gaps or overlaps in our services and work to address those and coordinate our services better.

How are we going to afford to do this?
Simplifying access and focusing on early and local intervention will reduce long term need and costs e.g.by preventing unnecessary ambulance call outs and hospital admissions.

Co-designing services with older people to focus on maintaining independence will reduce costs long term, but we will need to divert funding toward prevention, early intervention and planning for the future, reablement and care at home.

Co-ordinating services using a system-wide perspective will deliver more integrated, high-quality cost-effective care from multiple sectors so reducing waste and duplication so saving cost for our system.

We will also actively seek new external monies / funds to support people in later life where possible.

What are the key dates for delivery?

Year 1 April 2024 - March 2025
Implementation of the strategic Framework:

- Creation of a strong clinical community of practice to lead on frailty focussed hospital care
- Implement a system wide definition of frailty and standardised frailty assessment tool so that we can easily identify people with frailty.
- All providers signed up to the dementia charter

Year 2 April 2025 – March 2026:
Innovation and prevention

- Fully integrated care for people living in residential or supported living environments using technology where appropriate.
- Multi professional triage for older people, so that they can receive support through one stop or combined assessment and, treatment wherever possible, and in the most appropriate setting.
- Planning for older age – supporting people to take control of their health and maintain healthy older life and reduce the period of time spent in frailty.

Year 3 April 2026 – March 2027
Reflect, Review, Replan

- Ongoing use of the framework to address gaps in provision across our system.
- Ongoing use of the framework to identify opportunities for prevention and early intervention.

How will we know we are achieving our objective?

- Reduced unplanned admissions from care homes.
- Better understanding and coding* of our population with frailty, enabling specific support to be put in place.
- All providers signed up to the dementia charter and feedback from people with dementia and those who care for them that this is improving their experience

*clinicians describe a patients complaint, problem or diagnosis and treatment in their notes which is classified into codes for the purposes of activity reporting – this enables us to look at patterns and trends

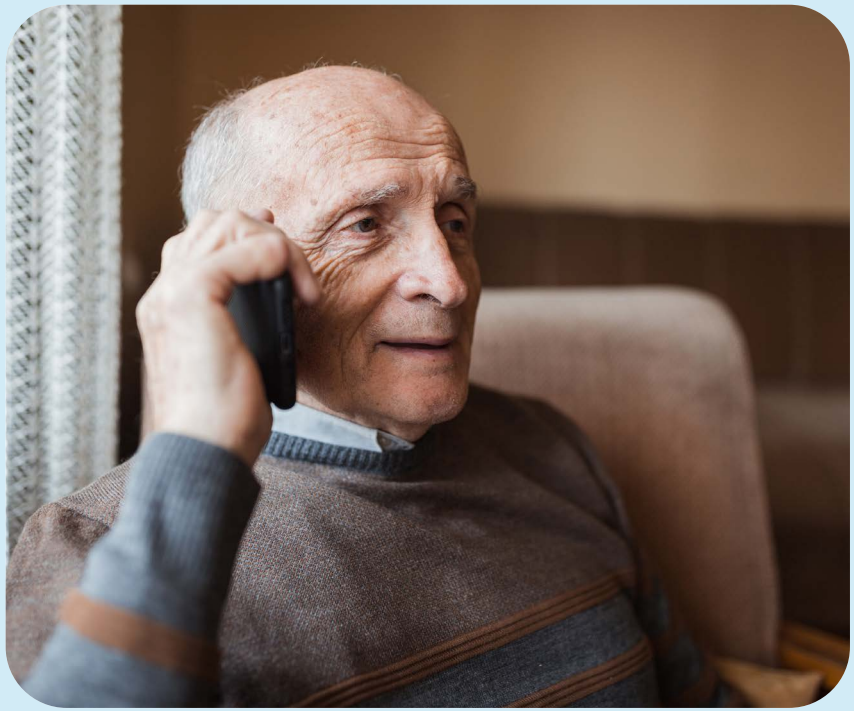
Case Study

Virtual ward prevents admission to hospital

John is an 84 year old man with long standing issues with his breathing. John was referred to the Virtual Ward by his GP when his breathing became difficult for the third time in 3 months. Both times this had happened before, he had ended up in the hospital emergency department which John found distressing and disorientating, and on one occasion he had been admitted to the hospital for 8 days.

John's GP referred him to the Virtual Ward during an emergency appointment at the surgery. The virtual ward hub accepted the referral and as part of his onboarding, they reviewed his health care records to gain more information about what had happened during his previous admissions and multiple A&E attendances. Remote monitoring equipment was delivered and setup for John at home within two hours of being onboarded. An initial assessment including blood tests were performed in John's own home to confirm the reason for John's deterioration. The virtual ward team developed a management plan and agreed this with John and his family using joint decision making.

John started treatment that day, and remained at home but with daily calls, 24/7 monitoring and two further home visits before he was "discharged" from the virtual ward. Before that happened, the virtual ward team, John and his family also agreed a long term health care plan to try to prevent the need for further A&E attendances and hospital admission.



Ambition 6: Improving Urgent and Emergency Care

Ambition 6: Improving Urgent and Emergency Care

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

Dr Lindy-Lee Folscher,
ICB specialty advisor for UEC

Our objectives

a) Improve emergency ambulance response times and ensure patients are seen more quickly in the Emergency Department by meeting the required % of patients being admitted, transferred or discharged within 4 hours

b) Expand virtual ward services as an alternative to an inpatient stay

c) Delivery of the RightCareNoW programme to reduce length of stay (LoS) in hospitals

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

Why we chose these objectives
We want our population to be confident that whenever they have an urgent care need or an emergency happens the local NHS is there to rapidly respond, we will continuously improve our emergency and urgent care services and adapt to our population's changing needs, take advantage of new technologies and develop trusted relationships across all health and care organisations in Norfolk and Waveney.

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

The Life Course Infographic in section 3.3 illustrates that for our working age people who have a heart attack or stroke, further work is required to improve admission to hospital where this is clinically necessary. Our priorities for urgent and emergency care take the next step in collaborative working across organisations to respond to patients when a need arises.

Objective 6a Improve emergency ambulance response times

What are we going to do?
We will work with the ambulance service and community teams to improve how quickly emergency ambulances can respond to our most unwell patients. To do this, we will support community teams to respond to urgent care needs which are not life threatening but cannot wait, thereby allowing the ambulance service to better respond to serious issues that are a threat to life or limb and are emergencies.

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

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

How are we going to do it?
Appropriate urgent 999 calls will be digitally transferred to community for local teams to respond. The Norfolk and Waveney unscheduled care hub (UCCH) will have clinical conversations with ambulance crews on scene to agree if there is a clinically appropriate alternative to hospital. This will allow crews to clear and move on to their next call whilst UCCH arranges to get the patient to the alternative service.

We will work collaboratively with clinicians in the ambulance service, the community, primary care and others to develop the framework and digital capability to identify and transfer patients from emergency services to urgent community services.

Our community response teams will be integrated working across organisations to share skills and make a greater impact by jointly responding and coordinating care and sharing resources.

Leaders from partner organisations will determine how this will be modelled and delivered to meet the needs of the local population. This may mean local variation in how services are set up across Norfolk and Waveney but the outcome will be the same – a rapid response from a clinician suitably skilled to assess and treat the patient.

For health and care professionals working in urgent and emergency care services this will result in consistent and standardised access points, a single access route for alternatives to emergency care and easier referral mechanisms to transfer patients between services, which will further support workforce satisfaction and retention.

How are we going to afford to do this?
We are working together as a system with all our partners, to make sure our resources are used to support transformation and deliver the care our patients need in the right place at the right time.

What are the key dates for delivery?

Year 1 April 2024 – March 2025

- Further testing and consolidation of urgent care coordination (UCCH) and develop commissioning model for a sustainable approach to care coordination
- Continue to review and expand the type of urgent calls suitable for transfer from 999.
- Review how community capacity can be expanded through continued integration at place level.
- Plan to integrate System Coordination and Care Coordination bringing operational escalation together with coordinating care at times of peak operational pressure

Years 2 and 3 April 2025 – March 2027

- Continued integration of urgent and emergency care provision, further collaboration across system partners, including VCSE to increase the support available.

Year 4 April 2027 – March 2028

- Fully embedded model of integrated urgent care in place across Norfolk and Waveney ensuring patients get the right care in the right place whenever the need arises.

Year 5 April 2028 – March 2029

- Objective to be reviewed / retired.

How will we know we are achieving our objective?

- Category 2 ambulance response times to average no more than 30 minutes across 2024/25
- Consistent 30min ambulance handover at hospital

National description of C2:
C2 - Emergency. These calls will be responded to in an average (mean) time of 18 minutes, and within 40 minutes at least nine out of 10 times (90th percentile)

Objective 6b Expand virtual ward services

What are we going to do?
Virtual Wards allow patients to get the care they need at home safely and conveniently, rather than being in a hospital setting. Support can include remote monitoring using digital technology, wearable medical devices such as pulse oximeters and face to face care provided by multi-disciplinary teams in the community.

Where patients can leave hospital earlier with remote monitoring support, we refer to this as step down. All three of our hospitals have a Step-Down Virtual Ward in place.

Step up virtual wards are an alternative to admission in a hospital setting, where patients can safely receive the same level of clinical care at home.

We will do this by:

- Building a new ICS collaborative partnership to promote joint working, innovation and new ways of working, instead of more traditional approaches of specifying and buying services
- Ensuring strong clinical leadership is in place to support collaboration. This will move towards an integrated model of care that uses resources across the system rather than in individual organisations.
- Developing a common digital solution with one dashboard for clinical teams to access.
- Expanding the conditions that a virtual ward can support to include respiratory, frailty and heart failure provision, as well as pioneering new, locally driven models of care.
- Develop a system wide step-up model which will play a key role in managing urgent care demand and building capability in the community to safely support people at home outside of a hospital setting.

- We will work with the whole provider community -Primary, Community and Acute care, 999 and 111 (CAS) all need to be part of developing, supporting and using the additional capability that the virtual ward creates, to deliver better outcomes for patients
- Integrate and embed virtual ward in the care system. As well as pioneering new ways of working, there is a huge opportunity to link all pre-hospital initiatives into one overall integrated urgent care 'pre-hospital' model with enhanced clinical oversight that allows the community teams to do more to safely support patients outside of hospital.

How are we going to do it?
Virtual Ward will work across the whole health and care system. We will identify referral routes in and out of virtual ward for equal service provision across Norfolk and Waveney. We will make sure there are automated, digital referral routes and the ability to transfer patient details electronically, so patients only have to tell their story once.

Local teams will design the new models of care and supporting processes that will form the Virtual Ward face to face response. These need to be joined up with existing services and offer staff opportunities to work across different organisations to enable better integration and use of skills.

How are we going to afford to do this?
Virtual Ward has an allocation of national funding that is to be used to maintain and expand services. In the longer term it is expected that local areas will need to fund virtual ward services.

As virtual ward expands, we anticipate there will be corresponding changes in where urgent care activity is managed, increasingly this will be outside of hospital settings.

What are the key dates for delivery?

Year 1 April 2024 – March 2025

- Continue to expand the specialties Virtual Ward can support to meet the minimum core specialties of Heart Failure, Respiratory and Frailty.
- Fully rollout the community step up model across the whole of Norfolk and Waveney
- Work to identify opportunities for integration of community step up with acute step down services that will allow patients to seamlessly move through a virtual ward service when receiving care

Year 2 April 2025 – March 2026

- Continue to expand appropriate clinical specialties in line with national and regional policy and best practice
- Develop digital interoperability between services to improve data capture, record keeping and monitoring

Years 3 and 4 April 2026 – March 2028

- Further evaluation and monitoring to continuously improve the service.

Year 5 April 2028 – March 2029

- Objective to be reviewed / retired.

How will we know we are achieving our objective?

Trajectories

- We will have achieved and be sustaining 368 virtual ward beds

Objective 6c: Delivery of RightCareNoW to reduce length of stay (LOS) in hospitals

What are we going to do?
We will continue to improve discharge planning and processes, so that you can take the next step in your recovery and rehabilitation after a period of illness, quickly and safely, in a place where you can be as active and independent as possible and stay connected with the people and activities that matter most to you.

The 'home first' principle is important to us when we start your discharge planning. We want to make sure that you can return to your home, if this is the right place for you, and meets your needs. If things have changed while you have been in hospital, and home is no longer the right place for you to live, then we can work together to plan what that will look like.

The date and time for your discharge home will be agreed with you in advance, to allow you to make plans with carers, loved ones and/or family members and we will make sure you have a supply of medication and a discharge letter to share with your GP so that they know what help and support you may need once you arrive home.

Better discharge planning helps to reduce your length of stay in hospital, and reduces deconditioning and the to go back into hospital, which also helps us to bring people into hospital more quickly when they need emergency or planned care because we have more space and resources. It's about getting you to the right place, for the right care and support, at the right time.

How are we going to do it?
The RightCareNoW Programme brings system partners together to lead and deliver improved discharge planning and reduced hospital length of stay, across Norfolk & Waveney. There are two timelines for the delivery of discharge improvement, which will happen alongside each other.

There have been recent improvements that mean we are making better progress to all of the things we said we were going to do.

The next priority is to make sure that we are able to provide the right number and right type of beds and care when people need them. To do this we need to ensure that we understand the requirements of our population both now and in the future. Over the next six months we will be developing ways of working to ensure that patients have care in the right place at the right time.

We also need to continue to improve the following priorities as we look further to the future requirements and plan for our local population who may need unplanned inpatient care in the next 3-5 years:

1. Mobilise a digital solution (Optica) for managing patients through their discharge pathway more efficiently.
2. Focus on early discharge planning, embed the SAFER flow care bundle, and increase the number of Pathway 0 discharges and weekend discharges for people who do not need additional care and support to go home.
3. Build an Integrated Transfer of Care (ITOC) Team at each Place, which will bring together hospital, community, voluntary, therapy, transport and pharmacy resources around the patient and deliver more seamless support.
4. Continue to develop collaborative leadership, with a clear and consistent governance structure to support delivery. Include the needs of people who are being discharged from Mental Health settings into the improvement journey.

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

Data and Digital
Data is a significant issue and risk for all partners due to the digital immaturity of the Norfolk and Waveney system, however, this highlights the importance of a digital solution to help us monitor, track and report on the discharge position and impact of our interventions and improvements. New national guidance has been issued in 2024 and NHSE will report more discharge data publicly. There is a new software system, called Optica, that will help us have better visibility of the progress on a patients discharge pathways and this will help us provide faster and better outcomes.

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

As part of this ambition, we need to develop a sustainable financing model. To do this we will need system-wide partner financial and operational engagement, to determine how we can resource changes in activity across organisations and develop workforce models that allow organisations to create the right capacity to meet demand, while also ensuring we meet our system's financial targets. This is part of Ambition 8.

How will we know we are making a difference?

- Reduction in length of stay is the key outcome metric of this programme and we should see a reduction in the average length of stay in acute and community beds and an overall reduction in use of intermediate care beds.
- Improved outcomes for patients following discharge, and better experiences for their carers.
- Deconditioning and readmission rates will fall.
- An increase in our daily numbers of patients discharged.
- We can stop using surge and escalation beds to manage day to day pressures.
- We have the correct capacity in acute, community and local authority to maintain smooth flow of patients through the system.
- We are meeting the RightCareNoW principles.

What are the key dates for delivery?

Years 1 and 2 April 2024 - March 2026
- Fully embed Optica digital tool.
- Create comprehensive evidence-based Place-level Discharge Demand and Capacity Plans.
- Evaluation of the programme's effectiveness; review the evidence base and celebrate and share successes.
- Review and reset goals and metrics to measure effectiveness and to evidence continuous improvement.

Year 3 April 2025 - March 2027
- Deliver a stable and sustainable model of care for discharge. Focus on discharge Pathways 1 to 3, for patients who require additional support following a hospital stay; ensuring there is better patient choice and communication with carers so that decisions can be made together.

Year 4 April 2027 to March 2028
- Digital maturity fully embedded.
- A model of care that meets demand.

Year 5 April 2028 to March 2029
- Ensure the system is operating a model of care that meets demand, ensuring the new acute hospitals will open with the right number of unplanned care beds.

How will we know we are achieving our objective?
Achieving or exceeding the national target to reduce hospital occupancy to 92% or less.

Case Study

Lung health checks launched in a drive to save more lives

Past and current smokers in Great Yarmouth are being invited to an NHS lung health check in a drive to improve earlier diagnosis of lung cancer and save more lives.

With one of the highest mortality rates for lung cancer in England, Great Yarmouth is one of 43 places across the country to launch the Targeted Lung Health Check programme.

The initiative means around 13,750 past and current smokers aged 55 to 74 years of age in Great Yarmouth are being invited to a lung health check by their GP. This will identify lung cancer earlier than it would have been otherwise.

People diagnosed with lung cancer at the earliest stage are nearly 20 times more likely to survive for five years than those whose cancer is caught late.

A patient who has had a lung health check, said: *"This is an excellent scheme and I was so pleased to be invited to attend this check up. Prevention is always better than the cure and this is a great example of the NHS, working together to help identify cancer much earlier. I am so grateful."*

Ambition 7: Elective Recovery & Improvement

Ambition 7 Elective Recovery & Improvement

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

Joanne Segasby
CEO JPUH and Senior Responsible Officer for elective recovery across Norfolk and Waveney

Our objectives

a) Effectively utilise capacity across all health system partners

b) Implement digital technology to enable elective recovery

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

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

There are increasing numbers of new cancer cases being diagnosed and we know that early diagnosis is key to saving lives so it is essential that we continue to ensure patients can be offered alternative locations for their care and are seen in the right place, at the right time, by the right person.

This will mean that complex health care is seen and treated at an acute hospital whilst less complex but potentially 'life limiting' health concerns may be treated elsewhere. This links to and aligns with the work we are doing around the way people are referred for diagnostic testing and/or treatment in the community or via the local GP.

Objective 7a Effectively utilise capacity across all health system partners

What are we going to do?
We will identify and utilise all available capacity to ensure residents access the right service, at the right time in the most convenient and suitable location. Through working in partnership, we will identify whole system transformational opportunities to reduce waiting times, deliver care in more convenient locations and provide a more patient centric service.

We will continue to reduce health inequalities in access, outcomes, and experience for our population and ensure this is supported by a strong workforce, digital capabilities and is co-produced with all partners including the residents and patients.

We will

- Deliver more diagnostic care.
- Deliver more elective care.
- Increase day case elective procedures.
- Reduce cancer backlogs.
- Reduce unnecessary outpatient follow up appointments.

How are we going to do it?

We will deliver more diagnostic care
Norfolk and Waveney have received confirmation of national investment to proceed with building four new Community Diagnostic Centres.

- We will be investing in state-of-the-art diagnostic equipment across our geography, three new diagnostic centres on the acute hospital sites and one in a community setting in east Norfolk to offer a suite of multiple diagnostic tests in 'one stop' closer to where you live.
- Streamlined access for Primary Care colleagues to enable direct access to diagnostic tests and clinical guidance across the health services to meet the needs of the individual.
- Tackle health inequalities by creating better access to diagnostic testing in our deprived areas.
- We will identify the workforce requirements needed to run diagnostic services effectively.
- We will optimise what we do and share best practice to standardise procedures, processes and pathways to increase productivity, efficiencies and clinical quality.

Norfolk and Waveney have also received confirmation of regional investment for a project that aims to minimise the number of patients that do not attend their diagnostic appointments through the use of volunteers.

- We will alleviate anxiety and concerns of patients through volunteers calling patients prior to their appointments.
- We will identify barriers that may be causing patients to not attend appointments.
- We will be reminding patients of their individual appointment requirements such as dietary preparation.

We will deliver more elective care

- 'Mutual Aid' (whereby patients are asked if they would be happy to be treated at any of the three acute hospital trusts in Norfolk and Waveney if their treatment can be completed sooner).
- We will build additional theatre capacity at our acute hospital sites. (called Elective hubs)
- We will more readily share best practice between the acute trusts thereby appropriately increasing standardisation of procedures, pathways and support functions.
- This will increase productivity where patients need to be treated in a hospital theatre and contribute to increased planned care treatments in Hospital Outpatient clinical areas, GP practices and Community care settings.

Increasing rates of 'day case' elective procedures

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

Reducing cancer backlogs

- We will use evidence and audit to co-produce pathways with primary and secondary care, standardising pathways and ensuring appropriate safety netting where possible.
- Continue to embed system-wide nationally defined Best Practice Timed Pathways (BPTP) for cancer, and vague symptoms pathways to improve efficiency, diagnosis, and patient experience
- This work will include risk stratification (for the prostate cancer pathway), completing local implementation of teledermatology, agreeing and implementing more consistent approaches to the management of iron deficiency anaemia, improving the management of breast pain and the management of women with post-menopausal bleeding who are on HRT. Provide additional workforce capacity to support clearance of the waiting lists.
- Ongoing work to raise awareness and provide training to support the national cancer guidance within primary care to reduce the variation in quality of referrals from GP's.

Reducing unnecessary outpatient follow up appointments

- One of key approaches is called PIFU (Patient Initiated Follow Ups) to prevent clinically unnecessary appointments and to ensure that any appointment is booked by the patient at a date, time and location which is convenient to them.
- Clinicians will discuss with patients what and when is expected after their treatment or surgery and, unless recovery is different compared to what is expected, the patient will not attend an Outpatient Follow Up appointment.
- We will ensure there are opportunities for the patient to request (or initiate) a Follow Up appointment if they are unhappy or worried in anyway and details how to do this will be given to patients.
- Patients will notice they have more involvement and/or choice of whether to have Follow Up appointments. This will save patients time and transport costs, whilst at the same time releasing clinician time to other priority areas.

How are we going to afford to do this?

National capital funding (TIF) has been requested through the development of local plans and business cases to support Elective Hubs, Community Diagnostic Centres and Diagnostic Access Centres. All programmes have identified capital in order to be able to build these sites and associated services.

What are the key dates for delivery?

Year 1 April 2024 – March 2025

- Mutual Aid for N&W ICS diagnostics services to be rolled out.
- Continue to embed Patient Initiated Follow-Up's (PIFU) across the system to give patients and their carers the flexibility to arrange their follow-up appointments as and when they need them.
- Norfolk and Norwich University Hospital Orthopaedic Centre (NANOC 1) due for completion – Summer 2024.
- James Paget University Hospital Elective Hub building work due for completion – Summer 2024.
- Two new Community Diagnostic Centres in East Norfolk opened.
- One new Community Diagnostic Centre in West Norfolk opened.
- Develop a system approach to support the transition from transformation to the sustainable delivery of nationally defined best practice cancer pathways.
- Develop career pathways for non-medical oncology workforce to support recruitment and retention.
- Three sites commence a pilot of volunteers to increase diagnostic appointment attendance, improve patient outcomes and reduce pressure on elective services.

Year 2 April 2025 - March 2026

- Full year capacity utilisation of Elective Hub and Orthopaedic Centre
- NNUH Orthopaedic Centre (NANOC 2) due to complete Autumn 2025.
- Move of non-acute activity to primary care following improvements to primary care estate.
- A further Community Diagnostic Centre in central Norfolk opened.

Year 3 April 2026 – March 2027

Expand collaborative working with Public Health, social care and VCSE partners. A further Community Diagnostic Centre opened in central Norfolk.

Years 4 and 5 Apr 2027 – March 2029

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

How will we know we are achieving our objective?
Waiting time will reduce for patients:

Elective

- Eliminate waits of over 65 weeks for planned care treatment as soon as possible and by September 2024 at the latest except where patients choose to wait longer or in specific specialities

Diagnostics

- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%

Cancer

- Improve performance against the headline 62-day standard to 70% by March 2025
- Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025

Objective 7b Implement digital technology to enable elective recovery

What are we going to do?
We will implement digital technology and initiatives to support our ambition for elective recovery and improvement.

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

- **Peri-operative care** - Digital initiatives will be rolled out in peri-operative care which will allow patients to complete important personal health and lifestyle questionnaires online to streamline the process.
- This will help ensure patients are 'fit and ready' for their planned care/ treatment which will reduce cancellations, reduce length of stay and improve recovery.
- We can identify and support patients to "wait well" and prioritise patients at risk of potential harm while waiting.
- We will ensure non-digital options will also be available for those who do not have access to, or cannot use, IT and those who prefer not to.
- **Single Waiting List -** We will have one waiting list across our three hospitals to ensure patients waiting for treatment at any of our hospitals will receive the same levels of access to care (i.e. waiting times for treatment) and we will proactively offer patients an alternative location to receive their treatment if they could be seen more quickly.
- We want to ensure everyone on the waiting list has 'equity of access' This is important as we have pledged to work to actively reduce health inequalities in Norfolk and Waveney.

How are we going to do it?

- Online Peri-operative care is being tested in Trauma and Orthopaedics first as this is a speciality which has large numbers of patients waiting for treatment.
- The next phase of testing with be specialities such as Ear, Nose and Throat and Gynaecology as these also have large waiting lists.
- The intention is roll out across all specialities in two of the three hospitals by March 2025. The final hospital intends to roll out online Peri-operative across its specialities by March 2026.
- To implement the single waiting list, a new way of working is currently being trialled in specific areas of care such as Trauma and Orthopaedic and Cancer to test that real benefit can be seen. It is anticipated the testing stage should be completed before the autumn of 2024.
- Next, we will expand the testing to other areas of care such as Ophthalmology, Vascular and Endoscopy, it is anticipated this will be completed by the autumn of 2024.
- This will enable us to actively manage our single patient waiting list to support patients to 'wait well' and identify and manage those at greater risk of harm.

How are we going to afford to do this?
We have purchased the software and hardware necessary for Peri-Operative Care. Future costs have been identified and agreed as part of approving the Peri-Operative Care business case.

What are the key dates for delivery?

Year 1 April 2024 – March 2025
- Online Peri-Operative Care implemented with key specialities across the system.
- Single waiting list testing phase for Trauma and Orthopaedic, Cancer, Ophthalmology, Vascular and Endoscopy complete.

Year 2 April 2025 – March 2026
- All patients at the point of referral to have the choice of the waiting list management to be predicated on the place of care or the timeliness of their care.

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

Year 4 and 5 April 2026 – March 2028
Throughout the phases of this objective, we will review the benefits and explore further opportunities to enhance our digital technology will inform our strategic direction for years 4 and 5.

How will we know we are achieving our objective?

We will measure

- how many patients have been offered mutual aid
- how many patients chose a different hospital
- how many chose to wait at their preferred treatment location.

Case Study

Shared Care Record sets to transform care in Norfolk and Waveney

The Shared Care Record is a way of bringing together the most important records from the different organisations involved in the health and care of our people and communities in Norfolk and Waveney.

These records are then visible to frontline health and social care professionals, at the point of care, in a read-only view. Our aim is to help our frontline health and care services by providing important information about you and your care, from your interactions with the following professional care services:

- GP
- NHS 111/out of hours service
- community services
- emergency department
- outpatient appointment
- hospital stays
- maternity service
- mental health practitioner or care practitioners

Patients' information will only be made available when needed at the point of care and will only be used by staff members with a legitimate basis to do so. The Norfolk and Waveney Shared Care Record helps meet this aim by reducing the time needed to learn about important health and care information, particularly in a time sensitive situation.

This can be particularly helpful when patients, their families and carers may not be able to answer specific health and care questions.

Ambition 8: Improving Productivity & Efficiency

Ambition 8 Improving Productivity & Efficiency

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

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

Our objectives

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

What would you like to see in our five-year plan for health and care services? What matters to you most?
The focus of this ambition is to systematically review data about our services and compare how we perform with other systems nationally, seeking out opportunities to work more effectively and efficiently for the benefit of our population.

We will work together in partnership to ensure we achieve value for money, ensuring we use our resources as wisely as possible for the benefit of our population.

Why we chose these objectives
Deciding where to look to improve productivity and efficiency has been driven by the data and in discussion with our staff. All partners are looking at their own internal efficiencies as a constant process. This ambition directly contributes to one of the "triple aims" of the NHS which is about having regard to the wider effect of decisions made about the provision of health and care. Efficiency and sustainability of use of resources is one of those aims.

We have access to the Model Health System Model Hospital which allows NHS organisations to compare themselves with each other and look for variances. Opportunities to improve productivity and outcomes identified though Getting it Right First Time GIRFT benchmarking are also being reviewed.

We look at examples of good practice across the local system, regionally and nationally, and use our Health Intelligence data to determine where to focus.

Objective 8a Improve the services we provide by enhancing productivity and value for money, embracing digital innovation and delivering services together where it makes sense to do so.

What are we going to do?
Our organisations have established improvement programmes examining a range of areas in which to increase productivity and value for money. We have already brought together some administrative functions to improve value for money.

Existing improvement programmes include a focus on Procurement, Estates, Digital, Workforce and Medicines Management opportunities.

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

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

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

How are we going to do it?
We have established our Improving Lives Together programme, an ambitious improvement programme, drawing together partners from across our system to work together to improve the services that we provide.

We will assess opportunities based on evidence and benchmarking of data through sources including the Model Health System. We will draw all these elements together under dedicated governance, led by our CEOs.

The initial focus of this work is on Digital and Workforce services, and we have already undertaken a detailed assessment of how we currently deliver these services to see how we can make improvements. Options are being developed that will help us to reduce duplication, improve outcomes and make best use of every pound we spend as an ICS.

How are we going to afford to do this?
This programme of work will deliver enhanced productivity and value for money and is not anticipated to increase overall costs in our system.

Options will be carefully assessed as part of approving the cases for change for individual service areas.

What are the key dates for delivery?

Year 1 April 2024 - March 2025
- In 2024/25 will begin to see the roll out and impact of any changes to Digital and Workforce services.
- We will establish further arrangements to coordinate and oversee our joint work on efficiency and productivity, closely linked the trajectory of our Medium Term Financial Plan (MTFP)

Year 2 April 2025 - March 2026
- We will begin to see the impact of our improvements in the second tranche of services identified for improvement as part of our Improving Lives Together Programme, and will continually review opportunities for improvement led by data and best practice.

Years 3 - 5 April 2026 - March 2029
- Our Improving Lives Together programme will continue to support review and improvements in services as part of our continuous service improvement approach.

How will we know we are achieving our objective?

- We will undertake post implementation reviews for changes led through our Improving Lives Together programme to formally assess that we have successfully delivered the operational and financial improvements set out in individual business cases..
- We will use national benchmarking data drawn from the Model Health System to measure our improvement relative to national benchmarks and other ICSs.

Case Study

What should quality feel like? Meet Charlie

Charlie, aged 19, has been a family carer for most of her life and a member of Norfolk Young Carers' Forum, supported by the charity Caring Together as part of Norfolk and Waveney ICS. The Forum helps to recognise the lives of young carers and ensure that health, care and education services across Norfolk understand their needs. The Forum has carried out surveys of young carers and ran a conference for people working across the health and care system. Forum members have recorded videos, shared their experiences and reviewed all of the materials which are used in carer-awareness training. Charlie has put a lot into the forum, and got a lot out of it too.

Charlie says: "At first I was surprised they gave a 15-year-old the responsibility of doing the lectures, but I'm used to it now. It's still nerve-wracking but I know exactly what I am doing. I was a shy kid, but when I joined the Forum, I felt a real surge in confidence; it gave me a voice. In the Forum, everyone accepts who you are. Everyone is in a similar boat. They all just get it. I've made a lot of friends that I will be friends with for the rest of my life and pushed me to do what I want to do."

Charlie's caring role continues and when she reflects on five years in the Forum, she is positive about the changes that have happened in that time. She remains committed to driving further change for young carers.

5.0 When we expect to deliver

5.0 When we expect to deliver

For each of the Objectives, we have developed a series of key milestones.

As this is a rolling five year plan it builds on the progress that was made during 2023/24 financial year.

To show how the overall profile of work looks for our key objectives, where it has been possible to do so we have split the first year into six-monthly timeframes to provide more detail and then we have included our longer-term planning years 2, 3, 4 and-5.

Year 1 relates to the financial year that starts 1 April 2024 and ends on 31 March 2025.

This provides a programme summary, which will be developed in more detail as our JFP evolves and responds to need and is shown in Figure 8.

Ambition	Ambition Objective	Timeline for delivery						
		Year 1		Year 2		Year 3	Year 4	Year 5
		1st	2nd	1st	2nd			
1	**PHM, Reducing Inequalities & Supporting Prevention**							
1a	Development and delivery of two strategic pieces of work: A Norfolk and Waveney Health Inequalities Strategic Framework for Action; and a Population Health Management Strategy	■	■	■	■	■	■	■
1b	Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people.	■	■	■	■	■		
1c	Early Cancer Diagnosis – Targeted Lung Health Check Programme.	■	■	■	■	■	■	■
1d	Cardiovascular disease Prevention – develop a programme of population health management interventions targeting High Blood Pressure and Cholesterol.	■	■	■	■	■		
2	**Primary Care Resilience & Transformation**							
2a	Developing our vision for providing accessible enhanced primary care services, improving patient outcomes and experience.	■	■	■	■	■	■	
2b	Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years.	■	■	■	■	■	■	■
3	**Improving Services for Babies, Children, Young People (BCYP) and developing our Local Maternity and Neonatal System (LMNS)**							
3a	Successful implementation of Norfolk's Start for Life (SfL) and Family Hubs (FH) approach.	■	■					
3b	Continued development of our Local Maternity and Neonatal System (LMNS), including the Three Year Maternity Delivery Plan.	■	■					
3c	Implementation of asthma and epilepsy recommendations, for Children and Young People.	■	■	■	■			
3d	Develop an improved and appropriate offer for Children's Neurodiversity	■	■	■	■			
4	**Transforming Mental Health Services**							
4a	We will work together to increase awareness of mental health; enable our population to develop skills and knowledge to support wellbeing and improve mental health; and deliver a refreshed suicide prevention strategy. This will prompt early intervention and prevention for people of all ages, including those who experience inequalities or challenges to their mental health and wellbeing.	■	■	■	■	■	■	■
4b	Mobilise an adult mental health collaborative and a children and young people's collaborative so that partners work as one to deliver better health outcomes for our people and communities	■	■	■	■			
4c	Establish a Children and Young People's (0-25 years) Emotional Wellbeing and Mental Health 'integrated front door' so all requests for advice, guidance and help are accepted, and the appropriate level of support is given to ensure that needs are met.	■	■	■	■	■		
4d	We will see the whole person for who they are, developing pathways that support engagement, treatment and promote recovery for people living with multiple and complex needs, with a focus on dual diagnosis and Complex Emotional Needs (CEN).	■	■	■	■	■	■	
5	**Transforming Care In later life**							
5a	To have health, carer and support services that are fit for our ageing population - supporting people as they age, to lead longer, healthier, happier lives	■	■	■	■	■		
6	**Improving UEC**							
6a	Improve emergency ambulance repsonse times and ensure patients are seen more quickly in the Emergency Departments	■	■	■	■	■	■	
6b	Expand virtual ward services as an alternative to an inpatient stay	■	■	■	■	■	■	
6c	Delivery of the RightCareNoW programme to reduce length of stay (LoS) in hospitals	■	■	■	■	■	■	■
7	**Elective Recovery & Improvement**							
7a	Effectively utilise capacity across all Health System Partners.	■	■	■	■	■	■	■
7b	Implement digital technology to enable elective recovery.	■	■	■	■	■	■	■
8	**Improving Productivity and Efficiency**							
8a	Improve the services we provide by enhancing productivity and value for money, and delivering services together where it makes sense to do so.	■	■	■	■			

Figure 8 – outline programme plan for the JFP objectives

Case Study

Reducing isolation and depression by increasing connections in the community

Anne is a 77-year-old lady who regularly attended her GP surgery. She has had to deal with several health conditions including cancer, diabetes, angina, and back pain after surgery.

Anne had been feeling isolated, depressed, and just wanted human contact to help her with these feelings. Anne's GP referred her to a Social Prescribing Link Worker.

The Link worker helped Anne, by forwarding her to a local befriending project in the area. The project aims to connect people to reduce loneliness and isolation by hosting walk and talk sessions. Anne now attends these sessions once a week and really enjoys them.

Anne feels a lot happier now, has reduced her social isolation, gained greater confidence and a wider social network. She also feels fitter, evidenced through lower blood sugar levels. Anne now attends fewer GP appointments.

6.0 How are we going to work together differently?

6.0 How are we going to work together differently?

How we work together differently is critical to the ambitions and objectives because it signals the change required to successfully deliver our plan.

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

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

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

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

5. **People and Culture** – continue to develop inclusive partnerships as our leaders work together to facilitate a climate of improvement for all our teams as they deliver the ambitions of our JFP.

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

7. **Our Voluntary, Community, and Social Enterprise (VCSE) sector as system partners**

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

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

6.1 Our place-based approach

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

We have five Place Boards and eight Health and Wellbeing Partnerships (HWPs) shown on the map below in Figure 9. The Place Boards and HWPs have complementary roles.

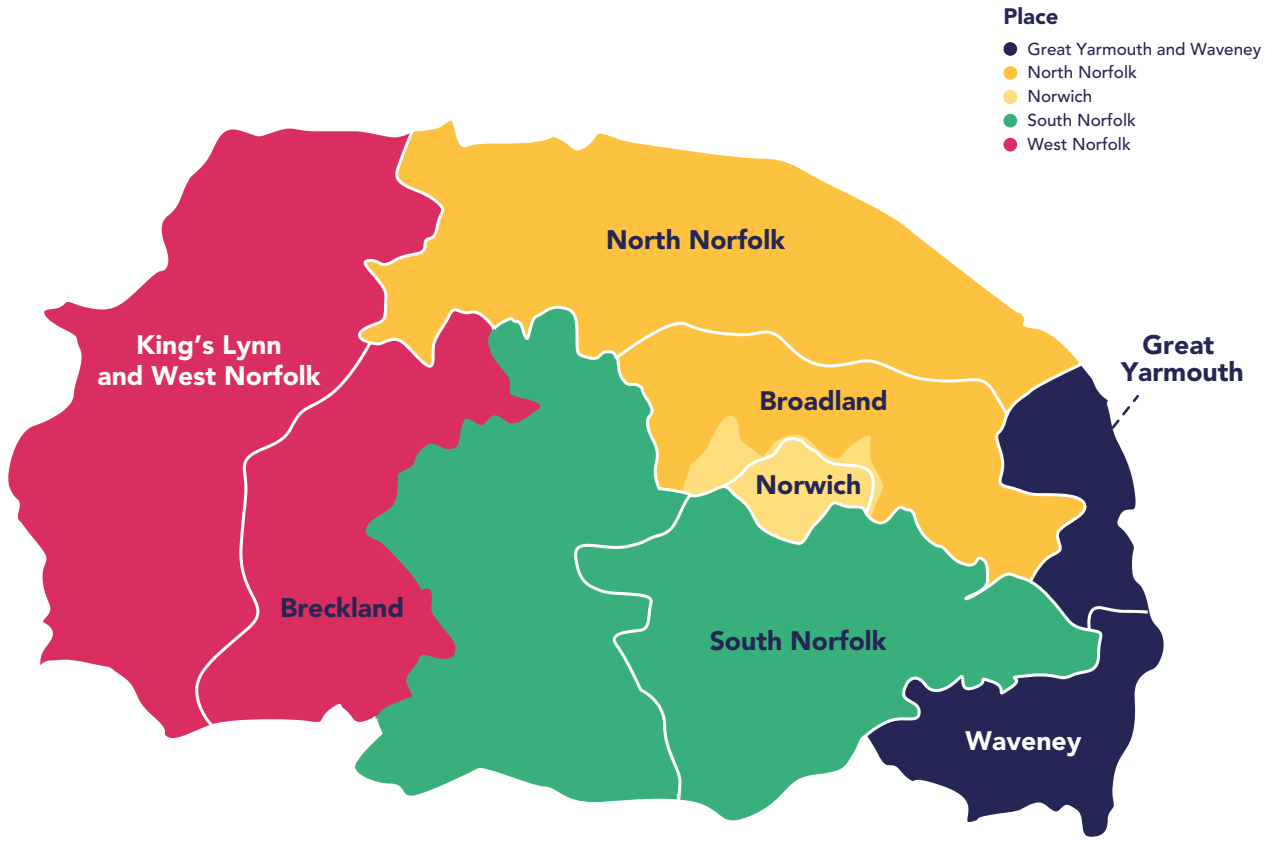


Figure 9 – Five Place Boards and eight Health and Wellbeing Partnerships map

- **Place Boards** bring together colleagues from health and care to integrate services, with a focus on effective operational delivery and improving people's care.
- **Health and Wellbeing Partnerships,** established on district council boundaries, seek to address the wider determinants of health and wellbeing by bringing together colleagues from county and district councils, the VCSE sector, health organisations, and other partners. The HWPs are optimally positioned to reduce health inequalities and focus on prevention through collaboration and empowering resilient communities.

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

Our Place Boards are primarily focused on delivering against two of our ambitions: population health management, reducing inequalities and supporting prevention, and primary care resilience and transformation. Other ambitions have Place Boards as key partners too, but it is acknowledged that more needs to happen to confirm details and resourcing. This approach sets out an intent and a signal that if we can deliver locally in our communities we will.

The responsibility map in Figure 10 supports our principles and overall direction of travel.

The HWPs have developed a strategy for each area across a two to five-year time period and action plans are in development which will identify timelines and milestones for delivery.. Future plans will be determined through place-based health and wellbeing strategies for the 2023-25 period and beyond, developed with reference to key strategic priorities from the district they serve and the ICS vision. Current priorities are set out in Figure 11 and all of them can be linked to at least one of the ambitions in the Joint Forward Plan. The HWPs have some resources allocated to them through funding from the Covid Recovery Fund, Better Care Fund, Active NoW, and Public Health. We are also reviewing the resources that are available to support the place-based approach, with support from clinical and care professionals.

Setting the Strategy

(Assessing need, priority setting and resource allocation)

ICS Level
- Integrated Care Strategy for Norfolk and Waveney
- Joint Forward Plan and transformation priorities
- Business planning
- Medium Term Financial Plan
- ICS Strategies e.g. clinical, research, estates, digital, people plan, population health

County
- Care Market strategy
- Joint Health and Wellbeing Strategies
- Joint Strategic Needs Assessments

Place
- Bottom-up input from local needs assessments / intelligence about health inequalities

Securing Services

(Specifying outcomes, designing services, shaping the structure of supply e.g. procurement)

Regional level
- Commissioning of specialised services

ICS level
- Commissioning of services, e.g. planned care, urgent and emergency care, primary care, community services
- Prioritising services
- Procuring services
- Contract management

Place
- Taking a lead on service re-design/ specifications/ outcomes
- Bottom-up input from local needs assessments and intelligence about health inequalities

Delivering Services

(Managing demand and capacity, delivering transformation and improvement)

ICS level
- Co-ordinating recovery plans
- Enabling functions and joining things-up e.g. data sharing agreements, business intelligence and information governance support, estates, wider digital functions, workforce, project management and communications and engagement

Place
- Providing a local response via partnership working e.g. with the voluntary, community and social enterprise sector, district councils, health and wellbeing partnerships

Monitoring and Evaluation

(Managing performance against agreed outcomes and seeking users' views)

ICS level
- Performance Committee
- Evidence and evaluation hub
- Quality Management Approach and faculty

Place
- Bringing the lived experience to the fore
- Case studies

Assurance

(Assuring quality, safety and governance)

Regional level
- ICB Performance committee and System Oversight Framework level 4 exit

ICS level
- ICB Board underpinned by Tier 2 ICB committee, e.g. Audit and Risk, Remuneration, People and Culture, Patients and Communities, Finance, Clinical Quality and Safety

Figure 10 - Responsibility Map

Partnership	Priorities
Breckland	Through inclusivity, innovation, and engagement: • Prevent Cardiovascular Disease • Improve Mental Health • Tackle issues arising from alcohol dependency and other alcohol related concerns.
Broadland	• Mental Health and Wellbeing • Resilient and Healthy Communities • Access and Prevention Cross-cutting themes: Covid-19 Recovery and Cost of Living Crisis.
Great Yarmouth	• Health Inequalities • Supporting Educational Attainment, Skills and Aspirations • Tackling Vulnerable and Exploitation • Reducing Loneliness, Isolation and Social Exclusion.
King's Lynn and West Norfolk	• Enhance Mental Health and Wellbeing • Improve Weight Management • Reduce alcohol consumption Cross-cutting themes: Prevention, Address Health and Wellbeing Inequalities, Engagement and Collaboration.
Norwich	• Social and economic wellbeing: Food equity, Social Mobility • Physical and mental HWB: Mental health and social isolation in targeted populations, Physical activity • Community resilience and voice: Hearing community voices, Community access to support.
North Norfolk	• Older people • Mental Health • Health Inequalities.
South Norfolk	• Mental Health and Wellbeing • Resilient and Healthy Communities • Access and Prevention Cross-cutting themes: Covid-19 Recovery and Cost of Living Crisis.
Waveney	A new strategy for Great Yarmouth and Waveney is being developed which may change Waveney HWPs priorities. However, the current sub-groups are: • Physical Activity • Children and Young People • Healthy Hearts • Prevention.

Figure 11 - Health and Wellbeing Partnership priorities

In summary we are clear about the role of the place-based approach in delivering the medium to longer term priorities in both the Joint Health and Wellbeing Strategies and the eight ambitions in the Joint Forward Plan, but we cannot do everything at once. We are pulling in the same direction and aiming for the same things, whilst ensuring the place-based approach can respond to local needs.

6.2 Provider collaboration

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

Acute hospital collaboration
The Norfolk and Waveney Acute Hospital Collaborative (N&WAHC) is a Provider Collaborative formed by the Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust, the Norfolk and Norwich University Hospital NHS Foundation Trust and the James Paget University Hospitals NHS Trust.

The purpose of the Collaborative is to enable the acute trusts to work even more closely together to deliver shared objectives and align decision making, whilst remaining separate organisations.

The N&WAHC's vision is to consistently provide equitable access for all patients to sustainable, high quality acute care through maximising the benefits of partnership. The mission is to radically transform and innovate acute health service provision for the next generation.

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

Current Objectives:

- Collectively deliver a single Electronic Patient Record (EPR) across the N&WAHC:
  - Within a comprehensive digital programme to streamline operations, improve communication, and enhance patient care, we will implement a single EPR across all acute hospitals by 2026. This will enable efficient sharing of patient information and enhance clinical decision-making, all of which will improve patient experience, timeliness of care and clinical outcomes.

- Jointly develop an Acute Clinical Strategy with a focus on working in partnership with the ICS to implement priority pathways:
  - The aims of the joint acute clinical strategy are to directly support the delivery of the ICS clinical strategy, identify shared clinical priorities and maximise the benefits of collaboration.

- Development of new hospitals:
  - Collaborative work on the planning for the two new hospitals proposed for Great Yarmouth and Kings' Lynn, which are part of the national New Hospitals Programme. We are committed to working together to take a holistic view of the future of acute hospital services across our system.

- Implementation of the Diagnostics Centres:
  - We will develop three new Community Diagnostic Centres across Norfolk & Waveney. This programme involves £86m investment to create new imaging diagnostic facilities which will work closely together and be fully digitally linked. The first Centres at JPUH and QEH will open in Summer 2024 and the NNUH Centre will open in Spring 2025.

- An aligned approach to transformational change across the N&WAHC:
  - Developing a collaborative approach to transformational change management to ensure we align the underpinning elements of transformational change. This will be achieved through developing a collaborative transformational change model, underpinned by plans for shared development of professional change management capability and capacity

- Supporting system-wide transformation:
  - We are committed to working with our wider System Partners to focus on delivery of transformational change in our priority areas. This work will include collaborative delivery of the agreed components of the Improving Lives Together programme and the agreed outputs of the Community Services Review. This work will focus upon transformational change within Discharge (aligned to wider Urgent and Emergency Care delivery) and corporate functions amongst other areas which are already in train / will be prioritised during the course of the next twelve months.

These acute hospital collaboration objectives map across into the JFP and other system strategies and plans and we can see how they are interlinked e.g. the EPR is a key strand of the ICS digital roadmap, the diagnostic centres are part of JFP objective 7a to support elective recoveryand the system-wide transformation work is what Ambition 8 of the JFP sets out to achieve. We've been careful to join these pieces of work so the effort is co-ordinated.

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

Our ambition was to establish an adult mental health system collaborative and a children and young people (CYP) system collaborative.

We established both system collaboratives in June 2023, with the Adults Mental Health Collaborative covering all of Norfolk and Waveney. The CYP collaborative covers Norfolk only, due to the way children's services are delivered on a county-based model. As such, the Collaborative was set up to work closely with the Suffolk Mental Health Collaborative to help plan services for CYP in Waveney. In developing these proposals Norfolk and Waveney ICS and Suffolk and North East Essex ICS have worked very closely together to ensure we have consistent delivery arrangements for integrated children's services.

Adult Mental Health System Collaborative:
We identified opportunities to work collaboratively using available data, intelligence, and insights, which focused on improving mental health and wellbeing of adults and older people. Initially, the Collaborative undertook a number of workstreams for people living with dementia – this programme of work has now been placed under the responsibility of the Aging Well Programme Board, as it is a better fit there and most of the pathway is delivered by members of that Board.

The adult mental health collaborative will continue to embed a new approach that:

a. focuses on early intervention and prevention – moving the resource and support further upstream, providing support to more people at an earlier stage and freeing up specialist support.
b. focuses on 'place' and the development of support within local communities – with less reliance on specialist settings, clinics, or institutions.
c. moves away from a focus on a clinical model to one which builds understanding and resilience of community-led early support, and which develops the skills and resources of people, families, and communities to help themselves.

Children and Young People System Collaborative:
We implemented the Thrive model through close working between the Norfolk and Suffolk MH CYP collaboratives, which are on a county council footprint. We made the structural, operational, and cultural changes required to deliver community based multi-disciplinary teams, working across organisations, and ensured collective support to meet the emotional wellbeing, mental and physical health needs of the child or young person and their family.

Initially the CYP MH collaborative focused on development of a model of prevention and intervention with an initial focus on the redesign of community-based services covering mental health services, the Special Educational Needs and Disabilities (SEND) redesign of the operating model and neurodevelopmental pathways. The CYP MH collaborative also launched an Integrated Front Door (IFD) to support Children and Young People (CYP) aged 0-25 with an emotional wellbeing or mental health need to access the right support at the right time. This will be a 'needs led' single integrated access point for all emotional wellbeing and mental health enquiries and requests for support.

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

The CYP Mental Health Collaborative will continue to work towards providing:

- Self-Care support, through digital resources and tools, including guided self-help, with a 'request for support' process that automatically leads to suitable resources.
- Improved access to advice and guidance through a single telephone number, and offering timely, single session interventions where clinically appropriate.
- Request for Support – One trusted pathway for children, families, and professionals to ask for emotional wellbeing and mental health support. The clinical team will assess every request for support and promptly allocate to the most appropriate service offer to meet the needs of children and young people if required.

Community services collaboration

A review of Community Services was undertaken to identify the optimal model needed to meet current and future need across Norfolk and Waveney.

From March 2023, an engagement process was undertaken by Tricordant, involving:

- Resident engagement
- >50 individual and group interviews with key leaders
- 2 system workshops, 5 Place Boards, Clinical Professionals Assembly meeting, 3 ICS Executive Management Team meetings.

They also reviewed good practice from the King's Fund and activity and financial data from comparable ICBs, testing and challenging models and assumptions.

The result was the creation of a framework to guide future planning, commissioning, and the delivery infrastructure of community health services in Norfolk and Waveney.

This framework revolves around four Strategic Impacts:

1. Proactive and personalised support from integrated teams
2. Delivering more specialist care in the community
3. Enabling healthy communities
4. Meeting local urgent and emergency care needs.

Through these impacts, community health services can make an important operational and strategic contribution to delivery of the Joint Forward Plan, system outcomes and a much desired 'left shift' where we deliver services closer to our population.

We now enter the implementation phase. This is planned through learning from a series of agreed 'prototypes' testing new ways of working and in some cases, new models of care.

Discussions with key organisations to date have given multiple and varying reasons for wanting to transform community services. Coupled with the differing health outcomes experienced by people across Norfolk and Waveney it is preferable to look to developing a strategic operating model for community provision built on the principle of subsidiarity.

It is currently proposed a number of community service alliances are formed. These will mimic our known functional economic areas (clusters of services where people naturally gravitate for services, work or leisure).

The establishment of three alliances will:

- Demonstrate subsidiarity – making decisions close to our communities so as to have the greatest impact.
- Provide a focused local forum - to facilitate partnership working and collaboration, and to ensure the delivery of local community health and care services in accordance with the agreed four Strategic Impacts.
- Ensure the 'buy-in' of all partners - understanding their specific needs in the short and longer term. Having an open and honest debate on a smaller footprint will enable a plan to emerge that delivers 'their' priority areas but also align with the strategic priorities.
- Create an environment whereby organisations are truly reliant on each other to succeed - In order to deliver critical programmes of work in the next few years (such as the New Hospital Programme) "interdependency is real not optional".
- Capture and include the views and opportunities afforded by non-statutory partners - recognising their number and 'offer' differs

- In real time and to inform the development of a rolling plan/ programme of work, understand the health inequalities and demographic specific to that alliance.
- Similarly, through demonstrable and pro-active inclusion of local residents seek to understand and capture their views on an ongoing basis.

Discussions are ongoing to agree the optimum number of alliances in advance of formal commencement in 2024.

6.3 Our partners' plans and existing ICS plans

A key principle of the JFP is that it builds on existing local strategies and plans, and this section shows how we are doing this by making connections between different pieces of work. By lining up our efforts and doing a few key things well, once, at system level and in a co-ordinated way with partners, ensures we are using these strategies to best effect.

Partners' plans

It is only by working together we can build system resources to address our ambitions and objectives in section 4 to overcome some of the biggest barriers we face, achieve improvements in productivity and efficiency and the deliver our ambitions across every organisation and every service. Local Authorities play a central role in providing local leadership for health improvement, arranging public health services locally, and influencing local action to address the wider determinants of health and health inequalities for both physical and mental health. The alignment in our shared ambitions is demonstrated below.

Norfolk County Council's Better Together for Norfolk highlights the need to work collaboratively and aims to ensure our residents are living healthy, fulfilling, independent lives with a focus on prevention, early help and levelling up health through provision of better local services. Improving access and integration also aligns with the aim of the core ambitions for Adult Social Services and the Public Health Strategic Plan. Flourishing in Norfolk: A Children and Young People Partnership Strategy – Norfolk County Council supports our work to embed the Thrive model and ensure resources work around the child, with the child at the centre, enabling them to Flourish.

Suffolk County Council's Corporate Strategy 2022-26 addresses their work with the NHS, district and borough councils, and other partners to prioritise the physical and mental health of all people in Suffolk to enable residents to lead healthier, active lives and address health inequalities, including working to combat isolation and loneliness and tackling obesity. Preparing for the Future supports the prioritisation of vulnerable children and young people, including delivery of further improvements in services for children and young people with SEND in Waveney.

Norfolk and Norwich University Hospital NHS Foundation Trust's Caring with PRIDE centres around multiple work programmes to deliver equitable patient access and experience, engagement and co-production, workforce development, integrated working with local providers, service transformation, estates and facilities.

James Paget University Hospitals NHS Foundation Trust's JPUH-Trust-Strategy-2023-28 focuses on empowering patient choice and reducing health inequalities, promoting compassion and staff wellbeing, effective partnership working and ensuring services and finances are sustainable.

Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust's Queen Elizabeth Hospital strategy is focused on equity of access and provision of timely care with an initial focus on emergency care, cancer services and elective recovery alongside a commitment to become a centre of excellence within the specialties of frailty and stroke. The QEH is updating its Corporate Strategy recognising the significant changes in recent years, including the addition of the Trust to the New Hospital Programme in 2023. The Strategy will continue to focus on 'Quality, Engagement and Healthy Lives' underpinned by nine Strategic Objectives. The Strategy will be published in April 2024.

Norfolk and Suffolk NHS Foundation Trust's Our Trust Strategy | Norfolk and Suffolk NHS (nsft.nhs.uk) centres on collaboration within our local system, early intervention to reduce inequalities and improve outcomes and experiences of patients alongside an ongoing improvement programme.

East Of England Ambulance Service NHS Trust's East of England Ambulance Service NHS Trust strategy is consistent with our hospitals' shared objective of care closer to home and will collaborate with primary care networks to ensure provision of care at home or in the community where possible, avoiding unnecessary admissions to hospital achieved through integrated partnership working and finding innovative ways to deliver the best possible care.

Norfolk Community Health and Care NHS Hospital Trust's NCH&C strategy aims to deliver seamless health and social care that creates healthier futures for everyone by developing partner integration, attracting and developing brilliant and fulfilled teams, continually improving standards of excellence and advancing the use of data and technology.

East Coast Community Healthcare's (ECCH) vision and strategy ECCH strategy proactively contribute to the delivery of the three ICS goals. ECCH has six ambitions that underpin service delivery, quality improvement and transformation activity which are informed, and driven, by the eight ambitions as we work in partnership at place and at system level.

We also evidence how the eight ambitions are supported by published ICS strategies. These provide enabling infrastructure to support the transformation.

Our Health and Wellbeing Strategies and our Integrated Care Strategy

Norfolk Joint Health and Wellbeing Strategy and the Integrated Care Strategy for Norfolk and Waveney Norfolk's Joint Health and Wellbeing Strategy focuses on:

Driving Integration by mobilising MH collaboratives and the delivery of people-centred care; by working together as a system to ensure people receive the right care, in the right place, at the right time and reducing LoS; by using and sharing data and evidence to inform planning; by working in partnership to ensure people age well.

Prioritising Prevention with a MH collaborative and shared resources, supporting people to be resilient throughout life; by early diagnosis and reducing waiting times therefore preventing, reducing and delaying need; by delivering the three prevention objectives in ambition 6 and promoting healthy lifestyles; through a systematic approach to preventing ill health from birth through early years and a focus on early intervention and prevention.

Addressing inequalities by improving accessibility and reducing ambulance wait times; by providing support for those who are most vulnerable using a collaborative approach to develop pathways; targeting interventions to those that need it the most and by improving care for people most at risk of falls.

Enabling Resilient Communities by supporting people with complex needs to remain independent whenever possible through promotion of early support and recovery; by supporting people to return back to their communities by reducing LoS and expanding virtual ward services; by supporting the population to live independent healthy lives in their communities for as long as possible, and by building a local resilient multi-skilled professional workforce.

Suffolk Joint Local Health and Wellbeing Strategy 2022-27, Preparing for the Future champions greater collaboration, system-working, developing shared priorities and power resource sharing including:

Strengthen protective public factors and lessen the impact of factors that adversely impact mental health, such as unemployment, loneliness, social isolation, crime, migration, unsafe environments, and poor housing. Promote healthy workplaces, listen to the voices coming from employers, have conversations that support mental health and wellbeing.

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

A good quality of life for **Suffolk's older people** is a priority. Working with partners to tackle loneliness and isolation, promote active participation in daily life, support greater opportunities for volunteering, and support the development of healthy and sustainable communities where people can live their best lives.

Reducing inequalities is a cross-cutting theme, with actions aiming to improve people's access to good jobs, raising incomes, and tackling the effects of poverty on families and children.

Our existing ICS strategies

Norfolk and Waveney ICS strategies have been through wide consultation and are agreed with system partners. The JFP ambitions lean into the infrastructure that these 'enablers' are developing, particularly the role of digital, workforce and estates.

Digital Transformation Strategic Plan and Roadmap
Nationally, data has become an increasingly vital part of health and care delivery. It supports the insight we can have into what is happening, which leads to better decisions earlier, and better outcomes. We have invested in a 'Data Hub' driven by new, national data standards as well as regional and local requirements. We will simplify, standardise, collate and link the data sets, providing the capability to connect what the data tells us, and aggregate it for strategic and tactical analysis, decision making and reporting to enable us to achieve our goals, drive quality improvements and to support front line services in the delivery of safe, effective, and person-centred care.

This strategy will enable electronic patient records across health and care settings, delivery of a single waiting list, sharing information and deliver the technology to support patient preparation for their planned treatment and operations and enable delivery of virtual wards.

Across primary care there will be integrated infrastructure such as wi-fi connectivity and cloud telephony. Digital workforce tools and fully integrated infrastructure and connectivity will have a direct benefit to productivity as they are linked to the HR/People and Digital changes that we intend to make through the Improving Lives Together change programme. Artificial Intelligence and automation will also increase productivity. Our PHM, HI and prevention ambitions will be underpinned by a specific PHM data-driven approach so we can undertake work in a targeted way, much earlier.

You can read the Digital Transformation Strategic Plan and Roadmap here.

People Plan
It is our intention is to review our approach to a refresh of the People Plan following the completion of the ICBs organisational change programme to ensure that our strategic intent is aligned locally and with national policies for people transformation in 2024/5. Multi professional educational and training investment plans with sufficient clinical placement capacity are required to maintain education and training pipelines. You can read more about this in Part 2 of the JFP where we describe our duty to promote education and training, and other information about our workforce plans.

In addition to this, several programmes are being delivered to improve efficiency and productivity across the system as part of Ambition 8. Our Scaling of People Services programme is looking at how to streamline back-office HR and workforce functions to reduce duplication and increase automation. A reduction in agency spend is required to meet national efficiency targets and integrated workforce plans across providers are being developed at system level to align with the 2024/25 operational planning requirements referred to in section 4.1 and the longer term JFP ambitions in section 4.2.

You can read the current Norfolk and Waveney People Plan here.

Estates
Our Estate Strategy is being refreshed to incorporate the latest NHS England guidance for System Infrastructure Strategies.

In order to provide integrated 'out-of-hospital care,' with a focus on prevention, self-care, and supporting people to live well at home for longer, our community-based providers will continue to work with PCNs to develop their integrated service models and implement PCN estate strategies. Health and care estate will be developed to maximise integrated spaces, and we are investing in health hubs formed from new and existing community located assets across the area. The intention is that this supports and encourages increased integration and that this will form a model for how estates can support care closer to home.

As the demand for mental health services has increased, our estate strategy recognises that more support is needed for communities, especially children and young people. We recognise that the correct infrastructure model can support the integrated mental health services

being developed through PCNs, focussing on prevention, early help, and health inequalities to promote healthier lifestyles and emotional wellbeing, and this is part of our JFP.

Significant investment in new hospital sites provides an excellent opportunity for us to care for our population in modern and well-equipped environments, securing better health outcomes, incorporating new ways of working, investing in technology and innovation, and aligning infrastructure to our long-term clinical plans. Development of the ICS estate aligns with the growing and ageing population, and a Planning in Health Protocol has been put in place to ensure the impacts on health and care services from local plans and a growing population are measured and managed appropriately. At the same time, we are implementing interventions to decarbonise our estate and reduce carbon emissions from our buildings, infrastructure, and services which is all part of our Net Zero Green Plan.

You can read the Estates strategy here.

Net Zero Green Plan
The NWICS Green Plan drives our journey toward achieving the Net Zero NHS between 2040-2045 through actions such as:

- Supporting Primary Care Network (PCN) development in ways that promote integrated services, closer to home
- Developing Family hubs
- Primary Care Hub projects
- Community Diagnostic Centres
- An expanding virtual ward service enabling patients to recover and be monitored at home

Other parts of our Green plan include digital transformation such as our electronic patient record programme, optimising medicines to minimise impacts on the environment such as our inhalers programme and changing to inhaler types that exclude harmful propellants. We also use our programme for Nature Connection and Biodiversity to coordinate investment in our built environment to provide spaces that promote health and aid wellbeing.

You can read the Net Zero Green Plan here.

Quality Strategy
Our Quality Strategy provides a clear focus on improving care quality and outcomes, using insights around health inequalities and population health to ensure services are safe and sustainable for future generations, underpinned by continuous development of clinical leadership, quality governance, management and assurance, research, evaluation and innovation. Quality is a key theme throughout the delivery of the objectives.

You can read the Quality Strategy here.

Clinical Strategy
Our clinical strategy has six objectives setting out "what my NHS will do" in Norfolk and Waveney. Each of the six clinical strategy objectives and their focus for year 2 of the strategy implementation can be clearly mapped against the JFP ambitions and we have adopted this approach to ensure we are consistently focusing on the same things and do not duplicate effort or reporting requirements. For example the statement "My NHS will see me as a whole person" has a focus on people with Mental Health needs this year and has series of specific actions, as well as a clear cross reference to Ambition 4 in the JFP. The ICS clinical strategy, digital roadmap, the Estates strategy and Net Zero Green Plan are inter-dependent and refer to each other which gives the JFP a good foundation to build upon. The acute clinical strategy referred to in section 6.2 uses the ICS clinical strategy as its over-arching framework to ensure our workplans are aligned.

You can read the Clinical Strategy and a comprehensive "You said, we did" analysis of Year 1 and future ambitions for Year 2 here.

Research and Innovation
Our recently published Research and Innovation (R&I) strategy has four principles:

Principle 1 - will be focused on our communities. By working with our population, we can understand needs and identify gaps to target research and innovation to improve experience of care, quality of services and health outcomes. For example, we can drive the

development of research which addresses the needs of people in later life and identify innovations which could enable more personalised care.

Principle 2 - will be driven by a confident and capable workforce by equipping our workforce with the skills and confidence to identify where an innovation could help to reduce wating lists.

Principle 3 - will be collaborative and co-ordinated by working together as a system we can make sure that R&I is championed and embedded across primary care. We can ensure new research projects are designed with people at the centre, so more research takes place closer to home.

Principle 4 - will embed everything we do using evidence from across our system when designing services, evaluating innovation and new ways of working, for example the impact of unplanned care hubs.

R&I can transform how we deliver care and support better use of resources to address differences in life expectancy, health outcomes and preventable causes of disease. Evidence from national research projects, as well as local evaluations and quality improvement projects from our system, can help us choose the best services and ways of working to address unequal health outcomes.

You can read the Research and Innovation Strategy here.

6.4 Empowerment

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

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

6.5 People and culture

Change happens when people work together differently.

Our Organisational Development (OD) Programme will improve performance and effectiveness to shape a thriving Norfolk and Waveney ICS. We will focus on relationships with and between people and organisations we work with, the culture and processes, and support our leaders to navigate the challenges and complexity of working across organisations to consolidate and align organisational goals with shared vision and purpose for an integrated Norfolk and Waveney system. The foundation of strong relationships, a deep sense of community, a desire to make the system work for the local population of Norfolk and Waveney and, positive developmental work with key stakeholder groups and Boards across the ICS are the bedrock of our maturing ICS.

Specifically, we are working on a collective system culture of compassion and inclusion to develop leaders and teams, with all our Boards and key stakeholder groups to develop mature working relationships and structures to support the goals and ambitions of the ICS, embedding our Leadership Framework to support the people that are leading the changes; and evaluate and review our actions with the aim of planning and co-creating the next phase of the maturity journey.

An integral part of the People and Culture enabler is the way that **clinicians and care professionals** (CCPs) are involved in decision-making. This ultimately improves the quality outcomes and experience of our local population, and it is also recognised nationally as best practice. The CCP voice is included in every decision-making group across the ICS – no decision regarding the care we provide or commission is made without formal consideration by a CCP.

We are implementing a **Leadership Framework and 10-point CCP manifesto which is on our website** CCPL Programme to take action on the 5 core principles for effective clinical and care professional leadership. New **CCP** leadership roles have been aligned to each of the ambitions outlined in the Joint Forward Plan with a focus on areas highlighted in the national Core20PLUS5 agenda, further strengthened by leadership development and wider training as we continue to establish a Norfolk and Waveney pipeline of suitably trained, supported and empowered CCPs.

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

You can read more about the Quality Faculty in part 2 of the JFP under the legal duty to improve quality of services.

We will focus on embedding a culture of innovation across the ICS and support the system to have an integrated innovation culture based on learning from, and sharing with, each other. We recognise that developing and nurturing an integrated innovation culture across a system is an evolving process, but we aim to position the importance of innovation as a central, shared concern. We will use a multi-level approach across the system to grow innovation culture and capacity, this includes a system-wide vision for innovation, sharing of innovation across teams and providers, upskilling staff across all levels, and working with external organisations. You can read more about our plans for innovation in part 2 of the JFP under the legal duty to promote research and innovation.

6.6 Engagement and Co-production

Norfolk and Waveney are committed to listening and facilitating inclusive engagement with our people, patients and their families and carers, so we can deliver responsive and joined up care that is genuinely co-designed and produced with those that use our services. We believe that all feedback has value and should be supported through a spectrum of participation methods (Figure 12):

Figure 12 spectrum of participation

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

We are working with system partners to align and develop a broad range of participation methods:

- A Norfolk and Waveney ICS Communications and Engagement (ICS C&E) group was established in September 2021 to work as a system on a variety of local priorities, such as communications campaigns, participation and co-production and to act as a learning network. Membership includes representatives from Norfolk and Suffolk - 8 NHS provider trusts, 2 county councils, 2 Healthwatch's, 8 district councils, Norfolk Police, 2 Chambers of Commerce, Out of Hours/111 provider, Active Norfolk, Norfolk Older People's Strategic Partnership, 4 VCSE organisations and representatives from housing associations.
- Work is currently underway to develop a Health Inequalities Framework for action the ICS which includes the Norfolk and Waveney Community Voices (NWCV) Programme. NWCV works with trusted communicators – "people like me" - to speak with communities who may not already engage with the NHS and other statutory bodies to hear what is important to them. We have learned that when talking to people about health services they also talk about a range of other issues that affect their health and wellbeing, such as housing and employment. We are designing ways to capture all this insight and make sure it is shared with people who design and deliver a range of services across Norfolk and Waveney.
- Each Place Board has access to some light touch support to support them to engage with their communities. Working with people and communities at 'place' level will support all the different voices of our people and communities to be part of local decision-making, as conversations about 'the place where I live' are often much richer.
- Norfolk and Waveney Patient Experience and Engagement Leads meetings have been taking place weekly for several years and give an opportunity for people working in NHS provider trusts to meet and share practice across the system and to begin to test and develop the idea of the 'wider team' working with people and communities across the ICS to listen to and involve patient experience feedback in quality and wider commissioning.
- Communications and engagement support is being given to the Norfolk and Waveney VCSE Assembly.

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

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

Communications and engagement work, at a very local level, is key to developing on-going relationships with people and communities and our new networks for engagement will be vital in supporting the work of the Joint Forward Plan.

One particular area of participation that we will be developing further is around the promotion of true co-production. This refers to a process of shared power to effect change.

Examples of co-production exist in Norfolk and Waveney

- Development of a co-production hub as part of our People and Communities hub to share examples from the system, to promote co-production principles and to signpost to support materials
- Development of a Norfolk and Waveney Mental Health Co-production strategy and interactive toolkit Mental Health Co-production strategy for lived experience to effectively influence ICS mental health transformation, services and support.
- The Norfolk Making It Real (MiR) steering group which promotes co-production particularly for people with lived experience of physical and learning disabilities. This is in partnership with Norfolk County Council Adult Social Care.
- Supporting the development of a Norfolk and Waveney Co-production Network in conjunction with local health and wellbeing partnerships.
- Supporting various NHS England funded initiatives in Norfolk and Waveney such as a series of co-production projects across the ICS around Quality Improvement
- Developing a Rewards and Recognition Policy that includes a threshold for when participation becomes co-production, and details how we can offer effective support for our people and communities through the whole spectrum of participation methods.

6.7 Our VCSE Sector as system partners

Norfolk and Waveney benefits from a broad and diverse VCSE sector in which there are 3645 registered charities, 220 community interest companies and 124 registered societies with their offices based in Norfolk and Waveney. Many of these organisations have been born of local communities of interest or geography, responding to the local and emerging specialist needs to provide not for profit services and support. Many of these organisations will focus on early intervention and preventative services, empowering their communities to build resilience and maintain control of their own lives.

Our VCSE Assembly launched in July 2022 with a headline objective to connect this rich and diverse public benefit across the overarching mission for Norfolk and Waveney ICS. The Assembly provides the sector with a space in which VCSE leaders can sit alongside statutory ICS partners where there is a shared agenda across local health and care priorities. Our current VCSE Assembly model aims to ensure suitable connectivity within our emerging ICS governance arrangement, enabling collaborative decision making and effective partnering.

The VCSE sector in Norfolk and Waveney continues to face a 'perfect storm' of rising running costs and reduced fundraising income against a backdrop of increasing demand for services. More and more VCSEs are currently facing tough decisions as they try to maintain their public benefit mission, inevitably capacity must be reduced and in a growing number of cases services are being forced into closure. With the establishment of our Assembly we have an opportunity for ICS partnership and strategic alignment across the early intervention and prevention ambition specifically. This could this start to shift demand away from more acute interventions and it will help our residents live longer, healthier, and happier lives.

At its heart, the VCSE Assembly is the vehicle through which our ICS will shape the development of effective strategic and operational partnerships across the diversity of our VCSE sector; listening to and seeking to involve any, and every, VCSE organisation providing health and care support for the benefit of their communities. The graphic below (Figure 13) sets out how the listening and involvement work of the Assembly is being augmented; through the support, nurturing and development work of our VCSE infrastructure organisations and through improved collaboration, co-production and shared governance as an integral part of our ICS.

Our ICS building blocks	Primary functions & responsibilities	Desired outcomes
Empowering Communities Partnership & CAS Support, nurture,develop	• Grow and enable volunteering for the ICS. • Build VCSE sector capacity & capability through practical advice, support & training. • Advocate widely on behalf of the sector and supporting sector collaboration. • Raise awareness of and support the sector to access funding and income sources. • Support the sector to maximise funding to provide sustainability and resilience. • Provide financial support to VCSE organisations seeking to grow, expand or innovate their services. • Provide opportunities for the sector to meet & collaborate for peer to peer support, and share insights.	**The collective ambition is to embed effective collaboration and partnership working between all ICS partners.**
Norfolk and Waveney VCSE Assembly Listen and involve	• Develop innovative engagement mechanisms to connect the sector into the ICS, focused on health inequalities and prevention - developed at system, place and neighbourhood levels of our ICS. • Increase the influence and participation of the sector in the collaborative design and innovative delivery of health and care services within the ICS. • Lead development of a MoU between ICS partners based on 5 priority areas of; equal partnering, sustainable resourcing, digital integration, data sharing & consistent evidence and evaluation.	**Closer working will support us to achieve our shared goals and priorities, and enable our ICS to harness the expertise, insight and innovation of the VCSE sector.**
Norfolk and Waveney ICS & VCSE Integration Collaborate, co-produce and embed	• Embed the sector in ICS governance to ensure involvement in system-wide workstreams, place-based partnerships, primary care networks and provider collaboratives. • Support sector sustainability through strategic investment and market development. • Commit to upholding the ambitions of the MoU developed in partnership with all ICS partners. • Lead a system-wide approach to developing and sustaining effective social prescribing. • Collaboratively develop a new approach to health and social care VCSE commissioning.	**N&W needs a VCSE sector that is vibrant, sustainable and resilient, is seen and treated as an equal partner and fully integrated into our ICS at system, place and neighbourhood levels.**

Figure 13 – building effective partnerships with the VCSE sector

VCSE Assembly Development
An initial focus on place based VCSE representation through the first pilot year of the Assembly has helped to build strong blueprints for improved partnering across some parts of our system. As we review our Assembly Board membership, we will take the learning from this experience to enable insight and best practice to have equal benefit across Norfolk & Waveney. We will continue to be cognisant of the vital contribution the strategic VCSE forums for Norfolk and Waveney bring as VCSE Assembly Board members and will work with Sector leads to further support the forums sustainability. We have also recognised a need to strengthen the way in which VCSE experience, and the lived experience of the communities which we serve, is brought to our emerging ICS strategic framework.

Facilitating the effective development of an Assembly operating model, alongside suitable Assembly Board memberships continue to demonstrate our shared ambition to respond to the national ICS commitment which highlights the VCSE sector is a key strategic partner with an important contribution to make in shaping, improving, and delivering services, and developing and implementing plans to tackle the wider determinants of health.

Health Inequalities Strategic Framework for Action
The VCSE sector was extensively engaged in the development of this ICS strategy, setting an approach for the way in which such lived experience is brought to the development of other ICS wide strategies. Following the re-structure of our ICB workforce a newly formed Head of Health Inequalities and VCSE partnering post will both champion the role out of this framework and the engagement of the VCSE sector in its delivery.

Impact and evaluation
So many conversations keep coming back to building a shared understanding of the value that improved VCSE partnering will bring to our system. To support this ambition, we continue to work collaboratively, developing a new approach to VCSE sector commissioning. There are numerous local examples of health and care commissioners working together with VCSE organisations, that demonstrate how we can deliver improved outcomes for our population. However, feedback from the sector and commissioners confirms us that having an effective ICS VCSE commissioning strategy would enable us to do more. Furthermore, following the publication of our Health Inequalities Strategic Framework, we will have more opportunity to understand and monitor the impact of preventative and early interventions for members of our local population who are in greatest need of support.

7.0 Commitment to achievable, measurable and impactful improvements

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7.0 Commitment to achievable, measurable and impactful improvements

The improvements we make are quantitatively and qualitatively measured through system Programme Boards and monitored using a Programme Management Office (PMO) approach, reported to the ICB's Commissioning and Performance Sub-Committee, the Integrated Care Partnership and Health & Well-Being Board in annual plans and on our ICS website. A summary of key metrics is shown in Figure 14.

Our commitment is to listen to the people who use our services to hear if we are successfully improving the health and care for the people and communities of Norfolk and Waveney and in doing so deliver our JFP ambitions.

Joint Forward Plan eight Ambitions and underpinning objectives

Ambition	Ambition Objective	How will we know we are achieving our objectives?
1	**PHM, Reducing Inequalities & Supporting Prevention**	
1a	Development and delivery of two strategic pieces of work: A Norfolk and Waveney Health Inequalities Strategic Framework for Action; and a Population Health Management Strategy	Publication of action plans to reduce health inequalities and develop our PHM approach over the next 5-10 years and the improvement we expect to see. Develop a programme of evaluation based on the best available data and insight to measure progress.
1b	Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people.	Reduction in the percentage of women in Norfolk and Waveney who are smoking at time of delivery, from 12% towards 9% over the next 2 years, and to 6% by the end of year 4.
1c	Early Cancer Diagnosis – Targeted Lung Health Check Programme.	Roll out TLHC's to people between the ages of 55 and 74 who are current or former smokers, tracking the number of invitations, uptake and CT scans against the agreed trajectory.
1d	Cardiovascular disease Prevention – develop a programme of population health management interventions targeting High Blood Pressure and Cholesterol.	Identify and offer high risk patients low intensity statins, aiming for 5% improvement in hypertension metrics 6 months after go-live
2	**Primary Care Resilience & Transformation**	
2a	Developing our vision for providing accessible enhanced primary care services, improving patient outcomes and experience	A rolling programme of targeted actions to respond to people's experience of poor access to primary care We will use feedback to understand any increased awareness and confidence in use of digital tools across primary care and our communities (e.g. NHS App) We will have a roadmap for protecting the provision of core primary care services locally as they are now, whilst supporting a transition to a more sustainable integrated neighbourhood model of care
2b	Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years.	We will have published our Long-Term Plan for dentistry by Spring 2024, informed by strong public engagement and using data to meet the needs of our population. Improved access for our population to urgent treatment services, and reduced impact on Emergency Departments and other system partners Improving access for our local population through management of health inequalities and for children and young people
3	**Improving Services for Babies, Children, Young People (BCYP) and developing our Local Maternity and Neonatal System (LMNS)**	
3a	Successful implementation of Norfolk's Start for Life (SfL) and Family Hubs (FH) approach.	Evaluation process being developed with the DfE/DHSC and 10 local key performance indicators have also been identified for tracking of progress
3b	Continued development of our Local Maternity and Neonatal System (LMNS), including the Three Year Maternity Delivery Plan.	Maternity workforce vacancies reduce and retention improves against the vacancy rate of 9% as at May 2023

Figure 14 final metric summary

Ambition	Ambition Objective	How will we know we are achieving our objectives?
3c	Implementation of asthma and epilepsy recommendations, for Children and Young People.	Decreased hospital admissions for asthma for young people aged 10-18 Decreased hospital admissions for epilepsy for children and young people aged 0-19. 20% of CYP from deprived areas have asthma care plans in place
3d	Develop an improved and appropriate offer for Children's Neurodiversity	Improved patient experience evidenced through feedback with families A reduction in waits to specialist services. Increase in 'appropriate' referrals to services Reduction in complaints regarding barriers to accessing care Number of unique users of the digital library
4	**Transforming Mental Health Services**	
4a	We will work together to increase awareness of mental health; enable our population to develop skills and knowledge to support wellbeing and improve mental health; and deliver a refreshed suicide prevention strategy. This will prompt early intervention and prevention for people of all ages, including those who experience inequalities or challenges to their mental health and wellbeing.	Self-reporting mental wellbeing – the number of people reporting high anxiety, low happiness and low worthwhile scores will reduce Suicide Prevention – Rates of suicide and self-harm will reduce.
4b	Mobilise an adult mental health collaborative and a children and young people's collaborative so that partners work as one to deliver better health outcomes for our people and communities	Access to support is streamlined, responsive and coordinated for: - Adults with mental health needs. - Children or Young Person with emotional wellbeing, mental and physical health needs. The impact will be measured by actively seeking feedback from our people and communities, families and carers, and workforce, before and after any change that is implemented.
4c	Establish a Children and Young People's (0-25 years) Emotional Wellbeing and Mental Health 'integrated front door' so all requests for advice, guidance and help are accepted, and the appropriate level of support is given to ensure that needs are met.	We will be able to measure an increase in the number of children and young people accessing the right support to meet their emotional wellbeing and mental health needs. This will be evidenced through the CYP Mental Health access metric within the national Mental Health Services Data Set (MHSDS) and through patient reported outcome measures.
4d	We will see the whole person for who they are, developing pathways that support engagement, treatment and promote recovery for people living with multiple and complex needs, with a focus on dual diagnosis and Complex Emotional Needs (CEN).	**Complex Emotional Needs** • 300 additional staff trained per year in Knowledge and Understanding Framework, Dialectical Behavioural Therapy, or psychologically informed approaches system-wide. • Increase in numbers of service users able to access a psychologically informed intervention outside of the NHS talking therapies and secondary care offer • A reduction in presentations to Emergency Departments for patients with Personality Disorder. **Dual Diagnosis** • Achieve an increased number of referrals (as per Y1 plans and trajectory) accepted via the dual diagnosis pathway. • A reduction in presentations to emergency departments for service users with mental health needs and drug or alcohol problems

Figure 14 final metric summary

Ambition	Ambition Objective	How will we know we are achieving our objectives?
	Transforming Care in later life	
5a	To have health, carer and support services that are fit for our ageing population - supporting people as they age, to lead longer, healthier, happier lives	Reduced unplanned admissions from care homes. Better understanding and coding of our population with frailty, enabling specific support to be put in place. All providers signed up to the dementia charter and feedback from people with dementia and those who care for them that this is improving their experience
6	**Improving UEC**	
6a	Improve emergency ambulance repsonse times and ensure patients are seen more quickly in the Emergency Departments	Category 2 ambulance response times to average no more than 30 minutes across 2024/25 Consistent 30min ambulance handover at hospital
6b	Expand virtual ward services as an alternative to an inpatient stay	We will have achieved and be sustaining 368 virtual ward beds
6c	Delivery of the RightCareNoW programme to reduce length of stay (LoS) in hospitals	Achieve or exceed the national target to reduce hospital occupancy to 92% or less.
7	**Elective Recovery & Improvement**	
7a	Effectively utilise capacity across all Health System Partners.	Waiting times will reduce for patients and cancers will be diagnosed earlier in line with trajectory.
7b	Implement digital technology to enable elective recovery.	We will measure: • how many patients have been offered mutual aid • how many patients chose a different hospital • how many patients chose to wait at their preferred treatment location
8	**Improving Productivity & Efficiency**	
8a	Improve the services we provide by enhancing productivity and value for money, and delivering services together where it makes sense to do so.	We will undertake post implementation reviews for changes led through our Improving Lives Together programme to formally assess that we have successfully delivered the operational and financial improvements set out in individual business cases. We will use national benchmarking data drawn from the Model Health System to measure our improvement relative to national benchmarks and other ICSs.

Figure 14 final metric summary

Glossary

A glossary of terms for the Joint Forward Plan is available here.

We have also developed a list of the latest acronyms and terms that are used in the NHS and on our social media channels for the Integrated Care System (ICS). It is available on the ICS website here.

Sources

The data that is referenced in Section 3.0 has been sourced from: https://www.nomisweb.co.uk/

https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice (during 2022)

https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/general-practice-data-hub/dentistry (to June 2022)

https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin/2021-22-annual-report

https://digital.nhs.uk/data-and-information/publications/statistical/hospital-accident--emergency-activity/2021-22

https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2021-22

https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice

https://fingertips.phe.org.uk/ (applying Norfolk prevalence to estimates to Norfolk and Waveney population 19+)

https://digital.nhs.uk/data-and-information/publications/statistical/case-mix-adjusted-percentage-of-cancers-diagnosed-at-stages-1-and-2-in-england/2020

https://www.norfolkinsight.org.uk/wp-content/uploads/2022/08/State-of-Norfolk-and-Waveney-health-report-2022_correctedByPAVE.pdf

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

https://www.norfolkinsight.org.uk/wp-content/uploads/2022/08/State-of-Norfolk-and-Waveney-health-report-2022_correctedByPAVE.pdf

https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice

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

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

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

https://www.cancerdata.nhs.uk/stage_at_diagnosis

https://www.cvdprevent.nhs.uk/home

Improving lives **together**

Norfolk and Waveney Integrated Care System

Norfolk and Waveney Integrated Care System

Joint Forward Plan 2024-2028/29

Part 2: Legal duties and other content

Contents

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

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

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

Our eight ambitions for improvement

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

The eight ambitions are explained in detail in the JFP, including clear objectives, trajectories and milestones.

Over the next five years we will provide more preventative care. We will better use data to identify people who could benefit from a particular course of treatment or support, and then contact them before problems arise or their condition worsens. We will proactively reach out to people with support and information about health conditions and importantly other issues, like debt and housing, which really affect people's health and wellbeing.

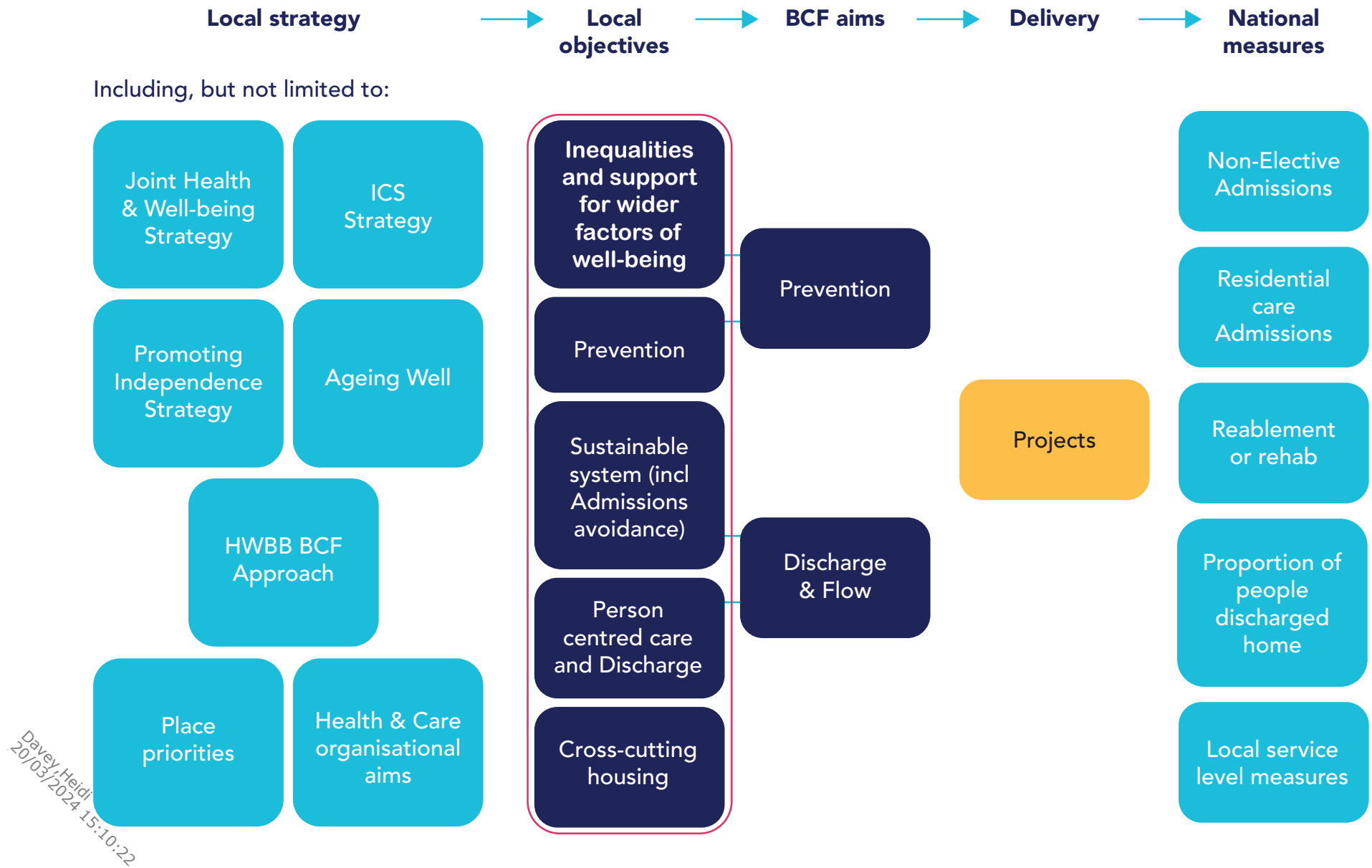
Duty to promote integration

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

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

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

- Prevention, including admission avoidance
- Sustainable systems
- Person-centred care and discharge
- Inequalities and support for the wider factors of wellbeing
- Housing, DFGs and overarching pieces of work.



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

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

- A Social Impact Bond for Carers – support carers with information, advice, support and Carers Assessments to improve their wellbeing and help them maintain their caring role. This is joint funded by NCC and NHS N&W, with joint membership at the Strategic Board.
- Norfolk Advice Network and Advocacy Partnership – this is a new service jointly funded by NCC and NHS N&W, which aims to provide a single point of contact for information, advice and advocacy in Norfolk.
- Intermediate Care – NCC and NHS N&W are working together to deliver appropriate, integrated intermediate care both preventing hospital admission and supporting discharge.

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

Duty to have regard to wider effect of decisions

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

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

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

People's health and wellbeing:

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

The quality of services:

- This plan has been developed in line with our quality objectives and processes, which are detailed in our Quality Strategy and outlined in the quality section of these legal duties plan. The system approvedgreed an implementation plan for our Quality Strategy in 2023/24, which sets-out the actions we will take in 2024/25 and beyond.
- Alongside this, the CQC's assessments of individual providers / services and our Integrated Care System, will help us to collectively understand and drive improvement in the quality of local health and care services.

The sustainable and efficient use of resources:

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

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

Overall, the duty aims to foster collaboration between local health and care organisations in the interests of the populations they serve. To achieve this, we have effective governance arrangements and clear processes in place. We continue to work on the cultural change needed, and as outlined in this plan, we have a significant organisational development programme to accomplish this.

Financial duties

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

The 'Revenue finance and contracting guidance for 2024/25 (Draft)' sets out that each ICB and its partner trusts must exercise their functions in respect of each financial year with a "Collective duty to act with a view to ensuring that":

- the capital resource use limit set by NHS England is not exceeded
- the revenue resource use limit set by NHS England is not exceeded

Capital resources describe the funds assigned to improve the infrastructure of the NHS, for example replacing large pieces of medical equipment or building a new hospital and health and social care facilities. Revenue funding is for the ongoing provision of healthcare services on an annual basis, for example paying the salaries of NHS staff and the consumable items such as needles and dressings.

Capital resource planning and approvals

Capital resources are distributed via the Norfolk and Waveney Strategic Capital Board (SCB), which includes representatives of all NHS providers, as well as speciality experts in digital and estates. All parties across the system identify their priorities and the SCB considers these. Examples of high priority investment programmes could be those where the CQC has reported that an area or location is now unfit for modern patient care, or national priorities and ring-fenced money for elective recovery, such as Diagnostic Assessment Centres.

Once the SCB has determined the priorities it makes a recommendation to the Finance Committee and the ICB Board for approval. ICBs and their partner NHS trusts and NHS foundation trusts are also required to share their joint capital resource use plans and any revisions with each relevant Health and Wellbeing Board and NHS England.

Once approved, organisations have the authority to proceed and spend the capital resource on the agreed schemes and this is monitored and reviewed by the SCB and ICB Finance Committee. Any in-year negotiations on under or potential over-spends and redistribution of capital resources are considered by the SCB and reported to the ICB Finance Committee in the same way.

In addition, capital performance is also reviewed at the Chief Finance Officers forum (chaired by the ICB Chief Finance Officer) which comprise the Directors of Finance from each of the NHS partners, together with any subject matter experts.

Revenue resource planning and approvals

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

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

The Chief Finance Officer forum is the initial place where organisational and system wide revenue financial plans are assessed, scrutinised and challenged with peers. The process is collaborative; system wide transformation schemes and other strategic system wide investments and disinvestments are included to create the complete annual revenue plan. The plan is then considered across a range of groups including with the NHS partners themselves, at the ICS Executive Management Team and with the chief operating officers and workforce

leads. Once individual NHS provider boards and the ICB Board are satisfied that the NHS Norfolk and Waveney system revenue plan is complete, it is then submitted to NHS England for final approval.

During the year operational delivery of the plan and achievement of financial objectives are manged via the Chief Finance Officer forum and the ICB Finance Committee, both meet and review progress on a monthly basis.

For a number of years the system has operated with an underlying financial deficit, this means that overall annual expenditure on health and social care services is greater than the resources available. This has been managed by utilising alternative sources of opportunistic funding to maintain the financial performance. The consequence of this is that whilst it can deliver financial balance on an annual basis, it is unstainable for future years.

To address this challenge the system is undertaking a more structured and system wide approach to the identification of service areas and expenditure where cost efficiencies can be considered. The "Model Health System" is the repository of data where organisations can compare themselves to others and then focus attention on areas where it seems efficiency opportunities could be realised. Once identified these opportunities, ideas and proposals are constantly part of our continued system working, drawing on our collective expertise to maintain quality services and achieve our financial duties. Ambition 8 is focussed on productivity and efficiency and all the ambitions within the JFP include a statement about their affordability so we ensure they are aligned with the Medium Term Financial Plan.

Where financial plans are not being delivered or are at risk of not being delivered, the first action is to review within the organisation and across the system collectively. We are working to a system control total, so the accountability for the under or overspend is shared and collective decisions have to be made as to how to manage this through risk/investment sharing.

Reviewing all current areas of expenditure spend would be an immediate priority to see what can be paused or stopped. However, the overriding management approach is to set a robust budget from the outset, with realistic transformation opportunities profiled across the year, with mitigations, escalation and ongoing dialogue so there is transparency and visibility of any emerging divergence from plan.

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

Delegated commissioning responsibilities from NHS England

The commissioning functions for primary, medical, pharmaceutical, ophthalmic and dental services were delegated to ICB's in 2023/24 and the roadmap of delegation continues in 2024/25 with the delegation of 59 specialised services. The six ICB's in the east of England have agreed a collaborative endeavour to collectively manage the commissioning of delegated specialised services in conjunction with the NHSE regional office. The details of financial arrangements and any risk sharing are set out in the agreement and will be executed through a Joint Commissioning Consortium (JCC). The Consortium is not a committee of the Board and decisions taken by the Consortium will only be those that are already within the delegated authority of the individual members.

Duty to improve quality of services

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

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

Well-led through a culture of compassionate leadership

There is clear evidence that compassionate leadership results in more engaged and motivated staff with higher levels of wellbeing, which in turn results in higher quality care.

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

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

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

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

The emerging Norfolk and Waveney Health and Social Care Senate is being developed.

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

Improving Care Quality and Outcomes

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

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

The **ICS Quality Management Approach Hub** brings system partners together to share insight and good practice in quality improvement (QI). Staff from across the ICS can access shared QI training and resources via the Hub to support cross-organisational and system-wide QI. The Hub has led on the development and roll-out of a prioritisation matrix to support the system with quality planning and is supporting co-production of QI programmes across the ICS.

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

"The voices of our people and communities are looked for early, when planning, designing and evaluating services."

"People feel listened to and empowered. They can see the difference their views and insight have made"

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

Quality and addressing Health Inequalities

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

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

One of our eight ambitions is Population Health Management, Reducing Inequalities and Supporting Prevention and we set ourselves an objective last year to develop a Health Inequalities Strategic Framework for Action, which includes our approach to CORE20PLUS5 health inequality improvement framework for both Adults, Children and Young People. We are on target to achieve this and it is referenced in the legal duty to reduce inequalities within this Part 2 of the JFP. Coordination of the implementation of this framework will ensure that we take a robust, joined up, evidence based approach in addressing health inequalities.

Quality continues to be central to our approach to responding to the Core20PLUS5 healthcare inequalities improvement framework and our systems workstreams through quality improvement and innovation, service user engagement and workforce skills development. We have some specific objectives in our JFP that respond to these such as an initial focus on asthma and epilepsy in children, reducing smoking rates in pregnancy and targeted lung health checks. The quality assurance and improvement approach will be key to the delivery of these objectives.

Safe System

Defining and Measuring Quality and Patient Safety

We continue to develop and refine our Quality Dashboard. Metrics align to the local objectives of the ICS Quality Strategy as well as the overarching NHSE Oversight Framework, ICB statutory duties and CQC Quality Statements.

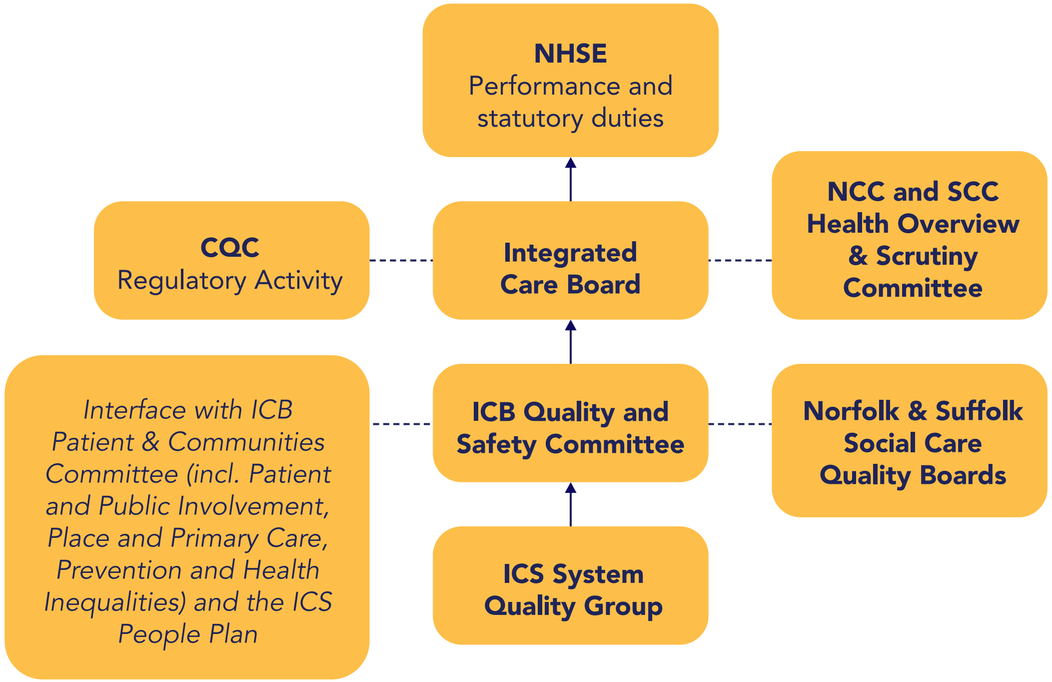
The dashboard will continue to evolve with a focus on ensuring that the way we measure impact of the strategy reflects patient and staff voices and what matters most to people living and working in Norfolk and Waveney. This will also include collaborative work with the local authorities to develop shared metrics around social care quality and Flourish outcomes for children, young people and families.

Patient Safety Incident Response Framework

The ICB continues to facilitate local adoption of the national framework, which represents a significant shift in the way the NHS responds to and learns from patient safety incidents. Local implementation is a major step towards establishing a joined-up approach to safety management across our system, in line with the NHS Patient Safety Strategy.

Quality Governance and Escalation

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



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

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

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

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

Sustainable System

As a system we recognise the impact of social and environmental challenges, including carbon footprint, within healthcare. Sustainability continues to be a theme running through quality improvement and innovation, service user engagement and workforce skills development. There is more about our Net Zero Green plan later in these legal duties.

Improving Pharmacy, Optometry and Dental services

Since we have assumed delegated responsibility for pharmaceutical, ophthalmic, and dental services, we have additional oversight of access, quality and outcomes relating to these elements of primary care. We are working alongside service providers to support and facilitate cross-system working to deliver transformation and continuous improvement. This will be extended to specialised services from April 2024 when these are also delegated to ICB's.

Duty to reduce inequalities

We are already taking action to reduce health inequalities across Norfolk and Waveney, but we want and need to do more. This is reflected in our 'Population Health Management, Reducing Inequalities and Supporting Prevention' JFP Ambition 1.

We have recently developed a Health Inequalities Strategic Framework for Action, in collaboration with our partners across the ICS. This Frameworks sets out how we plan to organise ourselves, what we will focus on, and our first steps we plan to take to embed a whole-system approach to tackling health inequalities.

The scope is broad, considering the action required to address healthcare inequalities, as well as the wider determinants of health including lifestyle factors and living and working conditions.

Our Framework will include our approach to reducing healthcare inequalities, including implementation of the NHSE Health Inequalities Improvement Framework 'Core20plus5' approach for adults and children. We will be aligning this with our ICS clinical strategy which you can read here and the FLOURISH children and young people framework which you can read here.

As part of the Framework we will be developing detailed action plans in the next 12 months for each of our three building blocks of living and working conditions, lifestyle factors and healthcare inequalities, ensuring that we strengthen our foundation to create the conditions for success.

Using data to identify the needs of communities experiencing inequalities

We use local data to identify the needs of communities experiencing inequalities in access, experience and outcomes. Part 1 of our JFP refers to this in the context of a life course approach.

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

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

As part of the system commitment to improving quality and outcomes through the learning from deaths process, we will continue to contribute to the Learning Disabilities Mortality Review Programme (LeDeR), to ensure that health improvements can be targeted to those areas which will have the biggest impact. Working as a system, we will aim to meet emerging need early.

Individuals with Autistic Spectrum Disorder (ASD) and Learning Disability (LD) face significant health inequalities compared with the rest of the population. The NHS Long Term Plan states a commitment for the NHS to do more to ensure that all people with a learning disability, autism, or both can live happier, healthier, longer lives. This means that we must provide timely support to

people and their families and ensure health and care services are accessible and make reasonable adjustments. Through our system transforming care plan, we will continue work to improve diagnostic pathways for autism and prevent admission for at risk groups.

We continue to work with system partners to;

- Build a collaborative approach to supporting neurodiversity
- Expand alternative care and support community models across the system to help prevent avoidable admissions to inpatient hospital services.
- Increase the number of annual health checks and health action plans being delivered by Primary Care
- Roll out the national Oliver McGowan training for staff on learning disabilities and autism to improve services and health and wellbeing outcomes.

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

A number of these are reflected within specific objectives in this plan, for example a focus on mental health, asthma and epilepsy for children and young people and reducing the rates of smoking in pregnancy and at time of delivery. This will complement the established work that is already ongoing within the system in relation to diabetes, respiratory disease and medicines management, together with the Protect NoW approach that is described in the Population Health management section.

Working with and listening to people experiencing inequalities

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

The five strategic priorities for healthcare inequalities

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

Priority 1: Restore NHS services inclusively

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

Priority 2: Mitigate against digital exclusion

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

Priority 3: Ensure datasets are complete and timely

- Improving recording of ethnicity data and other protected characteristics, to allow better analysis of health inequalities and targeting of interventions. This is detailed in our PHM section with the development of our data hub.
- We will be developing a dashboard to support our requirement under NHS England's Statement on Information on Health Inequalities (duty under section 13SA of the National Health Service Act 2006), which we will undertake collaboratively with our NHS trusts. This new requirement was published in November 2023 and identifies key information on health inequalities. We are required to evidence our response through our annual reports.

Priority 4: Accelerating preventative programmes (including Core20PLUS5 approach)

- **Vaccine inequalities** – a programme to improve the uptake of vaccines, including flu and COVID-19 – including data analysis, using local and national data resources; a roving model has been developed to target and achieve positive outcomes for underserved communities; development of Wellness Hubs to make every contact count and to offer a wider range of immunisations to local children and young people.
- **Core 20 PLUS 5** – co-ordination and monitoring of progress against all Core 20 Plus 5 programmes, including data analysis and dashboard development.
- **Clinically focussed projects including:** Cancer – addressing inequalities in screening uptake; Cardiovascular disease, NHS Health Checks; Smoking and Physical Activity.

Priority 5: Strengthening leadership and accountability

The Health Inequalities Strategic Framework for Action includes a clear governance and accountability structure for our ICS to lead our efforts to reduce inequalities. This includes a Population Health & Inequalities Board to provide oversight to our Healthcare Inequalities priorities.
The Population Health & Inequalities Board will oversee:

- The implementation of the actions articulated in the Health Inequalities Strategic Framework for Action for the next 12 months
- Further developing our JSNA's to expand our analysis on health outcomes and inequalities and evidence how to address them
- Our inclusion health work, including implementation of the NHSE national framework for action on inclusion health
- Community Voices, which builds capacity in our VCSE sector to have conversations about health and care in communities of interest through trusted communicators, providing a mechanism for insights to be gathered to inform future strategy, planning and decision making and improve access to services.
- Developing our Core20plus5 programme, which includes developing key leaders across the system as Core20 ambassadors to support the implementation of the Core20plus5 health improvement frameworks.
- Continuing to develop projects relating to the NHS role as an Anchor Institution. The legal duty in relation to social and economic development also refers to this.
- Implementation of the NHSE Statement on Information on Health Inequalities through the formation of a NHS body health inequalities working group, as referred to in Priority 3 above.

Duty to promote involvement of each patient

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

Norfolk and Waveney ICS is fostering a new relationship between people, professionals and the health and care system. This change shifts the power and decision making to enable people to feel informed and empowered to have a voice by working in partnership, connected to being focussed on a positive patient experience through their local communities having choice on control of health and wellbeing outcomes that are important to them.

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

Our GP practices work together in Primary Care Networks and provide a social prescribing service to patients, in addition, many employ other personalised care roles, such as care coordinators. These Additional Roles Reimbursement Staff (ARRS)-funded Personalised Care roles support and promote the involvement and activation of individuals, their wider families and carers to make informed decisions and take action to address their non-clinical health needs and wider determinants of health.

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

Personalisation for carers

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

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

Norfolk and Waveney is making good progress in personalisation and will continue to grow and expand in promoting personalised care with patients, their families and carers at the centre of all discussions about them. Local health and care intelligence highlights there is still work to do in supporting people to self-manage their conditions and non-clinical concerns no matter where they are in a demographic. As a system we will come together to understand how our population would like to do this ensuring supported self-management and shared decision-making being first option people choose. This will include giving people the right skills and knowledge to do so, through coaching, peer support and educating through collaborative and partnership approach, with patient's voice being heard in decision making and having more choice and control about their health and wellbeing needs.

Duty to involve the public

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

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

Our approach to Working with People and Communities is available on our dedicated webpage, including as an Easy Read summary. It has been tested with our local people and partners and will continue to develop and adapt as a working draft, to reflect local aspirations as needed. The original draft received very positive feedback from NHS England when assessed in 2022 and singles us out as a national exemplar for our work with inclusion health groups. You can read the full feedback from NHS England here. Plans are underway to engage with local communities to refresh the People and Communities approach alongside involvement surrounding the refresh of the JFP.

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

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

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

Work is currently underway to develop a Health Inequalities Strategic Framework for Action which includes the Norfolk and Waveney Community Voices (NWCV) Programme. NWCV works with trusted communicators to

speak with communities who may not already engage with the NHS and other statutory bodies to hear what is important to them. We have learnt that when talking to people about health services they also talk about a range of other issues that affect their health and wellbeing, such as housing and employment. We are designing ways to capture all this insight and make sure it is shared with people who design and deliver a range of services across Norfolk and Waveney.

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

The ICB Communications and Engagement Team supports the People and Communities work as well as offering professional support and guidance for the day to day and transformational work undertaken by the ICB staff. The Patients and Communities Committee has been meeting for a year, every other month in public. This committee also reports into the ICB Board and works closely with the Communications and Engagement Team to ensure all duties to involve are discharged. The Committee will include lived experience members. A recruitment pack is being developed in partnership with local people and system partners to ensure it is as accessible and open as possible. Lived experience members will then be recruited to the committee which will regularly review and update the ICB's People and Communities approach. This committee will apply the 'so what' principle to the insight received by the ICB to ensure it leads to change. It will also play a key part in monitoring the on-going participation that will take place surrounding the JFP as it is planned and delivered. The ICB is currently developing a Rewards and Recognitions Policy that supports people from all walks to life to take part in working with the ICB to effect change, including supporting people to understand documents and help with working whilst being in receipt of benefits.

Duty as to patient choice

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

The ICB patient choice policy can be found here and information about patient choice at the point of referral is on our ICS website.

Our demographics mean it is very important that we provide realistic options for enabling patient choice, for example for people living in areas of deprivation and in rural areas with limited public transport. We must take this into account when commissioning new services. This means that the location of new services such as Community Diagnostic Centres and community dermatology clinics for example need to be easy for patients to access with extended opening hours, and that a wider range of services can be delivered closer to home, or, by maximising use of new technology, in the patient's home. The use of Equality Impact Statements when designing new services or reviewing existing ones helps to focus attention on the needs of different patient groups and how best to deliver services that are inclusive and accessible to all.

The ICS is transforming the knowledge repository used by professionals and patients when making a referral or deciding on the next stage of treatment. The new website to be delivered in April 2024 will provide more information in Accessible Information Standard formats and in different languages. Updating this will help to ensure that a wider range of patients, and carers, have access to the information that they need to help them make an informed choice about their care.

The knowledge repository also contains details of all the services in the ICS, including community services, voluntary services, and independent sector providers. This is used as the central source for all referral forms, clinical pathway information, and patient information leaflets etc. The updated search facility will make it quicker, and easier for GPs, and patients, to identify the best service for their needs and have the right information available to help patients make an informed choice about their care and treatment.

Some services are not able to offer choice of provider at source, for example, high street optometrists. To ensure that the patient still has informed choice, the ICS commissions a cataract triage service for optometrist referrals. Patients are provided with information such as waiting times, location, opening times, transport options and if there are any clinical restrictions which might limit choice of provider. Patients are contacted by telephone and offered choice of provider and interpreter services used where appropriate. The call handers are also able to identify if patients can use services virtually, and flag to the providers if this is not an option.

Not all patients can access digital technology which means they may not be able to access services such as virtual outpatients or virtual wards. The ICS continues to work with partners to reduce the impact of digital exclusion by ensuring that patients still have a choice to access services on a face-to-face basis and promoting use of "Connect" pilots with the Library Service to support digital access.

Elective recovery is one of our eight ambitions and reducing the variation on waiting times across the ICS is part of that objective, through a single waiting list. Many patients may be unaware that they have the right to choose an alternative hospital if the waiting time for treatment is longer than 18-weeks. We are using a variety of social media platforms to share information about right to choose and GP practices have been provided with resources to support the offer of informed choice. The ICS has taken a proactive approach by contacting long wait patients to identify if treatment is still required and if the patient would like the opportunity to be seen elsewhere. Specialist call handlers are in place to provide additional support to those patients who require additional assistance with completing the questionnaires or require further information. The same team will also contact patients who have requested to transfer to an alternative provider via the national PIDMAS (patient initiated digital mutual aid system) programme thereby ensuring that all residents of Norfolk and Waveney have a choice of where to be treated with the aim of reducing overall waiting times for treatment.

Duty to obtain appropriate advice

The ICB and its partner NHS trusts and foundation trusts have strong relationships with and significant involvement from clinical and care professionals, including public health colleagues, which enable the organisations to obtain appropriate advice to effectively discharge their responsibilities. This involvement is evident in our JFP, which is based on evidence provided by public health and shaped by the knowledge and experience of a wide range of clinical and care professionals.
Membership of the ICB Board includes the director of nursing, medical director, a member nominated by primary care (currently a GP) and the Director of Public Health for Suffolk (the Director of Public Health for Norfolk is also a participant in Board meetings).

In addition to the ICB Board, clinical and care professionals are involved in the ICB's committees, the boards of our trusts and foundation trusts, our Integrated Care Partnership, Health and Wellbeing boards, Place-based arrangements, the system's Executive Management Team, and in projects and programmes of work.

We have a comprehensive Clinical and Care Professional Leadership Programme to further develop our approach. This is explained in more detail in section 6.5. As part of this, the ICB has conducted a review of its clinical advisors to ensure the organisation has the right expert advice to effectively discharge its functions effectively.

All of our work with professionals is complemented by research, co-production, engagement, consultation and co-production with local people – this includes the involvement of experts by experience.

Introduction to duties to promote research and innovation

Research and innovation can transform how people receive health and care services. The ICS Research and Innovation Strategy. developed with system partners, describes four principles:

- Focused on our communities
- Driven by a confident and capable workforce
- Collaborative and coordinated
- Embedded in everything we do

These underpin our approach to research and innovation.

Action plans are being developed for each principle. These will describe the key activities, timeframes and outcome measures which we will collectively implement so that research and innovation contributes to our population leading happier and healthier lives. The ICS research leadership group will ensure Board level awareness and support for the strategy within their respective organisations, including all NHS providers, recognising this is key to further build and embed a pro-research and innovation health and care environment. In doing so we will capitalise on our fantastic assets, including the University of East Anglia (UEA) which has a large Faculty of Medicine and Health Sciences and a health and care workforce of over 55,000 people.

Duty to promote research

Norfolk and Waveney ICS is committed to embedding a culture of research and evidence use for the benefit of our communities and workforce. Health and care research is fundamental to our health and wellbeing. It provides the evidence base for how services are designed and delivered and helps us to tackle unequal health and care outcomes.

Our workforce benefit from opportunities to become involved in research, including those provided by national and regional infrastructure such as the National Institute for Health and Care Research (NIHR) and the Clinical Research Network East of England (CRN EoE). Locally developed schemes such as the Embedded Research, Evaluation and Quality Improvement Scholarship, co-delivered by the James Paget University Hospital (JPUH) and the NICHE anchor institute at UEA, and the joint Norfolk and Norwich University Hospital (NNUH)-UEA Clinical Associate Professor scheme demonstrate the commitment to supporting our workforce. We will continue to embed and support these schemes and we will use the insights gathered as part of the strategy action plan development to ensure any future local schemes reflect the needs of our workforce. We plan to align these locally and nationally developed opportunities with local workforce planning to make research opportunities accessible and to the health and care workforce.

Alongside the CRN EoE, and through the transition to the Regional Research Delivery Network (RRDN), we will work collaboratively to ensure commercial research opportunities are available to our workforce and our population. This will directly support the national vision to increase clinical trial activity in the UK, embed national initiatives such as National Contract Value Review (NCVR) and maximise opportunities to build on our existing infrastructure through, for example, the NIHR capital investment calls. The N&W vaccine hubwill support the delivery of the national vaccine innovation pathway and the NIHR vaccine enablement fund. We are also committed to working with the East of England Shared Data Environment (SDE) team to ensure strategic alignment between Norfolk and Waveney ICS strategic data infrastructure initiatives and the SDE.

Working with NHS partners, VCSE organisations and the CRN we have received Research Engagement Network (REN) Development funding from NHSE to deliver three projects to increase the diversity of those taking part in and engaging with research. Training about research has enabled trusted communicators to talk to communities so we can hear what matters to them. Their views have been used to shape research funding applications and we are committed to an ongoing feedback loop so communities understand how the information they provide is used in research planning. We will continue to support robust engagement with communities when research teams are developing their funding applications and our dedicated community engagement coordinator will continue to work with system partners including the Citizen's Academy at UEA and VCSE organisations.

Norfolk and Waveney ICB established the Evidence and Evaluation hub to address increased demand to support decision making. The Hub will continue to ensure that research evidence is used by decision makers by producing bespoke, accessible evidence briefings. The Hub team will also continue to support and conduct evaluations, the results of which help understand intended or unintended outcomes and identify areas for improvement.

Duty to promote innovation

Innovation is central to addressing the challenges facing our health and care system. Innovation is a broad term, and to us, means new ways of doing things which could be a new technology or treatment, a new service, or an existing service in a new setting. The ICB has a statutory duty to promote innovation in the provision of health and care services.

We know that innovation can greatly improve healthcare and can lead to services being more cost-effective. It is useful to champion new ways of working to ensure our services are more reflective of the changing needs of our local population.

Innovation is a cross-cutting theme, and we aspire for it to be integral to everything we do. We wish to ensure that the opportunities for receiving innovative services are equitable across the ICS and we aim to support the adoption, evaluation and spread of innovations.

We have appointed a new Head of Innovation, jointly funded by Health Innovation East (HIE) whose role it is to help the ICB to meet the statutory duty to promote innovation across the ICS. In collaboration with HIE and by being selected by the NHSE funded Clinical Entrepreneurship Innovation Sites (InSites) as a 2024 InSite, we will support the system to optimise innovation culture, readiness, selection, implementation, spread and sustainment.

We will host and facilitate a regular innovation network of stakeholders and provide innovation learning opportunities to support collaboration and sharing of innovation needs, solutions and projects across teams. The aim of this network is to accelerate the use of innovation equitably across the ICS through partnership working, focussed on our local priorities as identified by community voices, JSNA's, our JFP and other strategies and frameworks. The network will also encourage and grow local innovation/innovators by supporting them to access support from Health Innovation Networks and identify funding opportunities. We also aim to establish further links with industry to support the use of innovations to overcome local healthcare challenges.

We will support teams to identify innovation needs alongside local communities (through initiatives such as community voices) and work with partners such as HIE and the NHS InSites programme to scope and match innovations that are of value and support the needs of our local population. We work with teams to support them to implement, evaluate, adopt, and spread innovations.
We understand that identifying innovation needs, matching them to suitable innovations that are safe, equitable and impactful to our local population and then implementing these, can be a complex process. By working together, we can match innovations to the identified needs. We will emphasise the importance of evidence, cost-effectiveness, safety, impact and reducing health inequalities in our selection of innovations. We will support due diligence and procurement processes to ensure that innovations are implemented as effectively and safely as possible.

Implementation of science principles and strategies will be used to support the adoption, evaluation, spread and sustainment of innovations into practice where these are deemed safe, impactful and provide value to our local population and the system.

We will also work with programme teams and commissioning teams to ensure that innovation scoping / horizon scanning informs commissioning, planning, and contracting activities. We have already started to work with colleagues within the ICB Programme Management Office (PMO) to plan the integration of innovation activities into future planning rounds and local prioritisation processes.

Duty to promote education and training, and other information about our workforce plans

#WeCareTogether, the Norfolk and Waveney People Plan

#WeCareTogether, the Norfolk and Waveney People Plan for 2020-2025, sets-out our ambition for the Norfolk and Waveney system to be best place to work. Following the pandemic, it was recognised that a refresh of the strategy would be required considering learning and experiences from Covid19. Since then we have also seen nationally a number of new policies and strategies relating to NHS and Social Care workforce which need to be implemented locally including the NHS Long Term Workforce Plan (June 2023) and the Future of HR and OD report (Nov 2021). Our intention is to review our approach to a refresh following the completion of the ICBs Change Programme to ensure that our strategic intent is fully aligned.

#WeCareTogether refresh

We know that the vacancies, staff absence and turnover rates for people working in health and care have remained the same or worsened for some areas since 2020. Our refresh of #WeCareTogether will take a structured and collaborative system approach to build capacity, capability, competencies, career structures and the infrastructure towards creating a 'One Workforce' approach across our ICS where we can maximise collaboration, resources and streamline the ways in which we work. Our provider partners have or will be refreshing their local people plans, and through our People Board infrastructure and networks, we will utilise the principle of subsidiarity to streamline transformation at the right place and at the right time.

A priority focus in 2024/25 will be to continue to build on existing work underway and incorporate these activities into the broader strategic priorities for the ICB and ICS. This includes our commitment to systems culture and inclusion, education commissioning and modernising the HR profession to improve employment practices and wellbeing for staff. We will ensure our plan is evidence-based and closely aligned to finance and activity planning as set out in our operational planning submissions and JFP.

The 10 ICS People Function Outcomes

The 10 ICS People Function Outcomes are set-out in 'Building strong integrated care systems everywhere: guidance on the ICS people function'. In all areas of transformation, we will take a long-term view using evidence-based modelling to re-design routes into careers. This will help to create a workforce who are trained not just clinically, but who also have a greater understanding of population health and inequalities, so that staff treat the whole person with compassion and care.

This work will include updating the way we attract and retain staff, refreshing education programmes (including lifelong learning and quality improvement), changing the shape of existing services and developing new ones, and using technology to take over tasks (not jobs) to release capacity. The activities below will form a key part of the delivery plan to achieving an integrated workforce across health and social care, and will be incorporated into the #WeCareTogether refresh.

Here is a summary of how we are working towards the 10 ICS People Function Outcomes:

Supporting the health and wellbeing of all staff

We know that if people feel safe and supported with their physical and mental wellbeing, they are better able to deliver excellent health and care. Over the last three years, individual employers and as a system, we have supported the physical and mental health of our staff, as well as the social and financial wellbeing needs of our workforce. The national restoration requirements for the NHS and more recently industrial action mean that, alongside our current workforce vacancy levels and system flow challenges, people's wellbeing continues to be impacted. Low morale, attrition from learners, burn out and moral injury are growing challenges which we must recognise and address openly across health and social care.

We know there is an urgent need to do more for our people and as such, our People Board endorsed an ICS wide Health and Wellbeing Plan in December 2023 which will continue to challenge, innovate and promote equitable offers for our whole workforce. Data and analysis has driven the creation of the system wide Health and Wellbeing plan, leaning into the staff survey results, Workforce Race Equality Standards (WRES) and DES data and the qualitative analysis of the Health and Wellbeing Framework diagnostic in each NHS organisation. In recent years we have also worked with partners to update policies, procedures and access for health and wellbeing support; embraced a culture of flexible working arrangements; initiated financial support schemes through Vivup and offered trauma based coaching programmes for front line leaders. System support has included the establishment of a Mental Health Hub and COVID-19 service for our health, social care and VCSE workforce.

A number of cultural Health and Wellbeing Initiatives have already been implemented across the systemusing the share, standardise and scale approach reflected throughout the ICS Health and Wellbeing Plan. The key areas are building and embedding a Restorative and Just Culture (RJC), further developing compassionate and transformational leadership with a collective resilience approach and becoming a menopause friendly employer.

A system wide approach and plan to RJC has been agreed and a training package developed, which will be digitised and scaled to ensure a wide reach over the coming year. We are collaborating, engaging and learning as system partners to establish a restorative just culture and by promoting civil and respectful behaviours. This can create a feeling of a compassionate and inclusive culture, leading to psychological safety and retention of our valuable staff. Organisations are subscribed to regular monitoring of the approach to ensure effectiveness of the programme is measured on a regular basis.

The Norfolk & Waveney system became a menopause friendly employer during 2023 with wide reaching initiatives, policies and resources put in place for staff. 80 members of staff trained as menopause advocates and a support network is in place across all organisations.

Growing the workforce for the future and enabling adequate workforce supply

Our integrated workforce planning approach is multi-faceted and relies on each of the 10 People Function outcomes converging. Working with health and social care partners to 'check and challenge' plans, we will identify system level opportunities and challenges, streamline our approaches to recruitment and retention, develop an at scale attraction plan for core roles such as nurses, allied health professionals and learners, to ensure education pathways are fully subscribed and talent retained in our system. Our role as an anchor institution will focus on widening participation, recruiting for values and experience, and supporting people to develop core skills and competencies 'on the job'.

Supporting inclusion and belonging for all, and creating a great experience for staff

The Norfolk and Waveney culture for inclusion continues to develop, but we recognise there is much more to do over the coming years so that our people may thrive and develop in compassionate and inclusive environments. The last Workforce Race Equality Standard (WRES) report for the ICS has highlighted significant challenges for our staff from ethnic minority backgrounds, centring around harassment, bullying or abuse from patients, relatives, the public and other staff. It also highlights higher than average levels of discrimination for these staff from a manager/team leader or other colleagues in last 12 months. The WRES does also highlight areas of best performance being career progression in non-clinical roles (lower to middle to upper levels).

Anti-racism

Over the last 12 months we have worked as system to deliver the NHS East of England Anti-Racism plan. We have a working group with NHS Providers aiming to refresh recruitment practices to remove bias and widen participation from applicants, we have developed and matured staff networks across protected characteristics and increased our approach to education and knowledge through the launch of our Equality, Diversity and Inclusion Resource Hub, which is open to both the workforce and the public. We launched our 'Stop the abuse' anti-bullying campaign in May2023.

Widening our EDI lens

We recognise that in addition to racism, the ICS needs to focus this year in particular on women, age and the impact of inequalities for our coastal populations. Our ambition is to bring together the pillars of health inequalities, population health management and workforce so that we can consider this cultural transformation holistically. This will form part our ICB Change

Programme, so that we ensure as an organisation, our infrastructure enables us to work with system partners and our local communities to tackle some of our biggest challenges, including racism and inequalities. Our Equality Diversity System (EDS2) submission was published in January 2024.

Creating a great experience

The NHS staff survey has highlighted three key themes of safety, recognition and compassion. Staff experience is an organisational responsibility but as an ICS we are committed to ensure that our 'one workforce' ambition allows us to work with partner organisations to agree some core principles for staff experience. The staff survey reports that we need to focus more on safety, recognition, and compassion, and we will work though our networks to identify opportunities for collaborative ways to improve in these areas.

Valuing and supporting leadership at all levels, and lifelong learning

We will continue to invest in leadership and management development programmes, mentorship opportunities and other initiatives to support the growth and development of our staff right across the ICS, particularly to ensure our leaders are representative of the workforce and population we serve. The health and wellbeing of our leaders will be a core thread of all programmes to ensure people have the tools and support to remain resilient.

A systems-wide approach to Leadership Development is in construction to remove duplication of effort and costs across the ICS and provide a more efficient delivery of training. Common leadership standards and shared learning across the ICS will strengthen delivery of a "One Workforce" culture. Higher quality leadership will directly improve system working and organisational cultures as measured by: CQC "Well-led" scores for example, and indirectly improve recruitment, retention, and patient care.

Leading workforce transformation and new ways of working

Our strategy and planning is informed by the work the system has completed with a range of organisations in recent years. Insights and recommendations from Viridian and Newton Europe have recommended a focus on efficiencies, particularly for reducing how much we spend on bank and agency staff. The Improving Lives Together programme has a lens on a review of corporate HR services and will similarly aim to improve quality and the experience for our workforce, whilst also making sure we use the system's resources efficiently. This is Ambition 8, Improving Productivity and Efficiency.

Alongside the ICS Digital strategy, this will enable service redesign through new ways of working, making the most of people's skills and time, and the better use of technology.

Educating, training and developing people, and managing talent

In line with the Long Term workforce Plan, the Norfolk and Waveney education strategy aims to provides the roadmap and ambitions to train, retain and reform our workforce.

Train: significantly increasing education and training to record levels, as well as increasing apprenticeships and alternative routes into professional roles to deliver more doctors and dentists, more nurses and midwives and more of other professional groups, including new roles designed to better meet the changing needs of patients and support the ongoing transformation of care.

Retain: ensuring that we keep more of the staff we have within the health service by better supporting people throughout their careers, boosting the flexibilities we offer our staff to work in ways that suit them and work for patients, and continuing to improve the culture and leadership across NHS organisations.

Reform: improving productivity by working and training in different ways, building broader teams with flexible skills, changing education and training to deliver more staff in roles and services where they are needed most, and ensuring staff have the right skills to take advantage of new technology that frees up clinicians' time to care, increases flexibility in deployment, and provides the care patients need more effectively and efficiently.

Education is key to developing our staff and equipping the workforce for now and in the future. Examples of best practice are being recognised by NHS England as ways to ensure largest numbers of individuals are upskilled. Development of new roles is key to support education and workforce plans. Education is recognised by Norfolk and Waveney as a key driver to support staff to provide quality care now and in the future.

Driving and supporting broader social and economic development

As the largest "employer brand", our health and social care organisations collectively employ the largest number of staff in Norfolk and Waveney. As such the ICS takes its responsibility as the largest employer seriously to create a vibrant local labour market, promote local social and economic growth, and to work to address the wider determinants of health and inequalities. Investment in Anchor Institutions locally provides us with unique opportunities to accelerate this ambition over the next few years. Working with UEA, we are taking a research-led focus on recruitment, retention and continuous development of our clinical workforce. Working with East Coast College we are actively co-designing as a system a holistic offer to local residents to widen participation into health, social care and voluntary sector roles.

Transforming people services and supporting the people profession

Upscaling HR services will support the delivery of Norfolk & Waveney ICS "Improving Lives Together" programme through delivering more efficient and effective HR services, improving staff experience at work and releasing clinical time to care. Upscaling HR services also supports delivery of the 2030 vision for "The future of NHS human resources and organisational development" by refocussing HR effort from transactional to higher value transformational activities, notably Organisational Development (OD) and workforce transformation. We successfully developed an outline business case which was approved by NHS England in December 2023. The business case builds on Newton Europe's findings, analysing in greater detail the opportunities identified in their "HR Case for Change" to improve HR productivity across the ICS which is part of Ambition 8 in the JFP.

The key drivers of the improvement in productivity are:

- Upscaling recruitment and "core HR" transactional processes by simplifying and standardising them prior to investing in digital automation.
- Outsourcing the management of the collaborative bank at scale.
- Scaling-up the procurement of outsourced HR services through consolidating existing contracts.

Leading coordinated workforce planning using analysis and intelligence

Our annual workforce planning submissions illustrate the ambition for workforce growth and to deliver operational priorities aligned to finance and activity. Plans are ambitious and centre on significant growth in the number of staff in post in registered nursing and those roles providing support to clinical staff.

We recognise that annual submissions of plans in isolation is not enough, and as such during 2023 we implemented an evidence-based, integrated and inclusive workforce planning approach. Working with our partner organisations we review of progress against plans and through the additional lens of education commissioning, look forward to workforce supply routes. Feedback to date has been positive with partners welcoming the regular opportunity to review how we commission education programmes, the importance of retention and career development for our medical and non-medical learners and challenge our ambition to reduce agency and bank spend. We also recognise that providing our workforce with the training and opportunities to take part in, and engage with research contributes to job satisfaction, enhances recruitment and retention and that research active organisations provide better quality health outcomes. As such we will work with our ICB Research and Innovation team, provider research teams and education providers to ensure local and nationally developed research schemes are incorporated into and align with workforce planning.

We have identified several workforce priorities for the next five years, such as 'over recruiting' to key roles at system level to achieve greater month by month net gains, growing the assistant and associate roles, and acting fast to build a pipeline of younger people (18 years plus) coming into health and care roles.

We note that whilst work is underway to support the 'one workforce' agenda, there are distinct differences across health and social care which need to be acknowledged and navigated, as these can act as a barrier to fully integrated working. For example, the number of small to medium sized enterprises in the social care market makes the transformation at scale seen in the NHS much harder, and so we will continue to work in partnership with Norfolk and Suffolk County Councils to promote opportunities to attract and retain our ICS workforce.

Supporting system design and development

Our approach to delivering this outcome is set out in section 6.5 of our Joint Forward Plan about people and culture.

Duty as to climate change

Climate change poses an existential threat to the whole planet and Norfolk and Waveney is not immune from its consequences. Taking decisive action to reduce our contribution to climate change will save lives, improve people's health and benefit health services.

The organisations responsible for health and care in Norfolk and Waveney have made significant steps towards more sustainable ways of operating. Our system's Green Plans take this further, establishing the bedrock for achieving Net Zero, and meeting the commitment set out in the Climate Change Act 2008 and the Environment Act 2021.

Our Green Plan for the Norfolk and Waveney Integrated Care System sets out how the NHS will work together and with system partners towards Net Zero, by sharing best practice, collaborating and holding each other to account. By working together to deliver our Green Plans, we will deliver against the targets and actions in the 'Delivering a Net Zero NHS' report, as well as the four core purposes of an ICS by:

- **Improving outcomes in population health and healthcare:** Adopting activities and interventions which slow the associated health impacts of climate change will help to improve population health.
- **Tackling inequalities in outcomes, experience and access:** Supporting action to address poor air quality, which disproportionally affects vulnerable and deprived communities through higher prevalence of respiratory illnesses, will help to tackle health inequalities.
- **Enhancing productivity and value for money:** Improving energy efficiency and using renewable energy sources across the ICS estate footprint will reduce long-term energy bills for the NHS and local councils.
- **Helping the NHS support broader social and economic development:** Ensuring all NHS procurements include a minimum 10% net zero and social value weighting will help to achieve this, as will adhering to future requirements set out in the NHS Net Zero Supplier Roadmap. Council procurements similarly place emphasis on reducing scope 3 carbon emissions and both the NHS and county councils require that bidders for contracts valued at over £5m per annum have a carbon reduction plan in place.

Governance

Our system ensures that appropriate board-level oversight and accountability of priorities are clearly stated in the Green Plan. The ICS Green Plan is co-ordinated through the ICS Estates team and delivered by the ICS Green Plan Delivery Group. The group membership is made up of focus area subject matter experts from across the ICS and ICB, and Green Plan leads from member organisations.

The system's Green Plan meets the requirements for ICSs as set out by the NHS. Significant engagement with public sector colleagues is bringing the system's Net Zero process into alignment with the wider work of the Norfolk Climate Change Partnership and the Suffolk Climate Change Partnership, to create close collaboration on the net zero.

The ICS Net Zero green plan delivery group's role is to maintain the plan through working with member organisations, ensuring Government, NHS and local Net Zero ambitions are met.

Monitoring of progress against the system action plan and objectives is co-ordinated by the ICS Estates team, with regular input from focus area leads, subject matter experts and member organisation leads. Progress reports are provided via frequent updates and data collections and are monitored via the ICS Green Plan Delivery Group. These feed into ICS Programme Board meetings and Executive Management Teams accordingly. Each county council reports progress on its respective climate commitments to its elected members.

Annual reporting (introduced from 2023) identifies movement in carbon emissions, programme progress and our journey towards Net Zero the plan and action required. The update of the operating plan highlights the planned focus and deliverables for the upcoming 12-month period. Both county councils have published dashboards showing their progress in reducing carbon emissions.

We will utilise all national data collections, and build on local benchmarking and analysis practices, to measure and report our success to stakeholders.

Collaboration

Our system's Net Zero Green Plan provides the ICS with a co-ordinated and strategic approach to the net zero programme and sets out how we embed, respond to, and deliver the NHS net zero ambition. The plan sits alongside, and complements individual organisations' plans and focuses on enabling without duplicating, achievement of Net Zero together. The plan identifies key areas to focus on over the next three years, and initiates action around what we will do, and are already doing, to respond to the environment and climate emergency.

The system works with partners to reduce system-wide emissions, including local authorities and the voluntary, community and social enterprise (VCSE) sector, patients and the public. The Norfolk Climate Change Partnership and the Suffolk Climate Change Partnership support local government in Norfolk and Waveney to deliver Net Zero objectives and their objectives align well with the NHS Net Zero ambitions. This programme of work is integral to our forward plan to reduce impacts on the environment and embed a 'one public estate' approach that positively impacts our journey toward net zero.

Workforce and Resources

We cannot deliver our Net Zero ambitions without our workforce. It is therefore vital that the system continues to inform, mobilise and train our staff so that they have the knowledge and skills required to help us on our journey. Net Zero is a priority and, accordingly, is led at Board level by the Director of Finance.

The system is engaged with the regional Greener NHS team and neighbouring ICSs to learn and share ideas and best practice. Through the green plan delivery group work the subject matter experts and sustainability leads collaborate to develop enable ICS Green Plan and Operating plan delivery. Existing pilot programmes for green initiatives are captured to harness their benefit to enhance positively, impacts on climate change and the environment.

The system has recruited resource to lead the delivery of ICS and organisations' Green Plans. These leads work collaboratively in the development and scaling of pilots and programmes that enable our net zero ambitions.

An ambitious programme of training has been identified to upskill the workforce at all levels, through use of best practice carbon literacy, to grow the knowledge and capacity to address the climate emergency. The ICB and Norfolk County Council have agreed to pursue joint carbon literacy training for senior executives across the system.

Adapting to the impact of climate change

There is a time lag between cause and effect in the climate system, which means that we will continue to be affected by past emissions for years to come. Consequently, adapting to the impacts of climate change is important for business continuity. Strategies to adapt to climate change are therefore part of local planning and decision making, bringing multiple benefits to the physical and mental health of the Norfolk and Waveney population.

Taking action on adaptation will improve the resilience of our services and the communities they serve, lessen the burden of illness and disease, and reduce health inequalities. Adaptation also means developing positive networks and sound communication between organisations and local communities, encouraging self-service and the resilience of local communities. Local action on adaptation will support requirements of the Public Health Outcomes Framework.

Norfolk and Waveney already experiences the effects of considerable coastal erosion and is subject to many flood areas associated with increases in sea levels. Many of the impacts of climate change, including those for health, will be felt locally. Therefore, the system needs to develop responses which encompass national guidance and yet are specific to our local circumstances. The system's Green Plan sets out the approach to mitigating climate change emissions from our activities and ensuring business continuity in a changing climate and includes a focus on increased readiness for changing times.

Both county councils have broader responsibilities for adaptation. These include steps to promote nature recovery, mitigate flooding and support sustainable development.

Addressing the particular needs of children and young people

Leadership has been identified in health and social care to drive forward the agenda and to ensure that the voice of children, young people and families is represented at the most senior level. The Children and Young People's Strategic Alliance Board provides oversight and assurance and is underpinned by thematic sub-groups leading on priority workstreams.

The voice of babies, children, young people (BCYP) and their families

We have invested in a participation and recovery model to ensure that transformation of services is co-produced and enables children and young people to hold us to account through strong and well-established forums. This enables children and young people to be heard by those who commission and deliver services in both Norfolk and Suffolk. We also have well-established parent carer forums to ensure the voices and needs of parents and carers are included in our planning and delivery of support.

Next steps will be to increase our reach into communities who are seldom heard to ensure that the experience of all our communities are captured and help to shape the future support to ensure the best start in life.

Data and insight

Our system approach, and the ongoing monitoring of its delivery, will be increasingly informed by data and evidence. We are developing a systematic whole-partnership monitoring framework alongside the FLOURISH outcomes, to enable the Strategic Alliance to track progress against each outcome, and as a whole, using data and evidence.

This will enable system understanding and oversight of where babies, children and young people are waiting to access care and support, and to inform our focus areas for recovery including access to mental health support, diagnostic delays, workforce information and an ability to focus system resource to the greatest areas of need.

Reducing health inequalities

The CORE20Plus5 approach (described in the **Duty to Reduce Inequalities** section) will support us to ensure that healthcare inequalities improvement is built into our strategies, policies, initiatives and programmes.

In addition to those areas identified within Core20PLUS5, our Flourish strategy Flourishing in Norfolk: A Children and Young People Partnership Strategy – Norfolk County Council identifies four priority areas for system focus:

- Prevention and early help
- Mental health and emotional wellbeing
- Special Educational Needs and Disabilities (SEND)
- Addressing gaps in learning following the pandemic

Family Hubs

Norfolk and Waveney system partners are implementing a Family Hub model and this is an objective within Ambition 3 Improving Services for Babies, Children and Young People.

Safeguarding

All systems have a statutory duty to safeguard. The Designated Safeguarding and Looked After Children teams influence, advise and support us to ensure it accords with the principles of the Children Act 1989 and is aligned to the Norfolk and Suffolk Safeguarding Children Partnership and priorities. The Teams ensure health and care services meet the statutory requirements of Section 11 of the Children Act 2004. Working Together to Safeguard Children 2023 has refreshed the principles of the multi agency safeguarding arrangements. N&W ICB continues to be one of the three statutory partners working with a clear vision to safeguard babies' children and young people. The designated safeguarding children team ensure effective participation in the Norfolk Safeguarding Children Partnership on behalf of the ICB and will continue to support local safeguarding arrangements with the update of this legislation. The priority continues to ensure 'safeguarding is everyone's business' and remains at the heart of service delivery.

Our safeguarding teams work in collaboration with all partners in N&W in the early identification of children at risk, including risk of exploitation and serious youth violence and recognition of all types of abuse and non-accidental injury promoting the needs of looked after children, those within the youth justice system and unaccompanied asylum seekers. Integrated working will support colleagues to work and communicate effectively across organisational boundaries, to ensure safety and provide child-centred care.

The Safeguarding Team provides training to primary care colleagues on how to recognise clinical presentations that are safeguarding relevant. This will assist GPs to prioritise safeguarding meetings, and to efficiently complete requested reports. This will be further strengthened by the development of Family Hubs and will be vital in the development of early intervention and prevention.

Going forward our teams will drive greater integration through matrix working and multi-agency collaboration. Digital solutions to enable safeguarding information to be disseminated will be further developed and sharing data will be integral to the partnership approach.

Safeguarding professionals will advocate for BCYP, and champion early intervention and prevention services to avoid long term damage that has implications across society. We aspire to be a trauma informed system, recognising the importance of the early days of a child's life and development, and impact of adverse childhood experience on long term health and economy.

Serious youth violence is an increasing concern amongst the multi-agency safeguarding system and partners contribute to the ongoing planning and implementation of strategies alongside and through the serious violence duty to try and mitigate the risks to the young people, their families and networks.

Continuing care for children and young people, including palliative and end of life care

The Council for Disabled Children describes a vision of a society in which "children's needs are met, aspirations supported, their rights respected, and life chances assured" (https://councilfordisabledchildren.org.uk/about-us). This underpins the work of our Children and Young People's Continuing Care Team where the aim is to achieve "gloriously ordinary" lives for the BCYP.

Continuing care packages are required "when a child or young person has needs arising from a disability, accident or illness that cannot be met by existing universal or specialist services alone" (National Service Framework for Children and Young People's (CYP) Continuing Care 2016, p5). Unlike adult continuing healthcare packages, which are entirely NHS funded, these packages can be jointly funded with education and social care and are very complex.

Norfolk and Waveney ICB currently offer two main approaches to the provision of continuing care – either a personal health budget (PHB) or a commissioned package of care, delivered by agencies procured specifically for care of children.

Palliative care is a low volume, but significant part of the care delivered to BCYP with continuing care needs. Our fast-track system complies with statutory guidance.

Partners have developed joint commissioning and quality oversight arrangements to ensure that all agencies are working together to meet the holistic needs of BCYP and their families. We collaborate with regard to quality assurance and improvement and work together to develop provision closer to home.

Special Educational Needs and Disabilities (SEND)

The Children and Families Act 2014 is a statutory framework for the integration and personalisation of services for children and young people that require education, health, and care services. To fulfil this statutory duty, we work collaboratively with children and young people with SEND and their families, alongside education and social care services to provide the right support. This must be using the key principle of co-production and be person centred.

This includes identification of children and young people with SEND and to enable them to access everyday activities with the right support and adjustments. We share support and resources across agencies for those on NHS waiting lists and skilling-up those working with children and young with key neurodevelopment difficulties, such as autism. We are committed to developing the wider workforce on key areas of SEND and to support workers to understand their duties and responsibilities. Children and young people with SEND are a vulnerable group and work will continue to drive equity of services and resources by raising awareness of the need and duty on services to make reasonable adjustments.

There will be key contact points across the health system to provide communication and support for children, young people and their families on health pathways. This will ensure families, young people and those working in education and the care system know where to go to get NHS health advice and resources.

We will continue to ensure that there are opportunities for children, young people and their families to contribute to service development and to ensure their lived experience is heard and understood.

There is a programme to review and improve health pathways. Publications on local websites and Just One Norfolk will also be reviewed and improved.

Working with local authorities and wider stakeholders, we will further develop the SEND annual survey, increase the survey response rate and disseminate the learning to further influence commissioning.

Joint quality assurance visits will take place into complex needs schools to further strengthen quality improvement and build confidence within settings to manage heath/medical needs.

Work continues to strengthen the use of shared data and analysis to inform commissioning of services for children and young people with SEND.

We aim to have a multi-agency SEND training platform that is accessible to all stakeholders, including children, young people and their families. We will develop a shared understanding and vision across children, young people and adult commissioning to ensure SEND is seen as everyone's business.

Partnership working will be strengthened through the SEND Partnership boards, multi-agency working, and we will feed in regional and national systems to develop innovations and initiatives.

System partners will work together to develop high quality information and support for children and young people with SEND, so that they know what can be accessed, what they can do to self-serve and to signpost to the most appropriate service when it is needed.

We will work as a system to become needs led and not medical and diagnostic driven and we will build confidence in the services and resources available by celebrating difference and individuality.

Please refer to duty to reduce inequalities regarding system work for Autistic children and adults and people with a Learning Disability (LD).

Children and young people's mental health

We aim to prevent mental illness, early identification of need and the promotion of initiatives that increase resilience to ensure children and young people are supported earlier around their wellbeing needs and reduce the burden on specialist mental health services in the future. Priority areas of focus include:

- Increasing access to mental health services through the Talking Therapies Collaborative to deliver an integrated service offer from VCSE sector and independent partners, where therapeutic care can be accessed from a range of providers.
- Providing early support in schools through Mental Health Support Teams
- By 2030 we aim to have 100% coverage of mental health support teams across all schools in Norfolk and Waveney and we will adopt a whole family approach to meeting mental health needs across Norfolk and Waveney, with a focus on communities and primary care.
- Providing 24/7 assessment and care to children and young people presenting in a crisis through an Integrated Practice Model, bringing together system partners to support children and young people with complex needs that present in crisis.
- To support early intervention and prevention, we will develop an all-age social prescribing offer ensuring that access to positive activities that improve wellbeing is tailored and accessible to all.
- Building on the use of the digital platforms, we will ensure all CYP have access to self-help resources and information about resources and support within Norfolk and Waveney.
- Working with the Anna Freud Centre, The Charlie Waller Trust, The National Children's Bureau and NHS England, we will co-produce, deliver and evaluate a whole system mental health training offer for the wider children's workforce.

Through the Strategic Alliance, decisions are made at a system level and challenges within the system are discussed and resolved in collaboration. To support the integration of services we are launching an integrated front door for all emotional wellbeing and mental health services, providing a trusted assessment and onward referral to the most appropriate service. The integrated front door is an objective within Ambition 4, the Transforming Mental Health Services.

Local Maternity and Neonatal System (LMNS)

The LMNS brings together the NHS, local authorities and other local partners with the aim of ensuring women and their families receive seamless care, including when moving between maternity or neonatal services or to other services such as primary care or health visiting.

Alongside this, NHS England published a single delivery plan (SDP) for maternity and neonatal services in April 2023 and we are implementing the four themes.

We will continue to focus on addressing exclusion and inequalities. The Local Maternity and Neonatal System has undertaken analysis of the needs and characteristics of its communities and has published an action plan to address these **(Norfolk and Waveney Maternity Equity and Equality action plan)**.

The LMNS will continue to put in place the infrastructure needed to enable rollout of Midwifery Continuity of Carer, so it is the default model for all women and so that 75% of women of Black, Asian and Mixed ethnicity and from the most deprived neighbourhoods are placed on pathways.

Addressing the particular needs of victims of abuse

Partners across N&W consider the needs of and provide support to victims of abuse (including victims of domestic abuse and sexual abuse, both children and adults).

We have important arrangements in place in N&W for partnership working on this agenda:

- The ICB is an active member of our two local Community Safety Partnerships:
  - Norfolk County Community Safety Partnership (NCCSP), which sits under the jurisdiction of the Office of the Police and Crime Commissioner for Norfolk (OPCCN).
  - East Suffolk Community Partnership (ESCSP), which is hosted by the Suffolk County Council.
- The new Serious Violence Duty (SVD) has been scoped through these partnerships, with both strategies published in January 2024. As part of this work, funds have been secured to place two Independent Domestic Abuse Advocates on fixed term contracts, into the acute hospital setting for two of the trusts. This will enable the individual needs of those subject to domestic and sexual violence, to be met, providing vital expertise and support from the earliest opportunity.
- The ICB Safeguarding teams currently support the 3 acute hospital trusts to meet their responsibilities to supply anonymised assault data to the Community Safety Partnerships. With the SVD now live, this reporting stream will be enhanced to meet the new responsibilities.
- The ICB is represented on the Norfolk Domestic Abuse and Sexual Violence Group (DASVG) by the designated safeguarding professionals (who represent the health sector).
- The deputy designated safeguarding professionals from both Adult and Children teams chair the Norfolk and Waveney Domestic Abuse and Sexual Violence Health Action Forum subgroup of the DASVG. Within this forum, health provider organisations are joined by colleagues from specialist domestic abuse and sexual abuse agencies, as well as from Public Health and mental health services. The forum ensures that the health system is sighted on all the available support services and resources to be able to meet their responsibilities in these areas of work.
- The ICB is represented by the Safeguarding Teams at the DASVG's Adult and Children's sub-groups and has strong links with the OPCCN and the Norfolk Integrated Domestic Abuse Service.

Here are some examples of the work we are doing as a system in N&W, and ways in which the ICB is delivering against its duty to address the particular needs of victims of abuse:

- The ICB actively participated in agreeing priorities and finalising the two SVD Partnership strategies which were published in January 2024. There is further detail and links to the strategies in the legal duty to address the particular needs of victims of abuse.
- The ICB joined other key system partners in signing up to the White-Ribbon pledge championed by the Office of the Police and Crime Commissioner for Norfolk. This is a commitment to a zero tolerance of domestic abuse and unacceptable behaviours by our workforce and towards the development of a strategy where there is a particular focus on addressing and working to prevent men's violence towards women and girls.
- The ICB will be leading a programme to ensure that the services it commissions are aware of the NHSE Sexual Safety Charter and will be supporting them to sign this important pledge.

- The ICB Safeguarding Named GPs continue to provide resources and are liaising with colleagues in specialist DA and SV roles to deliver training and learning from Domestic Homicide Reviews (DHR).
- The ICB has nominated a Domestic Abuse and Sexual Violence (DASV) Lead who is engaging in the newly formed national network workshops.
- The ICB is actively engaging and preparing for the DHR Scutiny process.
- The ICB has conducted an internal domestic abuse survey where over 150 respondents provided answers to questions that will now shape how the safeguarding teams, and Human Resources can support staff to identify, acknowledge and report cases of domestic abuse.
- The ICB DASV Lead has close working ties with the NHSE commissioned sexual assault referral centre Lead and both work together in a number of forums, including the police led: Rape and Serious Sexual Offences scrutiny panel.
- The ICB commissions a range of health specific pathways within a portfolio designed to support children and young people who are victim to serious violence. This includes but is not limited to: talking therapies for victims of and witnesses to sexual violence, trauma informed mental health provision and targeted support for children exposed to and at risk of displaying harmful sexual behaviours.
- The ICB also engages with relevant Suffolk workstreams, with NHS Suffolk and North East Essex ICB safeguarding leads.

The Serious Violence Duty (SVD)

In December 2022, guidance on the Serious Violence Duty was published by the Home Office. The 'lead' authority for meeting the Serious Violence Duty in Norfolk is the Office of Police and Crime Commissioner, while in Suffolk it is the county council. Each lead agency has convened a partnership group that the ICB attends through its Safeguarding Adult and Children and Young People's Teams.

The ICB actively and fully engaged with the two Serious Violence Duty Partnerships, helping shape the local definitions of serious violence, undertaking a strategic needs analysis of the health sector and contributed to and signed off on the resultant strategies, prior to their publication in January 2024.

You can find the strategies here:

Norfolk: https://www.norfolk-pcc.gov.uk/assets/Norfolk-Serious-Violence-Duty-Strategy-January-2024.pdf

Suffolk: https://www.suffolk.gov.uk/asset-library/suffolk-serious-violence-strategy-2024-27.pdf

The requirement to support NHS trusts to provide enhanced data will inform the wider response to tackling serious violence. The new Indepedent Domestic Violence Advisor roles will improve this data capture, whilst providing the most appropriate response to victims of domestic abuse and sexual violence. Creating these new specialist roles will also enable victims to access the most appropriate services, have equal access whilst considering their unique experience and outcome wishes.

Implementing any joint local health and wellbeing strategy

The N&W ICS covers the whole of Norfolk and part of Suffolk. As upper-tier local authorities, Norfolk and Suffolk each have their own joint health and wellbeing strategy:

- Norfolk's Joint Health and Wellbeing Strategy (which is also the Integrated Care Strategy for Norfolk and Waveney): https://www.norfolk.gov.uk/what-we-do-and-how-we-work/policy-performance-and-partnerships/partnerships/health-partnerships/health-and-wellbeing-board/strategy
- Suffolk's Joint Health and Wellbeing Strategy: https://www.suffolk.gov.uk/asset-library/imported/HWS-Strategy2023-HIGH.pdf

There is close alignment between the priorities in the Norfolk strategy and the cross-cutting themes in the Suffolk strategy:

Norfolk priority	Suffolk cross-cutting themes
Driving integration	Greater collaboration and system working
Prioritising prevention	Prevention: stabilising need and demand
Addressing inequalities	Reducing inequalities
Enabling resilient communities	Connected, resilient and thriving communities

The JFP is a delivery mechanism for these local health and wellbeing strategies and the Norfolk and Waveney Integrated Care Strategy is specifically referred to in section 1.2 of the JFP.

We are committed to supporting the implementation of both strategies and the JFP sets-out how health services in Norfolk and Waveney will do this.

We will continue to involve the health and wellbeing boards through the annual refreshing of our JFP (and if we choose to update the plan mid-year), and publication of their respective opinion on the JFP. As part of the development of the ICB's Annual Report, the organisation reports to the health and wellbeing boards how they contributed to delivering the priorities in each joint health and wellbeing strategy.

Digital and data

We are committed to investing in and using technology to improve people's health, wellbeing and care. Our Digital Transformation Strategic Plan and Roadmap sets-out how we will digitise services and connect them to support integration. This will enable new ways of working that can increase efficiency, improve patient experience and outcomes, plus reduce workforce burdens, and help to address health inequalities.

The plan and roadmap are in line with national guidance, such as the NHS Long Term Plan and the NHSX What Good Looks Like framework, as well as the Digital Health and Social Care Plan.

The digital plan and roadmap are a key enabler to the delivery of the eight ambitions in the JFP. Each ambition is co-dependent with digital and our plans for improvement are consistent so we can ensure all our efforts are joined up and focused in the right areas. You can read more about this in Section 6.3.

This diagram sets-out our vision and strategic priorities for Norfolk and Waveney:

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

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

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

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

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

Understand
Use data to drive decisions and harness population health insights

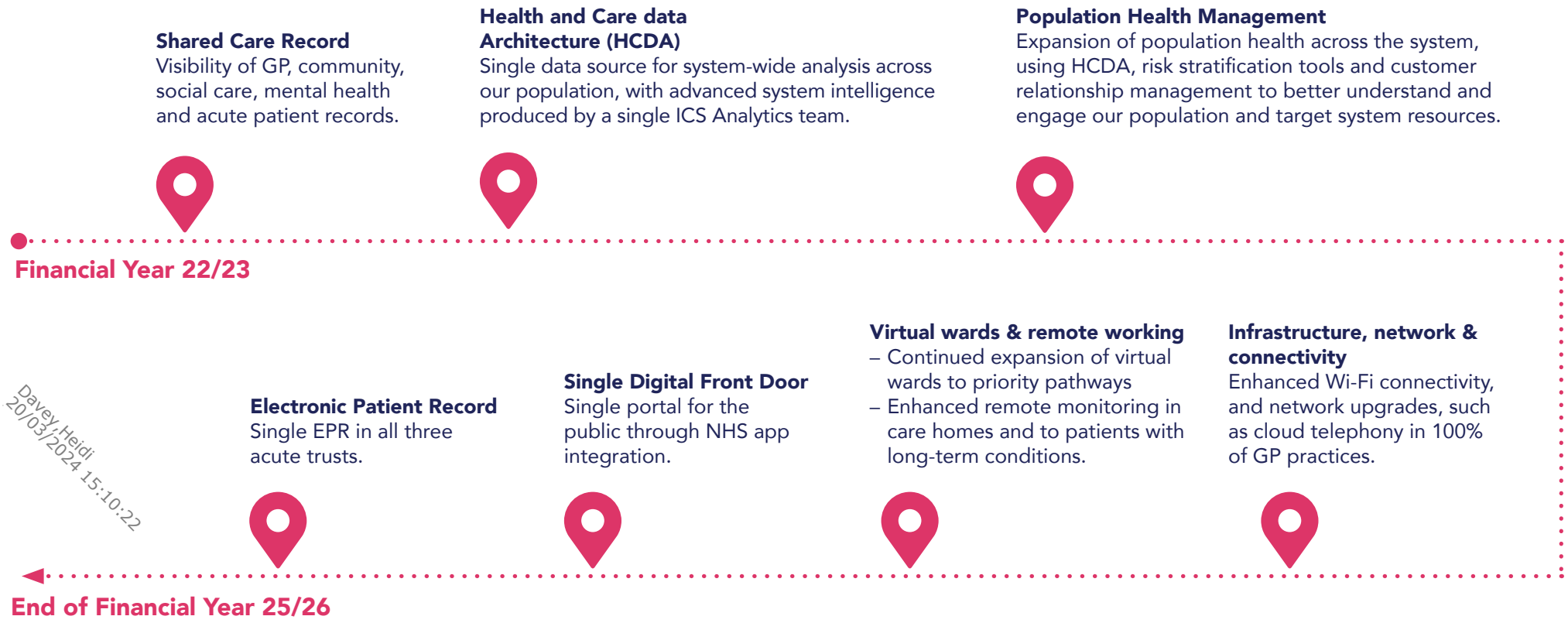
Innovate
Adopt a clear pathway for digital innovation and research to support the transformation agenda

Using digital systems, we will:

- Enable people to access their health and care records securely, quickly and when they want to see information or data.
- Support clinical and strategic decision making through technology, providing health and social care organisations who deliver care access to relevant, accurate and up-to-date information.
- Improve system wide IT services to increase safety and people's health and care experiences, whilst reducing duplication and waste.
- Support and empower people to maintain their health and wellbeing through digital solutions.
- Enable health and care staff and services to provide the best care in all settings, particularly via the use of mobile technology.
- Ensure personal health and care information is kept safe and secure.
- Invest in the infrastructure and technologies needed to help drive improvements to services and provide better care.

Digital Transformation Strategic Roadmap

Our roadmap details the key milestones:
Digital will enable transformation across all care settings, including outpatients.



In this last year, work to roll out the ICS wide Softwar Defined Wide Area Network (SD-WAN) to all GP Practice premises has begun, supported by funding from the NHSE Future Connectivity Programme. This ambitious infrastructure programme will also see full fibre broadband provided to practice premises to support staff and patients in accessing online apps and health information. GP Practices are embracing full cloud technology, with installations of modern telephony systems underway and improving access through navigation, queues and call back facilities.

Over 80% of Norfolk & Waveney's 555 Social Care Providers have been supported to implement a Digital Social Care Record (DSCR). This is bringing benefits to service users and staff in provider organisations, and will benefit the wider system once the DSCRs are joined up with the Shared Care Record. With over 150,000 patient records accessed, this is already delivering information to front line staff and ensuring that people need tell their story only once. In 24/25, the Shared Care Record will be delivered to VCSE organisations to support social prescribing and help to integrate health and care.

51% of eligible Norfolk & Waveney citizens are making use of the NHS App. 104/105 GP Practices have enabled Access to Records, and there have been 650,000 views of these by citizens in the first three months of live operation. GP Practices also offer online access via dedicated systems available on practice websites and over a million requests were submitted last year.

Remote access technology has been delivered to 40 care homes, with a further 40 planned for this year. Together with GP Connect, this is giving clinicians in Out of Hours services better information to support clinical decisions and is enabling people to stay in their own homes and receive care there. A new community based Virtual Ward is also enabling people to stay at home with support and monitoring which supports Ambition 6, Improving Urgent & Emergency Care.

The data hub is now live (this used to be called Health Care Data Architecture or HCDA in the digital roadmap), which has the capability to link data sets together, giving us the capability to look at trends at a population level. There is anonymous, aggregated and identifiable data, which can be mapped for different purposes. This is a key enabler to support Ambition 1 in the JFP, Population Health Management, Reducing Inequalities and supporting prevention and is a really useful tool.

Implementation of the digital road map is in step with the JFP and other ICS strategies. It provides some of the infrastructure to enable the delivery of Ambitions across all the areas, and many of these are cross-cutting.

Estates

Our Estates Strategy sets-out how we will create stronger, greener buildings, enable smarter, better health and care infrastructure, and use system resources fairly and more efficiently. It is based on extensive engagement, and a review of clinical strategies and investment requirements across the ICS.

Our vision and overarching aim is to provide estate that allows delivery of the right care in the right place, enables better patient outcomes, and empowers health, social care and third sector staff to provide the best possible care.

To realise our strategic vision, we have developed four strategic estate objectives:

- **Improving Access** – Ensuring that the right services are delivered in the right place, matching demand and capacity, delivering multi-disciplinary working in 'Places' and 'PCNs'.
- **Improving Quality and Condition** – Providing safe, flexible, modern, and fit-for-purpose estate and supporting services for our patients, visitors, and staff.
- **Improving Sustainabilit**y – Implementing interventions to decarbonise our estate and reduce carbon emissions arising from our buildings, infrastructure, and services.
- **Improving Efficiency** – Providing a right sized estate and supporting services that deliver value for money and long-term financial sustainability.

Systemwide, Person-Centred Estate

We have a significant part to play in supporting and enabling the delivery of a system-wide person-centred estate that serves the needs of all its users, enhancing both patient and staff experience.

We will enable the integrated care strategy through our estate objectives by:

- Developing a collaborative approach across the NHS to estates and facilities service provision, ensuring our assets enable integrated accessible services.
- Ensuring our estate supports the provision of preventative models of care.
- Working with local planning authorities and public health to ensure their programmes of work and ours are linked and we cooperatively help people live in healthy places, promote healthy lifestyles, prevent ill-health and reduce health inequalities.
- Support delivery of specialist housing programmes that enable people to remain independent and reduce demand on services.
- Enabling relocation of services closer to areas of high need, where clinically appropriate, and supported by investment decisions.
- Delivering our Net Zero Green Plan to reduce our carbon footprint and emissions and tackle the negative impact this has on health and our communities.

Managing the Estate Portfolio

The Estates Programme Board is an enabling service function within the ICS. It brings key system partners together to develop and deliver the strategic estates vision and objectives that support the Norfolk and Waveney ICS to realise its vision, purpose, goals, and deliver upon its priorities. Through our system wide estates collaboration we inform investment decisions for the benefit of the Norfolk and Waveney population.

To help manage our estate portfolio we have developed a complete inventory of estate that enables us to assess the location, ownership, capacity and utilisation, age and condition, value and running cost, and the energy performance of our occupied estate. This has allowed us to pinpoint specific metrics and rate performance against our objectives, such as areas of backlog maintenance and critical infrastructure risk, non-functionally suitable estate, underutilised estate, and high running costs.

The core, flex and tail framework (see page 34 of the estates strategy) has also been applied. Identifying what assets are core, flex, and tail forms a basis for investment planning and operational service planning. It will enable us to direct the use of resources, scheduling activities and so on. We will then be able to rationalise estate where there is tail estate to be disposed of.

Empowered and Skilled Estates Workforce

In order to provide an effective, safe, and efficient service, now and in the future, we need to have the right estates and facilities resource and expertise available. The ICS Estates workstream aligns its plans with the Norfolk and Waveney People Plan, as well as the national estates and facilities workforce strategies.

Net Zero Estate

Our Net Zero Green Plan is described in the Legal Duty as to climate change.

Emissions resulting from NHS building energy, water, and waste account for 11% of our total emissions, and 55% of the emissions we control directly. The Estates 'Net Zero' Carbon Delivery Plan provides a managed approach that will embed and enable the decarbonisation of the estate across the ICS.

Working through the ICS Green Plan delivery group, we will explore and implement interventions to decarbonise our estate and reduce carbon emissions arising from our buildings, infrastructure, and services.

Adapting to Climate Change

Climate change adaptation means responding to both the projected and current impacts of climate change and adverse weather events. Adaptation for our health and care estate is two-fold:

Health and Wellbeing:

- Investing in and managing estate that avoids negatively impacting the physical and mental health and wellbeing of our population.
- Flexibly managing our estate so that our health and care system can respond to different volumes and patterns of demand.

Operational delivery:

- The system infrastructure (such as buildings and transport) and supply chain (for example fuel, food and care supplies) need to be prepared for and resilient to weather events and other crises.

Transformed Models of Care

Transforming through the national New Hospital Programme
The New Hospital Programme delivers Government investment in the replacement of aged NHS hospital estate across the NHS. Norfolk and Waveney have been successful in securing funding that will see the planned rebuilding of the James Paget and Queen Elizabeth Hospitals. These investments will transform patient experience, providing innovative and modern and highly equipped hospitals from which our clinical services will continue to go from strength to strength.

Transforming through digital infrastructure and SMART buildings
The use of digital infrastructure and technology is important in delivering our vision and objectives. Digital innovation and enhanced infrastructure, devices, and information systems will help form SMART buildings that advance the experiences of our building users, improve sustainability, and drive financial efficiency.

SMART buildings will monitor, measure, and manage key aspects of a building's fabric and operational use, providing the data and knowledge to drive improvement. Good estates and facilities management can be ensured through the ongoing monitoring of maintenance, operations, and utilisation data generated by SMART building technology.

Digital infrastructure and platforms will include proactive use of digital systems to improve the performance, reliability, quality, and productivity of our estate, and reduce reactive and backlog maintenance costs. This is consistent with our Digital Strategy and Roadmap.

Infrastructure Design and Investment

Improving integration through One Public Estate
One Public Estate (OPE) is an established national programme delivered in partnership by the Office of Government Property and the Local Government Association. We have been an integral part of this programme for a number of years and we will continue this work. The OPE Board provides practical and technical support and funding to councils and other public organisations to deliver ambitious, property-focused programmes in collaboration with central government and other public sector partners.

We will continue to work with our partners through One Public Estate to design and deliver integrated infrastructure solutions that serve the needs of both health and care.

Procurement / supply chain

The Norfolk and Waveney Procurement Collaborative (NWPC) continues to synchronise purchasing under a formal agreement to buy in common wherever possible. As our frontline teams work more flexibly across different locations, this has helped us improve clinical effectiveness through use of standard equipment and products across all our sites.

This collaboration delivered over £5m of procurement savings in 2023/24 and will continue to ensure we get the very best value from our non-pay spend. Reviewed and updated category strategies for each of our key spend areas will identify a programme of product range consolidation, volume aggregation and commitment to strategic supplier partnerships across the system to support the development of integrated patient pathways. We will work closely with clinical networks and the clinically led, system wide Clinical Product Evaluation Group to ensure purchasing decisions take every opportunity for standardisation across Norfolk and Waveney where appropriate.

We will also continue to ensure we leverage NHS influence and scale at levels to secure the best commercial deals for Norfolk and Waveney. We will collaborate regionally with partners across the East of England where this makes sense and are already starting to purchase at increased scale where we have joined clinical networks such as the Eastern Diagnostics Imaging Network and East Coast Pathology Alliance. We will continue our support for the NHS England strategy of using NHS Supply Chain wherever possible, so that nationally there is the greatest opportunity for the NHS as a whole to leverage its national buying power.

We are fully engaged with NHS England's Strategic Framework for the NHS Commercial sector and will ensure our procurement services are assessed and showing improvement against the UK Government's Commercial Continuing Improvement Assessment Framework. The NNUH and joint NCHC / NSFT procurement teams were both accredited as 'better' (level 3 out of 4) in 2023 and QEHKL as 'good' (level 2 out of 4). The ambition is for all procurement teams to reach the level of better or best (the top level) by 2027.

NWPC has been a national leader in deploying the NHS's single commercial system known as Atamis. All contract information is now shared across the system's providers and wider with spend analytics analyse where we can further improve our spend efficiency. We will continue to use this intelligence to prioritise our procurement resources effectively as we align our contracts and we will extend our use of other digital and transparency functionality to improve contract and supply chain management.

The Health Care Services (Provider Selection Regime) Regulations 2023 came into force on 1 January 2024 and we expect the Procurement Act 2023 to go live in October 2024. Both of these provide opportunities to make procurement decisions that prioritise patients across the system and we will review how we work to ensure we take full advantage whist maintaining focus on securing value for money. With this comes a commitment to improve the visibility of how we select suppliers and engage with the supplier community including small to medium enterprises and VCSE organisations.

We will continue to deliver on our value and sustainability commitments. For all contracts over £5m per annum, we require the supplier to provide a carbon reduction plan. We will also ensure our procurement tender activity supports UK government social value targets, the Greener NHS Programme to deliver a net zero health service and the drive to eliminate modern day slavery. This is consistent with our Net Zero Green Plan which is within the legal duty as to climate change.

We have skilled and experienced commercial professionals available across the NWPC partners, with a number of MCIPS (Member of the Chartered Institute of Procurement Supply) qualified staff which is the gold standard for procurement. We will continue to invest in increasing commercial skills of our people across the organisation, not just procurement, as commercial acumen is a growing key strategic competence required across the NHS.

The ICB continues to directly host its own procurement function. This manages predominantly procurements for healthcare and non-healthcare services, reflecting the commissioning responsibilities of the ICB. The focus of the ICB procurement team is to ensure that the ICB complies with the legal requirements for awarding service contracts that deliver the best services for patients at the best value for the system. The Provider Selection Regime introduction means that the ICB is making changes to its processes for procurement to reflect the new requirements. The new regime is intended to deliver greater flexibility to support collaboration in the delivery of services in the Norfolk and Waveney system.

As separate legal entities and to reflect the different obligations of commissioning and provider organisations, to date the ICB and provider collaborative procurement functions have operated independently. These teams are however in regular dialogue and work together to identify the most efficient and effective routes to complying with our responsibilities under legislation to the benefit of the whole system. As the system continues to develop, the way in which procurement activities are undertaken and responsibilities for specific programmes of work will continue to be reviewed to ensure that the procurement function is being delivered in the most effective way.

Population Health Management

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

Our ICS Population Health and Inequalities Board is leading the implementation of a new strategy for PHM. This is a specific objective within Ambition 1 of the JFP: PHM, Reducing Inequalities and Supporting Prevention.

The new strategy sets out our ambitions in relation to the delivery of population health management, our priorities and plans for a system level programme and our approaches for all partners within the system to take forward their own programmes of PHM, focussing on local communities.

By focussing on prevention and health inequalities, and by partners working together to identify new things that can really help to improve health, the strategy supports people to live as healthy a life as possible. It impacts on the way we plan, prioritise and deliver care. The PHM approach is a way we can act together to improve health and wellbeing, making the best use of the resources we have available to us, removing barriers and supporting integrated working across our system.

The strategy sets out our approaches to use joined up data and information to better identify and understand the health and care needs of our population, to identify opportunities for improvements and put in place targeted interventions to support these.

We are aspiring to a reduction in the differences in outcomes we currently experience in terms of accessing services and improvements in the health care processes for our most deprived populations.

We are also seeking to prioritise prevention activities, particularly relating to smoking, alcohol, diet and physical activity and uptake of cancer screening and immunisations.

Our approach is also driven by the needs of local communities and interventions designed to support them. We will support Place-led projects to deliver local priorities and to support working with wider partners to develop joint initiatives to address the wider determinants of health, such as housing.

Our strategy includes the need for evaluation to measure progress and impact. Progress reports will be received by the Population Health and Inequalities Board, led by our Executive Medical Director, which has a broad membership of ICS representatives, including county council, adult social care and Children's Services, Public Health, NHS providers, and place board and health and wellbeing partnership representatives.

We have identified initial PHM priorities at a system level to address health inequalities and meet the Core20PLUS5 priorities, which will have the greatest impact and where we know there are opportunities to improve. These are:

- Smoking, especially smoking in pregnancy
- Serious Mental Illness
- Chronic conditions – cancer (including earlier diagnosis), cardiovascular and respiratory.

Our ICB PHM team have achieved a number of improvements as part of our "Protect NoW" programme of work. This programme is a collaboration between NHS organisations, local authorities, the voluntary sector and independent partners working across Norfolk and Waveney. It comprises a growing number of projects, each focused on optimising physical and/or mental health and wellbeing. Alongside clinical leadership, our PHM digital supplier provides the bespoke data analysis, technical solutions and digital platforms that underpin the "Protect NoW" projects.

Projects to date have included topics such as:

- **COVID-19 vaccination uptake** – Increasing vaccine uptake and gaining insight into how we can support people to take up the vaccine offer.
- **Falls prevention** – Engaging with people who are vulnerable to having a fall or waiting for a hip or knee operation and assessing if any adaptations or equipment are required, in partnership with the Local Authority Home Adaptations team.
- **Pain management** – Triaging patients on the pain waiting list so that those suffering the most pain are prioritised.
- **Improving Access to Psychological Therapies (IAPT) uptake** – Increasing referrals to the wellbeing service and addressing clinical variation.
- **Cervical screening uptake** – Increasing the uptake of Cervical Cancer Screening – reducing inequalities and unwarranted clinical variation.
- **Long Covid clinic design** – Gaining insight from those with lived experience of Long Covid to inform design of service specification for commissioning Long Covid clinics from the community provider.
- **Diabetes prevention** – Increasing referrals into the National Diabetes Prevention Programme to prevent / reverse type 2 diabetes and address clinical variation.
- **Priority Patient Review** – Reducing hospital admissions through primary care risk alerts relating to six biomedical markers. The pilot is seeking to demonstrate that the proactive management of patients with reversible risk across six clinical pathways will result in reduced hospital admissions.
- **ActiveNOW** – focused on supporting health and care professionals to quickly and easily refer patients into suitable physical activities based on their needs.
- **Digital Weight Management Programme** – increasing the numbers of people referred to this national programme, to improve healthy weight in people with diabetes and hypertension.

In order to better understand the health needs of our population and plan and deliver the PHM programme in an integrated way, we need to further develop our infrastructure that underpins it. The development of this infrastructure is closely linked to our ICS digital strategy.

At the moment, data is mostly held within separate organisations and this limits the ability to see the bigger picture. PHM will be optimised when we can join up data sources (including hospital, general practice and social care) to analyse need and plan care at a population level. This includes accessing linked-up data across our system using the ICS's new data hub. More details about how we are doing this can be found in our Digital Transformation Strategic Plan and Roadmap.

Clear and robust information governance systems and agreements enable us to share and analyse data safely and appropriately. As we develop our PHM programme, we will be ensuring that our cross-system information governance systems and safe access controls are clear and communicated to all partners and break down existing barriers to sharing data.

Access to such data will allow us to undertake sophisticated analysis, modelling future demand, and using techniques known as "population segmentation", "risk stratification" and "financial risk modelling"– identifying where we can make the most impact and supporting more personalised care. We will be supported to do this by skilled analytical support from our ICS-wide intelligence function. We will also be training our wider workforce to interpret the available information and identify their own, more local, priorities for action.

System Development

To create the change that we want to see and to make the most of the opportunity arising from the transition to an ICS, it is vital that we look at and understand what needs changing in our governance, processes, leadership and culture.

Information about our plans for developing and strengthening how our system works can be found in the following sections of this plan:

- **Neighbourhood level working**: Working at this very local level is a theme throughout our ambitions and underpinning objectives which are about ensuring provision is very accessible, is what our population needs, and finding out what matters most so it can be delivered as effectively as possible. The continued development of our integrated neighbourhood teams is an important part of this and our plans for developing these teams are set out in section 4.0 of our Joint Forward Plan, under Ambition 2: Primary Care Resilience and Transformation.
- **Place level working**: Our place-based approach is set out in Section 6.1 of our JFP.
- **Closer working between providers of health and care services**: Our plans for working collaboratively are set out in Section 6.2 of our JFP.
- **Working with the Voluntary, Community and Social Enterprise (VCSE) sector**: Our plans for developing how we work with the sector, including through our VCSE Assembly, are set out in Section 6.7 of our JFP.
- **Improving the quality of care**: Our plans for how our system will build our capability to identify and address quality challenges are set out in the section about quality of services, included in these legal duties.
- **Our financial performance**: Our plans for how our system will build our capability to identify and address financial challenges are set out in our financial duties, included in these legal duties.

Our Integrated Care Partnership (ICP) was built on the well-established Norfolk Health and Wellbeing Board, incorporating additional members from Suffolk to cover the Waveney part of our system and the chairs of our place boards to further strengthen the relationships and links between system and place level.

A significant amount of work was done in 2023/24 on the ICB's organisational review. The new structure will enable the ICB to better support system working and collaboration. The structure takes account of the organisation's new functions and role as a convener of the system, as well as what we have collectively learnt since the organisation was formed in July 2022. While the review was challenging for the organisation and hard for staff, the benefits to the system and to local people will be felt in 2024/25 and beyond.

For Norfolk and Waveney to be a really thriving system, staff need to be supported to work in different ways and this is why we have put in place a comprehensive organisational development programme for our system and for staff at all levels. Specific programmes of work have been developed for the ICB Board, the ICB's senior managers and the system's Executive Management Team, along with training packages and support for the wider workforce, all of which is complemented by the Clinical and Care Professionals' Leadership Programme.

This organisational development work started well before the Health and Care Act (2022) came into force and has played an important role as our system has moved towards greater collaboration over the past few years. The work will continue as our system develops and matures.

Supporting wider social and economic development

We recognise our role as anchor institutions to explore opportunities to collaborate to influence the wider determinants of health within the heart of communities. This ranges from creating opportunities to listen and hear the voice of citizens, sharing data to alleviate respiratory conditions and improve the quality of housing, to accessing and signposting to partners' skills, training and employment pathways in order to grow our system's workforce and create a vibrant local employment market.

Our newly developed Health Inequalities Strategic Framework for Action describes the role of the wider determinants of health in supporting health and wellbeing outcomes. It recognises the role of Anchor organisations, and there is a clear action for our ICS to undertake a baselining exercise so that we may better understand our current position and where we need to make improvements.

We will utilise the 'How Strong is Your Anchor' toolkit developed by University College London partners to undertake this baselining exercising and utilise this to develop a local Anchor Charter and Improvement Plan.

Working collaboratively with our partners in Public Health will be building leadership capacity through the 'WorkWell' programme to establish an ICS work and health partnership and develop a 3-tiered plan focusing on worklessness, workplace and workforce. This Partnership will include local authorities, Department of Work & Pensions, VCSE organisations, employers, GPs and the primary care system and the wider NHS.

We will utilise tools such as the Community Voices programme to listen to communities and empower them to be their own agents for change, utilising their insights to influence the services and interventions we develop.

Our eight Health and Wellbeing Partnerships (HWPs) play a significant role in supporting decision making that reflects community need, assets and strengths, and are referenced in 6.1 of Part 1 of the JFP. They provide a platform to engage a wide range of partners at a local level, that can support the design and transformation of health and care services, whilst ensuring connectivity to other services that can support their wider needs. These HWPs will provide the vital infrastructure, expertise and reach to support development and delivery of the proposed system Health Inequalities and PHM strategies.

Through our HWPs and Place Boards strong equitable relationships exist with local government. Working together we can influence, support and add value to a wide range of programmes that seek to improve access to green spaces, provide access to our collective facilities to support health and wellbeing, support local regeneration and generally provide opportunities for residents to improve their own health and wellbeing. An example of this is the adoption by Norfolk's seven Local Planning Authorities of the 'Norfolk Planning in Health Protocol' (2019).

Improving lives **together**

Norfolk and Waveney Integrated Care System

Integrated Care Board Finance Report

January 2024

(Month 10, 2023-24)

ICB Board – Part One: 26th March 2024

Contents

1. Executive Highlights

- This report represents the January 2024 year-to-date position of the ICB as part of the 2023/24 Financial Year.

- The ICB has reported a **<u>Year-to-Date break-even position</u>**, which is in line with the plan submission

- The **<u>Forecast out-turn position is break-even</u>**, 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 £17.8m have been progressed to delivery stage (i.e. an over delivery of £0.8m). The £17.8m achievement is spread across all directorates (albeit it on different spread than the original unidentified efficiency targets). The following variance commentary excludes the impact of this.
    - ➢ £(19.3)m Continuing HealthCare (CHC) pressures as result of increases in High Costs Learning Disability packages and Fast Track packages
    - ➢ £(6.5)m Prescribing Pressure due to the Edoxaban Prescribing Rebate loss, national stock pressures, diabetes prescribing and increase in Oxygen Costs
    - ➢ £(14.7)m Pressure in Acute, including £10.7m anticipated system support required for QEH and additional independent capacity to reduce 78 week waiting list.
    - ➢ £16.3m under spend in Primary Care which includes a £17m anticipated underspend in dental contracts
    - ➢ £17.6m of combined smaller favourable benefits to include Prior Year, contract negotiations and other planning benefits.

- **<u>The Underlying position at M09 is £(102.4)m deficit</u>**, a deterioration of £(45)m against the £(57.4)m financial plan for 2023/24. Key adverse drivers: £(17.5)m relates to delivery of efficiencies in a Non-Recurrent Way, and a further £(33.6)m due to Operational Pressures in CHC, Acute Independent Sector, Prescribing and Mental Health Packages. This is a further deterioration of £(2.8)m against M09 underlying deficit of £(99.6)m.

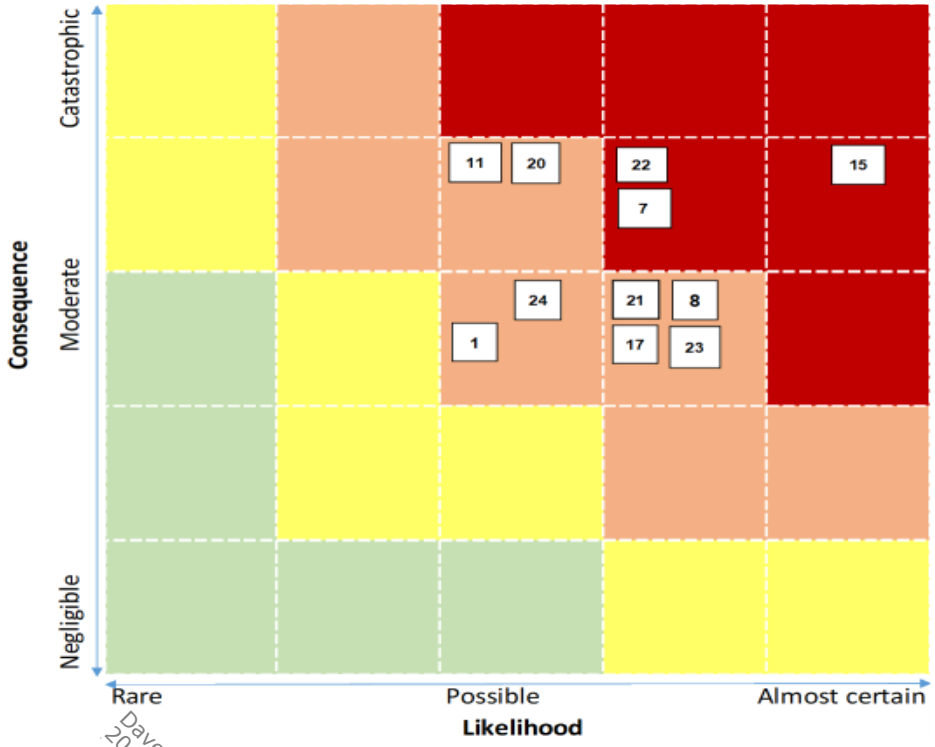
- The **<u>2023/24 Financial Plan included £75m of unmitigated risks</u>** in-line with NHSEI guidance relating to efficiency delivery, investment slippage, service demand, inflationary pressures beyond funding, and corporate pay costs for the Re-Organisation.

- As at **<u>M10 the £75m planning risk is reassessed for all aspects equating to £7.3m</u>** net risk on a probability basis, which is excluded from the forecast. This risk has decreased from M09 (£11.3m). Remaining risks include the operational pressures in 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.

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



Financial Strategic Risks	Ref.	Details	Tolerated Risk appetite	Nov-23	Dec-23	Jan-24
Achievement of Plan	1	Achieve the 2023/24 financial plan **(BAF 11)**	12	12	12	12
	15	Underlying deficit position **(BAF 11A)**	12	20	20	20
	17	Inflationary pressures	9	15	12	12
	20	Impact of new prescribing guidance	8	12	12	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	16	16	16
	23	Debt and Working Capital Management (NCC)	6	9	12	12
Demand and Capacity	7	Continuing Health Care demand growth	9	20	16	16
	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	4	3	3
High	7	8	8
Moderate	0	0	0
Low	0	0	0
Total Risks	11	11	11

As at M10 (January) 11 Key Financial Risks remain open of which 3 Risks are considered Extreme for the underlying deficit, Re-Organisation Programme financial delivery and CHC demand growth. The position is consistent to risks reported in M09 (December).

Whilst Risk 15 'Underlying Deficit' remains consistent, the actual reported underlying deficit continues to deteriorate which remains a cause for concern in 2023/24 and beyond.

Cash Risk : The Board were advised of an emerging cash risk for the current financial year. Since this last update the ICB have been awarded sufficient cash in March to pay all of its suppliers and main NHS Provider contracts per contractual conditions. The ICB still however awaits confirmation that these cash funds awarded are recurrent and therefore remain with the ICB not causing any further cash concerns for 2024/25.

3. Statement of Financial Position (SOFP)

The Statement of Financial Position presents the aggregate closing position of the ICB as at 31st January 2024.

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 prepayments and aged debt. The £31.6m balance is made up of aged debtors of £7.9m (including NHSE £6.6m), net of a provision against this balance of £1.7m and prepayments and accrued income of £25.4m (including provider system support £17.8m). 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 £87m since year end, driven principally by ICB and system invoice accrual timing. The £139m balance is made up of trade creditors of £6m, Prescription Pricing Authority accruals of £18m, dental accruals of £4m, payroll costs including GP pensions of £3m, deferred income of £10m, prior year accruals of £22m and ICB and system invoice accruals of £76m. 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 £4.9m.

Long Term liabilities
The non-current payables balance is the deferred income relating to research & development which are funded in advance.

General Fund
This ICB is directly funded by NHSE with cash allocated on a monthly basis. Any future commitments to balance the general fund shortfall will be supported by the next months cash request from NHSE. This will however continue to remain negative as the NHSE principle is that cash should only be drawn based upon one months commitment at a time.

NHS NORFOLK & WAVENEY ICB STATEMENT OF FINANCIAL POSITION	Position as at 31/03/23	Position as at 31/12/23	Position as at 31/01/24
ASSETS EMPLOYED			
Non-Current assets			
Right-of-use Assets	1,152	1,005	1,005
Accumulated Depreciation	(147)	(284)	(300)
Total non-current assets	1,005	721	705
Current assets			
Trade and Other Receivables	8,676	31,106	31,588
Cash and Cash Equivalents	1,649	1,659	2,801
Total current assets	10,325	32,765	34,389
Current liabilities			
Trade and Other Payables	(225,918)	(160,961)	(138,976)
Lease Liabilities	(219)	(191)	(192)
Provisions for liabilities and charges (including non-current)	(4,732)	(4,732)	(4,712)
Total current liabilities	(230,869)	(165,884)	(143,880)
Long Term liabilities			
Non-Current Payables	(686)	(686)	(686)
Non-Current Lease Liabilities	(775)	(520)	(511)
Total non-current liabilities	(1,461)	(1,206)	(1,197)
Net assets employed	(221,000)	(133,604)	(109,983)
FINANCED BY TAXPAYERS EQUITY			
General fund	(221,000)	(133,604)	(109,983)
Total taxpayers equity	(221,000)	(133,604)	(109,983)

4. ICS Financial Summary - Revenue

Revenue surplus/(deficit) £m	Month 10 YTD			Forecast Outturn			FOT
Organisation	Plan	Actual	Variance	Plan	Actual	Variance	Confidence RAG
JPUH	(0.6)	(2.3)	(1.7)	0.0	(4.8)	(4.8)	Green
NNUH	(2.9)	(4.6)	(1.7)	0.0	0.0	0.0	Green
QEH	(2.0)	(9.4)	(7.4)	0.0	(0.9)	(0.9)	Green
NSFT	(2.5)	(2.5)	0.0	0.0	0.0	0.0	Green
NCH&C	0.1	0.2	0.0	0.0	0.0	0.0	Green
Provider Subtotal	**(7.9)**	**(18.6)**	(10.8)	**0.0**	**(5.7)**	(5.7)	
ICB	0.0	0.0	0.0	0.0	0.0	0.0	Green
N&W System Total	**(7.9)**	**(18.6)**	(10.8)	**0.0**	**(5.7)**	(5.7)	

- The position M10 YTD is a £18.6m deficit, which is £10.8m adverse against plan.
- The most significant adverse variance is at QEH being £7.4m adverse to plan. This is primarily driven by the under-delivery of their CIP programme where the trust has not been able to close down the additional bed capacity in 2023/24 as planned.
- The Forecast outturn for the system is £5.7m deficit, £1.7m is in relation to the impact of December & January Industrial Action, and £3.0m for operational pressures at JPUH.

5. ICS Financial Summary - Capital

System CDEL £m	Forecast Outturn @ Mth 10											
	System CDEL					IFRS 16			Total System Performance			
Organisation	Plan	Plan Adj	Total Plan	Actual	Variance	Plan	Actual	Variance	Tot. Plan	Actual	Variance	
		Inc./(Dec)			(Under)/Over			(Under)/Over			(Under)/Over	
JPH	7.0	0.0	7.0	7.0	0.0	0.1	0.5	0.4	7.1	7.5	0.4	
NNUH	14.6	0.0	14.6	15.2	0.6	8.1	4.3	(3.8)	22.7	19.5	(3.2)	
QEH	6.7	0.0	6.7	8.1	1.4	0.0	0.0	0.0	6.7	8.1	1.4	
NSFT	12.6	0.0	12.6	9.6	(3.0)	2.4	1.2	(1.2)	15.0	10.8	(4.2)	
NCH&C	4.8	0.0	4.8	4.5	(0.3)	0.0	0.5	0.5	4.8	5.0	0.2	
Subtotal excluding RAAC	**45.7**	**0.0**	**45.7**	**44.4**	**(1.3)**	**10.6**	**6.5**	**(4.1)**	**56.3**	**50.9**	**(5.4)**	
RAAC												
JPH	7.8	0.0	7.8	7.8	0.0				7.8	7.8	0.0	
QEH	25.0	7.0	32.0	32.0	0.0				32.0	32.0	0.0	
NCH&C	0.0	2.3	2.3	2.3	0.0				2.3	2.3	0.0	
Subtotal Including RAAC	**78.5**	**9.3**	**87.8**	**86.5**	**(1.3)**	**10.6**	**6.5**	**(4.1)**	**98.4**	**93.0**	**(5.4)**	
Adjustments												
Reduce 5% overplanning assumption		(3.7)	(3.7)		3.7			0.0	(3.7)	0.0	3.7	
Additional CDEL re: 2022/23 Rev Perf.		4.2	4.2		(4.2)			0.0	4.2	0.0	(4.2)	
Reduced IFRS 16 Allocation			0.0		0.0	(2.5)		2.5	(2.5)	0.0	2.5	
Total Adjustments	**0.0**	**0.5**	**0.5**	**0.0**	**(0.5)**	**(2.5)**	**0.0**	**2.5**	**(2.0)**	**0.0**	**2.0**	
N&W System Total CDEL	**78.5**	**9.8**	**88.3**	**86.5**	**(1.8)**	**8.1**	**6.5**	**(1.6)**	**96.4**	**93.0**	**(3.4)**	

Central Programmes £m	Forecast Outturn @ Mth 10											
	CDEL					IFRS 16			Total System Performance			
	Plan	Plan Adj	Total Plan	Actual	Variance	Plan	Actual	Variance	Tot. Plan	Actual	Variance	
		Inc./(Dec)			(Under)/Over			(Under)/Over			(Under)/Over	
Total Central Programmes	123.9	0.0	123.9	126.9	3.0	0.0	0.0	0.0	123.9	126.9	3.0	
N&W Total Capital Programme			**212.2**	**213.4**		**8.1**	**6.5**		**220.3**	**219.9**		

The Month 10 Total Forecast ICS Capital Expenditure performance is £93.0m, £3.4m below plan.

The Capital Delegated Expenditure Limit (CDEL) performance is £86.5m against a plan of £88.3m, an underspend of £1.8m.

The IFRS 16 Capitalised Leases performance has reduced since Month 9 leading to the underspend position of £1.6m.

In addition to system CDEL, RAAC & IFRS 16 funds, there is £123.9m of Central Programme funding, making the total capital resource available for the Norfolk and Waveney ICS equal £220.3m, against this £219.9m is forecast.

Glossary of terms (1)

Term	Description
BCF: Better Care Fund	A programme which supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers.
BPPC: Better Payment Practice Code	The NHS national payments code for good practice with associated mandated reporting. Sets a target of 95% compliance of paying suppliers within 30 days.
Cat M: Category M drugs	Part of the Drug Tariff which is used to set the reimbursement prices of over 500 medicines. It is the principal price adjustment mechanism to ensure delivery of the retained margin guaranteed as part of the contractual framework, using information gathered from manufacturers on volumes and prices of products sold plus information from the Pricing Authority on dispensing volumes to set prices each quarter.
CIP: Cost Improvement Programme	A provider measure of Efficiency and Productivity.
CHC: Continuing Health Care	A package of care for adults aged 18 or over which is arranged and funded solely by the NHS. In order to receive funding individuals have to be assessed according to a legally prescribed decision making process to determine whether the individual has a 'primary health need'.
GIRFT: Get It Right First Time	A national programme designed to improve the treatment and care of patients by reviewing health services. The programme undertakes clinically-led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.
GMS: General Medical Services	Contract which forms the basis of the relationship between the NHS and its GP contractors. The current contract came into force on 1 April 2004 and has been negotiated and updated annually between NHS Employers and the British Medical Association (BMA) since then. It is based upon a multi facetted formula which identifies spend and applies specific ratios resulting in an overall annual percentage pay award for each practice.
GPFV: General Practice Forward View	National development programme of investment in workforce, technology and estates designed to speed up transformation of General Practice services.
HDP: Hospital Discharge Programme	National funding stream to enable earlier discharge increasing flow in the system and release capacity in the acute hospitals.
LCS / LES: Locally Commissioned Services or Locally Enhanced Services	Services provided by GP practices that are either enhanced or additional to the core services offered. These are generally commissioned to meet a local need based on either deprivation or proximity to existing services. Includes services such as phlebotomy, anti-coagulation, atrial fibrillation and care homes. They can reduce onward referrals to Acute settings and funding is separate to practices core contracts.
Model Hospital	An NHS digital information service designed to help the NHS improve productivity, quality and efficiency. Enables health systems and trusts to compare their productivity and quality, and identify opportunities to improve.

Glossary of terms (2)

Term	Description
MHIS: Mental Health Investment Standard	The nationally set requirement for ICBs to increase investment in Mental Health services in line with their overall increase in allocation each year. This is subject to separate external audit on an annual basis to confirm compliance.
NCSO: No Cheaper Stock Obtainable	Items for which in the opinion of the Secretary of State for Health there is no product available to contractors at the price in Part VIII of the Drug Tariff, generally resulting in a higher priced product having to be used.
PHM: Population Health Management	An approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population by focusing on the wider determinants of health by using data to design new models of proactive care and deliver improvements in health and wellbeing which make best use of the collective resources.
PLICS: Patient Level Information and Costing Systems	Costing system which brings together healthcare activity information with financial information in one place. PLICS provides detailed information about how resources are used at patient-level, for example, staff, drugs, and diagnostic tests and combined with other data sources, provides trusts with a rich source of information to help understand their patients and their services.
PMS: Personal Medical Services	Voluntary option for GPs and other NHS staff to enter into locally negotiated contracts. PMS contracts offer local flexibility compared to the nationally negotiated GMS contracts by offering variation in the range of services which may be provided by the practice, the financial arrangements for those services and the provider structure (who can hold a contract).
QIPP: Quality, Innovation, Productivity and Prevention	The collective measure of system transformation efficiencies and productivity.
QOF: Quality and Outcomes Framework payments	This is a voluntary annual reward and incentive programme for all GP practices in England, detailing practice achievement results. It is not about performance management but resourcing and rewarding good practice.
Rightcare	Teams who work locally with systems to present a diagnosis of data and evidence across that population, working collaboratively with systems to look at the evidence to identify opportunities and potential threats. They use nationally collected robust data to complete delivery plans on a continuous basis, to evaluate the system and establish a base plan to maximise opportunities and turnaround issues.
Running costs / Programme costs	Running costs represent the costs of administering the ICB and the work it carries out / Programme costs represent the costs of services commissioned by the ICB.
s.117: Section 117 of Mental Health Act 1983	Entitlement to free after-care if a patient has been in hospital under specific sections of the Mental Health Act 1983. It meets the needs that a patient has because of the mental health condition that caused them to be detained and is designed to reduce the chance of the condition getting worse so avoiding a return to hospital.

Norfolk and Waveney
Integrated Care Board

Agenda item: 11

Subject:	**Fit and Proper Persons annual assurance report**
Presented by:	**Karen Barker - Executive Director of Corporate Affairs and ICS Development** **Rt Hon Patricia Hewitt, Chair**
Prepared by:	**Nikki Bartrum, Corporate Governance Manager**
Submitted to:	**ICB Board – Part 1**
Date:	**26 March 2024**

Purpose of paper:

For information and assurance.

Executive Summary:
In line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, NHS Norfolk and Waveney Integrated Care Board (ICB) is required to ensure that all relevant individuals meet the requirements of the Fit and Proper Persons Test (Regulation 5).

This report provides assurance to the board, in respect of the ICB's compliance with the Fit and Proper Persons Test (FFPT).

1. BACKGROUND

Under the requirements, the ICB must not appoint to a post under the scope of the Regulated Activity Regulations without first satisfying itself that the individual:

- Is of good character
- Has the necessary qualifications, competence, skills and experience;
- Has the appropriate level of physical and mental fitness;
- Has not been party to any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out a regulated activity;
- Is not deemed unfit under the Regulated Activities Regulations provisions;
- Can provide the personal information as set out in the regulations which must be available to be supplied to the CQC when required.

The Fit and Proper Person Test Framework for Board Members was published in September 2023 for implementation from 30 September 2023. NHS organisations are not expected to collect historic information, but to use the Framework for all new board level appointments or promotions and for annual assessments going forward.

2. APPROACH

In addition to board members, the ICB has also chosen to apply the FPPT to existing and new directors at Very Senior Management (VSM) grade. This approach goes above and beyond the requirements of the FPPT guidance which is only required to be applied from 30 September 2023, for new employees or those leaving the organisation.

FPPT due diligence checks are undertaken in addition to the standard employment checks at recruitment stage and then on an ongoing annual basis.

The ICB has robust processes in place with regard to the appointment of board members and VSMs. These processes include conducting a number of checks e.g a review of employment history and references, social media checks, searches of the disqualified directors register and insolvency/bankruptcy register, qualifications and professional registration checks, 3 yearly Disclosure Barring Service checks and a signed self-attestation form from each individual.

The ICB is also responsible for ensuring the continued compliance of those persons to whom the Regulated Activity Regulations apply. This requirement is fulfilled through a number of processes including annual due diligence checks as set out in Appendix 7 of the Framework, a formal appraisal process and the completion of an annual self-attestation by each board member and VSM.

3. ANNUAL REVIEW

The due diligence process for 2023/24 was undertaken in line with the Framework.

- The Corporate Governance Manager maintains a database to support compliance of the FPPT.
- The portfolio of evidence for each individual is stored on local HR personnel files.
- The new mandatory fields on ESR have been updated to record FPPT outcomes and have been checked as part of the validation process.
- Before commencing the collection of any FPPT evidence, organisations must issue a privacy notice advising how their information will be used and stored. This was issued to board members and VSMs in August 2023.
- Self-attestation forms were issued and have been signed and returned by individuals and also signed by the Chair to confirm receipt. The deputy Chair signed to confirm receipt of the Chair's form.
- For our partner members on the board, written confirmation that FPPT checks were undertaken at recruitment, has been received from their employing organisation.
- Ongoing annual FPPT checks for partner members have been conducted by the ICB e.g. social media checks, disqualified director, employment tribunal and insolvency checks.
- Informal reviews have been completed for all board members and VSMs and formal appraisals, incorporating the Leadership Competency Framework, are being scheduled for the new financial year.
- Board Member References have been completed for those leaving the organisation.
- Internal Audit will be asked to schedule a review of the processes, controls and compliance with the FPPT, at least every three years.

4. LEADERSHIP COMPETENCY FRAMEWORK (LCF)

The LCF was published on 28 February for implementation in 2023/24. We have feedback to the national team on the difficulties of the timeframe given that the LCF was originally due to be published back in September 2023.

The ICB is committed to fully implementing the LCF in 2024/25. The 360-stakeholder process was launched in February and we are in the process of scheduling formal appraisals for board members and VSMs.

The LCF will be incorporated into board and VSM job descriptions and recruitment processes by 1 April 2024.

5. VALIDATION

In order to ensure appropriate checks were performed in relation to individual outcomes, a summary of the FPPT outcomes, including the ESR report and supporting evidence was provided for review and validation as follows:

- FPPT results for the Deputy Chair and Board members was provided to the Chair for approval.
- FPPT results for the Chair was provided to the Deputy Chair for approval.

- FPPT results for the VSMs was provided to the Chief Executive for approval.

All individuals have been concluded as fit and proper with no issues arising from the FPPT.

The FPPT declaration form has been signed by the Chief Executive, Deputy Chair and Chair to confirm the outcome of the FPPT for 2023/24. The declaration will be submitted to NHS England by 31 March 2024.

6. RECOMMENDATION

The board is asked to note the contents of this report.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	Risk to reputation if ICB breaches FPPT requirements.
Legal:	There is a risk of legal challenge/action if the ICB breaches the Requirements.
Information Governance:	Risk of IG and Data protection breaches if recruitment documentation is not handled, shared and stored correctly.
Resource Required:	ICB - Corporate Governance and HR team AGEM CSU - Recruitment Team
Reference document(s):	• Kark Review of the FPPT • Regulation 5: Fit and Proper Persons - directors • NHS England FPPT Framework for Board Members and Appendices • Guidance for chairs on implementation of the FPPT for board members • FPPT for board members – guidance on ESR
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	Risk to reputation if the ICB does not implement the FPPT or breaches the requirements.
Legal:	Risk of legal challenge if ICB does not fully implement the FPPT or it breaches the requirements.
Information Governance:	Risk of IG and Data protection breaches if recruitment documentation is not handled, shared and stored correctly.
Resource Required:	ICB - Corporate Governance and HR Team AGEM CSU - Recruitment Team
Reference document(s):	Good Practice Recruitment Guide: Designate Independent Non – executive Members for Integrated Care Boards B1551 Guidance to CCGs on the preparation of Integrated Care Board Constitutions Kark Review
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)	

Norfolk and Waveney
Integrated Care Board

Agenda item: 12

Subject:	**Governance Handbook - Proposed Changes**
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:	**26 March 2024**

Purpose of paper:

The ICB Board is being asked to approve amendments to the Governance Handbook's Scheme of Reservation and Delegation and to the Primary Care Commissioning Committee's Terms of Reference.

Executive Summary:

Introduction
The Governance Handbook is designed to support and supplement the ICB Constitution. It sets out a framework which demonstrates the ICB's governance arrangements for exercising its duties and functions. In this respect, whilst it is not a legal requirement to have a Governance Handbook, it supports the ICB to build a consistent corporate approach and form part of the corporate memory.

Attached are updated sections of the NHS Norfolk and Waveney Integrated Care Board (ICB) Governance Handbook in track for Board approval.

The approved version of this document will become version 7.

Changes made to the document are summarised below:

Sections 1 – 4 – no change

Section 5 - Scheme of Reservation and Delegation – Appendix A
This section sets out the functions reserved to the Board, functions delegated to an individual or Committees and functions delegated to other bodies or to be exercised jointly.

- *Decisions and functions delegated by the board to individual board members and employees*

It is proposed that the ICB's Authorised Officer for specialised commissioning is the Executive Director for Performance, Transformation and Strategy and Deputy CEO. This is in respect to the delegation of 59 specialist services by NHS England to the ICB in accordance with the Specialist Commissioning Delegation Agreement and pursuant to the arrangements set out in a Collaboration Agreement between the six East of England ICBs and NHS England and to take effect on 1 April 2024.

- *Decisions and functions delegated to the board by other organisations*

The delegation from NHS England to the ICB of the 59 specialised services is listed under this section.

In addition, it is proposed that the role titles in this section be updated in line with the staff re-organisation, to take effect from 1 April 2024.

Sections 6 to Appendix E – no changes

Appendix F – Primary Care Commissioning Committee – Appendix B

In March 2023, the Primary Care Commissioning Committee (PCCC) Terms of Reference were updated to reflect the expanded responsibilities for all primary care services under the Primary Care Delegation Agreement with NHS England from 1 April 2023.

To facilitate and streamline discussions and decision making, two delivery groups, one for dental services and the other for general practice, were established under a Scheme of Delegation for PCCC. At the time, it was acknowledged that the primary care governance framework may need to be amended and would evolve as the Committee became more familiar with the role and responsibilities of the Delivery Groups.

The ICB has now reviewed how this governance framework has been working since April 2023 and proposes a number of amendments to make the Committee more effective from April 2024. This includes freeing up PCCC agendas to allow more time for strategic oversight and delivery of its assurance role, receiving reports from the operational delivery groups and to allow time for planning and deep dives into specific topics. Amendments therefore include:

- Wording to give PCCC explicit oversight for the primary care strategic framework (included in ToRs)
- Clarification about how primary care quality matters will be managed given explicit responsibility in the Delegation Agreement which PCCC is responsible for
- Explicit wording in the Delivery Group ToRs to enable escalation to PCCC (rather than being implicit)

It is proposed that PCCC meets quarterly as a minimum unless there is urgent business to discuss.

Membership of Part 2 to include Healthwatch and representatives from Health and Wellbeing Boards Board Assurance Framework (Primary Care) risks will continue to be presented to PCCC for strategic assurance and discussion. All other risks will be overseen by the Delivery Groups with a summary provided to PCCC in the regular assurance reports and an annual update. The PCCC reviewed and agreed the proposed changes at its March 2024 meeting. **Sections Appendix G to F – no change**

Recommendation to the Board:

The Board is asked to approve the amendments to the ICB Governance Handbook as detailed in the report above.

Key Risks	
Clinical and Quality:	Primary Care Commissioning Committee has responsibility for quality in primary care
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:	
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	BAF14, BAF18 and BAF22

Governance

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

Appendix A

Decisions and functions delegated by the board to individual board members and employees

Individual board member or employee	Decisions and functions delegated to the individual	Reference
Executive Director of Strategy and Deputy CEO	Production of the ICB's Plan.	
	ICB's Authorised Officer for Specialised Commissioning (and in their absence Executive Director of Finance). This is with regard to specialist services as defined by the Collaboration Agreement as agreed from time to time by the six East of England ICBs and NHS England.	

Decisions and functions delegated to the board by other organisations

Body making the delegation	Decisions and functions delegated to the individual	Reference
NHS England	Primary Medical Services, Primary Dental Services and Prescribed Dental Services, Primary Ophthalmic Services, Pharmaceutical Services and Local Pharmaceutical Services	Delegation Agreement
NHS England	59 Specialised Services	Delegation Agreement

Appendix B

Item No 5

APPENDIX F

Norfolk and Waveney Integrated Care Board
Primary Care Commissioning Committee
Terms of Reference

Revision History

Revision Date	Summary of changes	Author(s)	Version Number
January 2023	Changes made to reflect transition of responsibility for pharmacy, dental and ophthalmic from NHS England to ICB		
March 2024	Changes made to update the Terms of Reference to improve effectiveness		7

Approvals
This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	ICB Board		1
28 March 2023	ICB Board		2

1 Constitution

1.1 The Primary Care Commissioning Committee (the Committee) is established by the Norfolk and Waveney Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.2 The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2 Authority

2.1 The Committee is authorised by the Board to:

- Investigate any activity within its terms of reference.
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference.
- Create a Primary Medical Services Delivery Group and a Dental Services Delivery Group that will undertake specific agreed tasks and decision making as set out in the ICB Governance. The Committee shall appoint the Chair and agree the membership and terms of reference of these groups in accordance with the ICB's constitution, standing orders and SoRD.

2.2 For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions and the SoRD.

3 Purpose

3.1 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.

The duties of the Committee will be driven by the ICB's objectives 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.

3.2 The Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

4 Membership and attendance

Membership

4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than 4 members of the Committee based on their specific knowledge, skills and experience.

4.2 The members of the Committee who will attend Part 1 and Part 2 meetings are:

- A Local Authority Partner Member from the ICB Board (Chair)
- Non-Executive ~~Director~~ Member from the ICB Board (Deputy Chair)
- Executive Director of Nursing or their nominated deputy
- Executive Director of Finance or their nominated deputy

4.3 Where a member of the Committee is unable to attend a meeting, a suitable deputy may be agreed with the Committee Chair. The nominated deputy will count in the quorum for the meeting and be able to cast a vote if required.

Chair and Vice Chair

4.4 The Chair of the ICB will appoint a Chair of the Committee who has the specific knowledge, skills and experience making them suitable to chair the Committee.

Committee members may appoint a Vice Chair from amongst the members.

4.5 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.

Attendees

4.6 Only members of the Committee have the right to attend Committee meetings. The following individuals, who are attendees and not members of the Committee, will be invited to attend Part 1 and Part 2 meetings subject to s.4.~~10~~7:

- ICB Board Partner Member – Providers of Primary Medical Services
- Local Representative Committee members – Local Medical Committee, Local Dental Committee, Local Pharmacy Committee and Local Optical Committee
- Director of Patients and Communities
- Director of Primary Care
- One practice manager (or other suitably experienced individual) from primary medical services and one individual from (NHS) primary dental services
- Representatives from Local Authority Public Health teams in Norfolk and Suffolk

~~The following attendees will be invited to attend Part 1 meetings only:~~

- Healthwatch Norfolk
- Healthwatch Suffolk
- Health and Wellbeing Board representative – Norfolk
- Health and Wellbeing Board representative – Suffolk

4.7 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Boards, Secondary and Community Providers.

Attendance

4.8 Where an attendee of the Committee who is not a member of the Committee is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

5 Meetings Quoracy and Decisions

5.1 The Committee will meet at least 4 times a year in public subject to the application of 5.4 below. The Committee will operate in accordance with the ICB's Standing Orders. The Secretary to the Committee will be responsible (or delegate where appropriate) for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each voting member and non-voting attendee at least 7 calendar days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he/they shall specify. Additional meetings may take place as required in public or private as appropriate for the nature of the business to be transacted.

The Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

5.2 In accordance with the Standing Orders, the Committee will normally meet virtually unless a face to face meeting is deemed necessary.

The Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

Quorum

5.3 For a meeting to be quorate a minimum of 3 Members of the Committee are required, including the Chair or Vice Chair of the Committee.

If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.4 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. If an urgent decision is required, the process set out at 5.~~11~~ 7 and 5.~~12~~ 8 may be followed.

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Decision making and voting

5.5 Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may

call a vote.

Only members of the Committee or nominated deputy may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

5.6 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote or in their absence the Vice Chair.

Urgent Decisions

5.7 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

In the event that an urgent decision is required, if it is not possible for the Committee to meet virtually an urgent decision may be exercised by the Committee Chair (or Deputy Chair if the Committee Chair is conflicted) and relevant lead director subject to every effort having been made to consult with as many members as possible in the given circumstances (minimum of one other member).

5.8 The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification and noted in the minutes.

6 Responsibilities of the Committee

6.1 NHS England has delegated to the ICB authority to exercise the primary care commissioning ~~and dental~~ functions in accordance with section 13Z of the NHS Act with specific obligations set out in Schedule 2 of the Delegation Agreement and general obligations set out below:

Delivery and oversight of the primary care strategic framework;

Schedule 2A: Primary medical services

- decisions in relation to the commissioning, ~~and~~ management and quality of Primary Medical Services;
- planning Primary Medical Services in the Area, including carrying out needs assessments;
- undertaking reviews of Primary Medical Services in respect of the Area;
- management of the Delegated Funds in the Area;
- co-ordinating a common approach to the commissioning and delivery of Primary Medical Services with other health and social care bodies in respect of the Area where appropriate; and
- such other ancillary activities that are necessary in order to exercise the Delegated Functions.

Schedule 2B: Primary dental services and prescribed dental services

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- decisions in relation to the commissioning, ~~and~~ management and quality of ~~Primary~~ Dental~~,~~ Services; for clarity this includes primary care, community care/special care dental services and secondary care dental services;
- planning ~~Primary~~ Dental Services in the Area, including carrying out needs assessments;

- undertaking reviews of Primary Dental Services in the Area;
- management of the Delegated Funds in the Area;
- co-ordinating a common approach to the commissioning and delivery of Primary Dental Services with other health and social care bodies in respect of the Area where appropriate; and
- such other ancillary activities that are necessary in order to exercise the Delegated Functions.

Schedule 2C: Primary ophthalmic services

The contracting of Ophthalmic services are hosted by Hertfordshire and West Essex Integrated Care Board (H&WE ICB) on behalf of the ICB. In accordance with the Memorandum of Understanding with HWE ICB and other ICBs in the East of England region, H&WE ICB will report general optometry services matters to the Committee including information to support decision making as and when matters arise. The Norfolk and Waveney ICB remains responsible and accountable for the provision of this service.

- decisions in relation to the management and quality of Primary Ophthalmic Services;
- undertaking reviews of Primary Ophthalmic Services in the Area;
- management of the Delegated Funds in the Area;
- co-ordinating a common approach to the commissioning of Primary Ophthalmic Services with other commissioners in the Area where appropriate; and
- such other ancillary activities that are necessary in order to exercise the Delegated Functions.

Schedule 2D: Pharmaceutical services and local pharmaceutical services

The contracting of Pharmaceutical services are hosted by HWE ICB on behalf of the ICB.

NHS England has established a mandated local committees to be known as the Pharmaceutical Services Regulations Committees (PSRC). The PSRC is an ICB committee with representatives from all East of England ICBs attending. NHS England has delegated decision making to each PSRC in relation to matters under the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 as amended.

H&WE ICB will coordinate and host the PSRC to agreed Terms of Reference as set out in the NHS England Pharmacy Manual (**https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-manual/**).

In accordance with the Memorandum of Understanding with HWE ICB and other ICBs in the East of England region H&WE ICB will provide quarterly reports to the Committee on decisions made at the PSRC.

Applications and Notifications will be made by H&WE ICB on behalf of the Norfolk and Waveney ICB to the PSRC for determination.

The Norfolk and Waveney ICB remains responsible and accountable for the provision of this service and for the direct commissioning, management and quality of local pharmaceutical services.

6.16.2 Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the ICB acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

- Management of conflicts of interest (section 14O);
- Duty to promote the NHS Constitution (section 14P);
- Duty to exercise its functions effectively, efficiently and economically (section 14Q);
- Duty as to improvement in quality of services (section 14R);
- Duty in relation to quality of primary care services. The Committee has the remit for reviewing primary care quality. Due to the interface with other services, however, the Quality and Safety Committee will maintain oversight of issues which may require more system wide assurance and support.;
- Duties as to reducing inequalities (section 14T);
- Duty to promote the involvement of each patient (section 14U);
- Duty as to patient choice (section 14V);
- Duty as to promoting integration (section 14Z1);
- Public involvement and consultation (section 14Z2).

6.26.3 The functions of the Committee are undertaken in the context of a desire to promote increased quality, efficiency, productivity and value for money and to remove administrative barriers.

The role of the Committee shall be to carry out the functions relating to the commissioning of primary care services under the NHS Act and detailed in the Delegation Agreement with NHS England.

6.36.4 In performing its role, and in particular when exercising its commissioning responsibilities, the Committee shall take account of:

a) The recommendations of the executive management team, the relevant Delivery Group and other Board committees;

b) The needs assessment and plan for primary ~~medical~~ care services in the areas covered by the ICB including the resilience of all primary care providers;

c) The co-ordination of a common strategic and operational approach to the commissioning of primary care services generally including supporting developments in respect of integration with providers and local authority services including co-location of services;

d) The management of the budget for commissioning of primary care services in the area covered by the ICB;

~~d)~~e) How it discharges its duties under the Delegation Agreement for quality matters relating to primary care services. The Executive Director of Nursing or their nominated deputy (Quality lead) is a Voting Member to ensure there is a joined up approach to managing quality matters between this Committee and the ICB's Quality and Safety Committee (QSC). The Quality Lead and Director of Primary Care will ensure collaborative working to avoid duplication. There will be a standing item on the Committee's agenda to report on pertinent matters relating to primary care from QSC by exception.

~~e)~~f) In accordance with its duties to reduce inequalities,14T, in the exercise of its functions, the Committee will have regard to the need to:

- Reduce inequalities between patients with respect to their ability to access health services, and
- ~~reduce~~ Reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services

7 Behaviours and Conduct

ICB values

7.1 Members will be expected to conduct business in line with the ICB values, objectives and follow the seven principles of public life (the Nolan Principles), comply with the standards set out in the Professional Standards Authority guidance.

Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy and Conflicts of Interest Policy.

Equality and diversity

7.2 Members must demonstrably consider the equality and diversity implications of decisions they make.

Conflicts of Interest

7.3 Members and those attending a meeting of the Committee will be required to declare any relevant interests to the ICB in accordance with the ICB's Conflicts of Interest Policy.

A register of Committee members' interests and those of staff and representatives from other organisations who regularly attend Committee meetings will be produced for each meeting. Committee members will be required to declare interests relevant to agenda items as soon as they are aware of an actual or potential conflict so that the Committee Chair can decide on the necessary action to manage the interest in accordance with the Conflicts of Interest Policy.

Confidentiality

7.4 Issues discussed at Committee meetings held in private, including any papers, should be treated as confidential and may not be shared outside of the meeting unless advised otherwise by the Chair.

8 Accountability and reporting

8.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The Chair of the Committee, if not a member of the ICB Board, may be invited to attend Board meetings at the request of the Chair of the ICB.

8.2 The Chair of the Committee will be accountable to the Chair of the ICB for the conduct of the Committee.

The minutes of the meetings, including any virtual meetings, shall be formally recorded by the secretary. A report of the Committee's work will be submitted to the Board following each meeting.

8.3 The Committee Chair shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

9 Secretariat and Administration

9.1 The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Committee Chair with the support of the relevant executive lead.
- ~~Attendance of those invited to each meeting is monitored, highlighting to the Chair those that do not meet the minimum requirements~~.
- Good quality minutes are taken in accordance with the Standing Orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Board.

- The Committee is updated on pertinent issues/ areas of interest/ policy developments.
- Action points are taken forward between meetings and progress against those actions is monitored.

10 Review

10.1 The Committee will review its effectiveness annually.

These terms of reference will be reviewed annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the ICB Board for approval.

Date of approval: XX~~28 February 2023~~March 2024

Version 3~~2~~

NHS
Norfolk and Waveney
Integrated Care Board

Agenda item: 13

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:	**26 March 2024**

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 January 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 23 January 2024:

- **BAF22 Specialised Commissioning**. The mitigated risk rating has decreased bringing it in line with it's tolerated risk score. The proposal therefore is to close this risk. New risks will be considered as a matter of course as the delegated services embedded.

Finally, the ICB will be fully implementing its new digital risk system and rolling this out to all teams in 2023/24. As part of this bottom up review of risks, we expect this may support with the review of strategic risks on the BAF and help identify critical risks which threaten our ability to deliver our objectives.

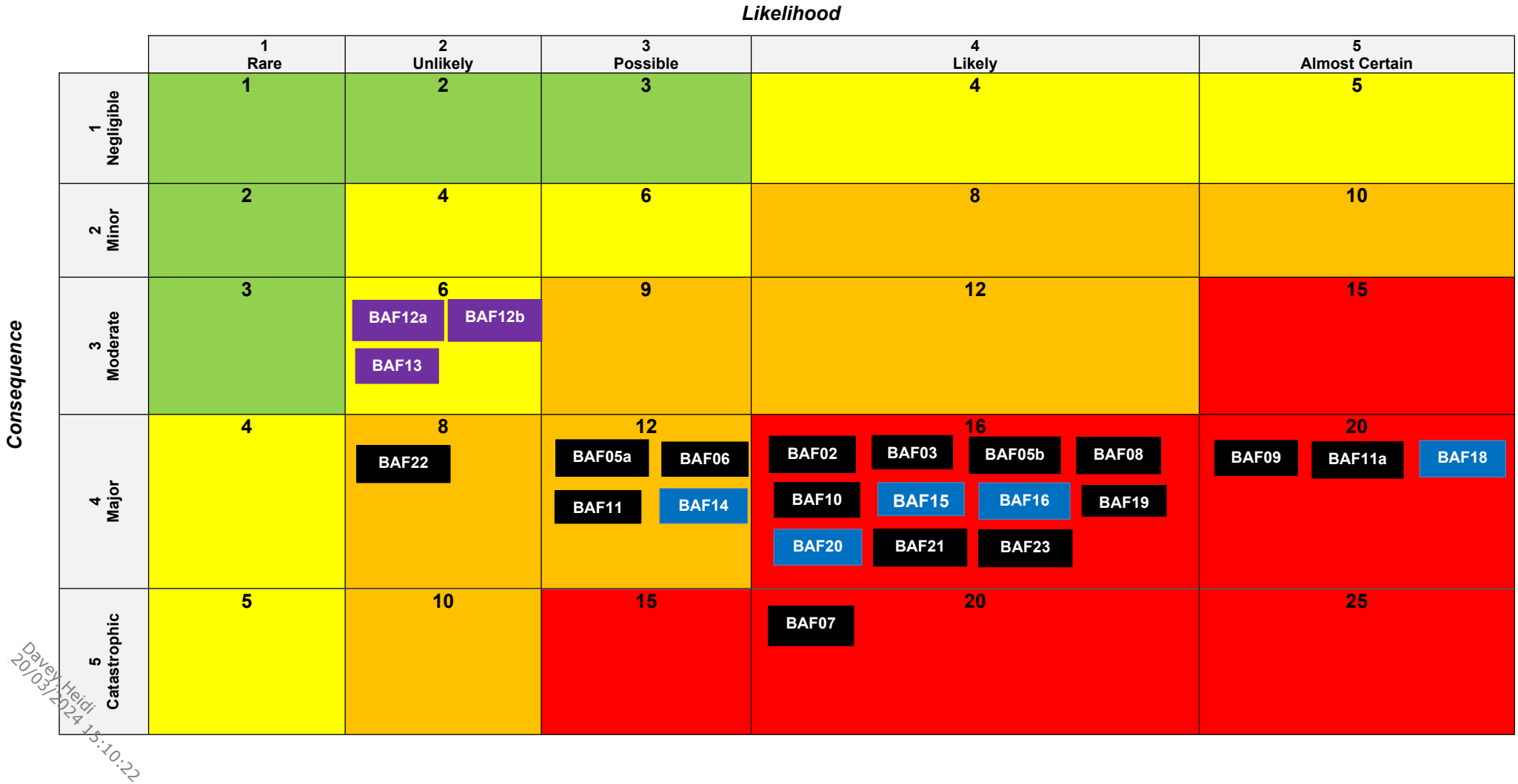
Recommendation to Board:

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:	7	Date:	19 March 2024

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	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	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	16	Closed in M09			
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	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	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	12	12	12	12	

BAF07	RAAC Planks	Steven Course	01/07/22	31/03/24	15	20	20	20	20	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	16	16	16	16	
BAF09	NHS Continuing Healthcare	Tricia D'Orsi	01/07/23	31/03/24	9	16	16	16	16	20	20	20	20	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	20	16	16	16	
BAF11	Achieve the 2023/24 Financial Plan	Steven Course	01/07/22	31/03/24	12	16	16	16	16	16	16	12	12	12	12	12	
BAF11A	Underlying Deficit Position	Steven Course	01/07/22	31/03/24	12	20	20	20	20	20	20	20	20	20	20	20	
BAF19	Right Care Now	Tricia D'Orsi	25/10/22	31/03/24	6	15	15	12	12	12	15	15	15	16	16	16	
BAF21	Mortality Action Plan NSFT	Dr Frankie Swords	18/07/23	31/03/24	4				20	20	20	16	16	16	16	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	8							16	16	12	12	8	
BAF23	System failure to meet access standards for cancer diagnosis and treatment	Dr Frankie Swords	22/11/23	31/03/24									16	16	16	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	Assurances on 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	**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 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	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

- 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.
- Transformation plans continue to progress alongside Quality Improvement.
- ICB attending Trust Quality and Safety Reviews (QSR) with frontline teams and working closely with NHSE.
- 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 2024.
- A new model of care is currently being piloted in Suffolk.
- High-level oversight of mortality review actions in place. Bereaved families, Healthwatch and ICBs included.

Assurances on controls

Internal: Clinical Governance Meetings, Quality and Safety Committee, ICB Executive Management Team (EMT), System EMT, and ICB Board. Trust CQC Evidence Panel chaired by ICB.

External: ICB attendance at Key Trust Meetings, Care Quality Commission, System Quality Group, Norfolk and Suffolk Healthwatch organisations, NHSE/I Oversight and Assurance Group, NSFT Quality Improvement Board, NSFT Quality Pillars and NSFT Quality Committee, Evidence Assurance Panel. Norfolk and Suffolk HOSCs.

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. Impact of 'inadequate' rating on staff wellbeing and morale. Significant change within top leadership level.
- Long term sustainability of improvements, to BAU, is required to move out of NOF4 status.
- Publication of the NSFT Review of Mortality Reporting (see BAF 21) led to adverse media attention. High-level oversight is in place, however there is still work required to ensure that the evidence of progress is shared and monitored consistently.
- Continued work to improve data validation across the Trust.
- 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 is being piloted in Suffolk.	**G**	31/03/24
19/02/24	RSP strategic framework is a priority focus to ensure the Trust does not re-enter RSP again. Key priorities; improving health, improving care, improving value, and improving culture with 11 large-scale change programmes.	**G**	31/03/24

Visual Risk Score Tracker – 2023/24												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	12	12	12	16	16	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 • 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 embed 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 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. Stocktake of Community Transformation underway to understand current position regarding recruitment, activity and spend against original transformation ambition and plans.	**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	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	Assurances on controls
• Dedicated CYP strategic commissioning team now in place • Effective System wide governance framework • Collaboration with system partners to understand demand and capacity has begun and the shared resource is better understood. • Development of robust understanding of the financial envelope available to drive the transformation, and investment necessary, including appropriate measures to reconcile these is still in process. • System approach to increasing knowledge skills and expertise across agencies and developing additional capacity through use of digital. Greatly assisted by digital appointing a digital lead. Digital workstream initiated. • Financial slippage is being mitigated against protecting our ability to maintain MHIS investment. • Implementation of system wide transformation programme • 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 • Intensive day support unit now open for eating disorders and parent support offer in place. • Professional Therapeutic Pathway in place • Integrated Front Door phase one in place. • Enhanced support offers for 18–25-year-olds in wellbeing hubs. • Gender Identity Service in place	**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**
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. Update 02/01/2024. Recruitment remains problematic. Workforce information requested from NSFT through newly re-established SPQRG	R	31/01/24
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. Update 02/01/2024. Recruitment remains problematic. Workforce information requested from NSFT through newly re-established SPQRG	R	31/01/24
08/11/23	Castle Green Integrated Intensive Day Support/Short Breaks Unit paper presentation and prioritisation matrix complete. Risks identified regarding financial implications. Presented to deliberation panel – scoring ratified and funding identified. Awaiting next steps. Need to confirm with NHSE due to capital funding allocation	A	31/03/24
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. Update 02/01/24Workshop completed 15/12/2023. Priorities for workstreams proposed and will be established within January 2024	A	31/01/24
02/01/24	Additional capacity within Professional Therapeutic Pathway identified using winter funding. Monitor impact through waiting list updates.	A	31/03/24
02/01/24	Integrated Front Door further role out to include NSFT direct referrals scheduled to commence April 2024	A	31/03/24
02/01/24	Recruitment to mental health care navigator team commenced. Some delays due to organisational restructure – Project Manager in post, recruiting to programme lead role.	G	31/03/24
02/01/24	Castle Green Integrated Intensive Day Support/Short Breaks Unit paper presentation and prioritisation matrix complete. Risks identified regarding financial implications. Presented to deliberation panel – scoring ratified and funding identified. Awaiting next steps. Need to confirm with NHSE due to capital funding allocation	R	31/03/2023

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	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. 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 proactively addresses 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 PHM team working closely with the health inequalities SRO and Clinical Lead.
- Plus groups now defined for N&W
- PHM and HI 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.
- Community Voices gathering insights into HI and connecting with local communities
- ICS Inclusion health groups and vaccines inequalities reporting into HIOG

Assurances on controls

Internal: PHM and addressing HI has been identified as a priority in our JFP. Progress against key national delivery timelines reported and led by appropriate governance structures: Health Inequalities Oversight Group (HIOG), PHM oversight group 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
Health Needs Assessments for Inclusion Health groups developed to be published on JSNA

External: Health & Wellbeing Partnerships, Place Boards, Clinical programme boards 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
31/01/24 31/01/24	Engagement events held and draft PHM strategy and ICS HI Framework for action (including wider determinants of health) under development. Progression with data hub and scoping for dashboard in respect of reporting for NHSE Statement on Information on Health Inequalities	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	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 conducted 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. • Regular meeting established with NCHC and regional RAAC team to track progress on the community storage site RAAC removal.	**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
12/12/23	RAAC works at JPUH reduced to support ambulance handover capacity. works for the HSDU and kitchen will continue and will complete a significant area, so the overall programme is not significantly impacted	**A**	Ongoing
12/03/24	Programme to eradicate RAAC at the community site is progressing well and is planned to be completed on budget within the financial year	**G**	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	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.
- Introduction of national PIDMAS system to assist with offering alternative choice of provider to long wait patients.

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 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 processes.
- Critical incidents declared at trusts due to intense pressure on emergency capacity.
- Staffing challenges at the Trusts with consultant sickness and vacancies.
- ICB admin resource to manage PIDMAS requests as well as limited Trust resource to undertake clinical and administrative validation of these requests.
- Limited capacity within the ICS and East of England to accommodate PIDMAS requests within timescales.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
03/01/24	• PIDMAS process implemented on 31/10/23 with 11,581 patients contacted (40+waiters). 437 PIDMAS requests received by ICB. Capacity identified for 13 to be treated locally and 78 to be added to the national DMAS system as they were willing to travel nationally. • New paediatric theatres at NNUH opened January 24releasing main theatre capacity for gynaecology surgery.	R	

	• Providers continuing to maximise use of Insourcing and Outsourcing opportunities to assist with T&O, dermatology, gynaecology and ENT backlogs. • JPUH currently forecasting 214 78-week breaches for end of Dec. • NNUH currently forecasting 766 breaches. • QEH forecasting 5 breaches – all due to patient choice. • Two more junior doctor strikes Dec & Jan impacting elective services and ability to deliver recovery targets.		

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	16	16	16	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	**Assurances on controls**
• Recruiting to vacant posts within the CHC team to support assessments and care sourcing. • Commence work with finance team and contract team in NWICB and Local Authorities (LAs) to work to stabilise the market. • Link with Local Authority (LA) workforce teams to support care providers in additional training and support required. • Regular financial updates to Finance Committee and Executive Management Team (EMT) to monitor impact of cost of care packages. • Monthly operational finance meetings for Quality in Care (QiC) team. • Monitoring of time taken to secure complex care packages and escalation process for CHC team if unable to source. • Attendance at regional meetings to support feedback and sharing of good practice and innovation. • 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. • Implementation of increased financial control. • Increased staff establishment.	**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 – ongoing.
- 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

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**	31/03/24

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

Controls	**Assurances on controls**
• Daily sit-rep ensures ICB is sighted on real-time demand and resource. • HALO role across all Acute sites to support Emergency Departments (ED). • 999 / 111 multi-disciplinary approach via CAS at IC24 to manage some ambulance calls and dispositions • Pre-alert and 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. • System has agreed to a zero-tolerance position for ambulance handovers >30min as of November-December 2023. This has resulted in a reduced number of adverse incidents and has supported improved ambulance response times in the community for C1 and C2.	**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. The occupancy and utilisation of escalation areas has increased as an unintended consequence of 30min ambulance handover improvement, ongoing impact of IA and seasonal pressures, including infectious illnesses.

- Significant challenge remains in social care re: capacity and workforce required to support packages of care in the community.
- 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.
  During the festive period, there have been some delays due to congested flow in the hospitals.

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	31/07/24
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	31/07/24
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
03/01/24	All ambulance handovers equal or greater than 8hrs are to be reported to NHSE regional and national teams and the Department of Health.	G	31/07/24
28/02/24	C2 response mean for Feb 24 remains variable, demonstrated improvement in November and December 23 but have struggled to maintain performance in January and February.	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	20	16	16	16	
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	Assurances on 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.	**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

1. No contingency reserve in plan;
2. £75m of unmitigated risks against the plan at the point of final submission, of which £52.2m (70%) assumed credits embedded within the plan;
3. As at M10 (January 2024) the £75.0m planning risks have been re-assessed to £3.4m on a probability basis with the remaining planning risks relating to further Prescribing and CHC pressures and Identified Efficiency Delivery.
4. In addition to the remaining £3.4m Planning Assumption Risks, a further £3.9m of Net Risks have been noted at the end of M10 (January 2024) resulting in a Total net risk of £7.3m (M09 £11.3m).
5. The improvement of total risk reported against M09 arises from the H2 system redress exercise identifying non-recurrent measures to support the system and the ICB as a result of the unplanned Industrial Action impacts which are now included in the reported forecast position.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
13/06/23	Review of monthly year to date performances 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	12	12	12	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	01/07/2022	31/03/2024

Risk Scores

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

Controls	Assurances on controls
• Analysis and understanding of underlying recurrent position, including drivers of the deficit 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.	**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 and Protocol conditions.

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 is 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.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
13/06/23	Develop ICS and ICB medium term financial plan to determine likely future underlying position. Developed in draft.	G	30/09/2023
13/06/23	Identify mitigations to risk in plan to include unidentified efficiencies. Ensure new schemes deliver on a recurrent basis.	A	31/12/2023
20/02/24	The M10 Forecast Outturn underlying position is £(102.3)m deficit (M09 £(99.6m), which against the plan of £(57.3)m is a worsening position of £(45.0)m. Principle drivers are Non-Recurrent efficiencies, and operational pressures through CHC & IPP packages.	R	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	20	20	20	20	
Change	→	→	→	→	→	→	→	→	→	→	→	

BAF19

Risk Title	**Right Care NoW Programme**
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 previously named 'Discharge from inpatient settings. Renamed January 2024 to align with new programme title.

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	01/06/24

Risk Scores

Unmitigated			**Mitigated**			**Tolerated** (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**4**	**4**	**16**	**2**	**3**	**6**

Controls	**Assurances on controls**
• Daily review of all system discharge delays. • Escalation process for problems. • Local authority incentives in place to support care market. Supplementary P1 capacity/reablement commissioned by NCC. • NCC trialling Social Work support to Community wards to reduce long length of stay (LLOS). • Seasonal funding has set up 10 additional beds coming online to support discharge. • Unmet care need list is being monitored through NCC. • 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, implementation has been delayed, planned to commence Q4 16 March 2024. This has the potential to reduce length of inpatient stay and streamline system data. • 7-day discharge is embedded in the Central, East and West localities. • 7-day Discharge Hub has been set up in Central. Hub Managers participate in LLOS meetings at Acute sites. • Local authority funding agreed for Norfolk and Waveney.	**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, Trust Discharge Programmes e.g. HomeFirst, 3 x Acute System Operations, Resilience and Transformation Boards; NHSE oversight. Local Authorities.

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.
- 7-day working needs to embed fully across the whole Norfolk and Waveney footprint. This is improving but is still a risk.
- 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	31/10/24
22/06/23	System awarded capital investment for modular build at NCH&C, with a potential of 48 beds. Planned to mobilise in June 2024.	G	30/06/24
29/08/23	Roll-out of Optica system, this has the potential to reduce length of inpatient stay and streamline system data.	G	10/04/24
19/10/23	SCC are pulling together the local authority funding allocation plan on behalf of both areas.	B	31/01/24
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.	B	31/01/24
01/11/23	A paper has been received by ICB EMT, to explore future funding streams to support discharge.	G	31/01/24
28/02/24	Discussions ongoing awaiting final decision.		15/03/24

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	15	16	16	16	
Change	→	↓	→	→	→	↑	→	→	↑	→	→	

BAF21

Risk Title	**Mortality Action Plan NSFT**
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	Assurances on controls
• NSFT have formulated an Action Plan for both Grant Thornton and Seagry recommendations with senior NSFT SROs aligned to specific actions 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. Approved by board and both ICSs. • Trust has developed a Standard Operating Procedure (SOP) to manage data recording and validation with auditable trail. • Standardised automated reporting in place, approved through 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 Coroners to enable sharing of cause of death data.	**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. The Trust's Learning from Deaths quarterly Board report now includes thematic analysis of key metrics such as age, diagnosis, cause of death and deprivation indices. **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.

Updates on actions and progress												
Date opened	**Action / update**									**BRAG**	**Target completion**	
31/01/24	Mortality plan approved and update provided to N&S HOSCs January 2024									**B**	30/01/24	
28/04/24	Monthly meeting continues chaired by Gary Ohare to support work programme and progress on data validation									**G**	30/06/24	
Visual Risk Score Tracker – 2022/23												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score				20	20	20	16	16	16	16	16	
Change				New	→	→	↓	→	→	→	→	

<table>
<tr><th colspan="9">BAF22</th></tr>
<tr><td colspan="2">Risk Title</td><td colspan="7">Delegation of 59 Specialised Services to N&W ICB from NHS England on 1 April 2024</td></tr>
<tr><td colspan="2">Risk Description</td><td colspan="7">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 timing of the ICB re-structure and full recruitment to the structure, specifically the appointment of the commissioning team and the Director of Commissioning and Performance. It is likely there will be a gap of a number of months between delegation and the team being fully appointed.

Inadequate current capacity / bandwidth within the areas of Finance, BI, Quality, IG, Contracting, Complaints, Comms & Engagement, Workforce and Commissioning may lead to issues post-transfer. If so, then a new risk will be opened.</td></tr>
<tr><td colspan="2">Risk Owner</td><td colspan="2">Responsible Committee</td><td colspan="2">Operational Lead</td><td>Date Risk Identified</td><td colspan="2">Target Delivery Date</td></tr>
<tr><td colspan="2">Andrew Palmer</td><td colspan="2">Transformation Board</td><td colspan="2">Liz Joyce</td><td>3/10/23</td><td colspan="2">31/03/24</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</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>2</td><td>4</td><td>8</td><td>2</td><td>4</td><td>8</td></tr>
<tr><th colspan="5">Controls</th><th colspan="4">Assurances on controls</th></tr>
<tr><td colspan="5">
• Fortnightly N&W ICB internal Task & Finish group has been meeting and the NHSE lead for Spec Comm in N&W joined the group from January. The NHSE lead for Spec Comm in N&W is also part of the System Contracting Development Group
• The NHSE EoE Commissioning Team are the commissioning resource for the ICBs in regard to specialised services and we are now working with them more closely to manage the transition.
• Working with the other five ICBs and NHSE to complete the Safe Delegation Checklist, which has developed into five workstreams: Strategy & Planning, Governance & Clinical Leadership, Quality, Finance, Contracting & BI and Workforce & OD. N&W is represented on each and good progress made.
• The regional Finance Sub-Committee and Finance workstream have agreed the proposed risk-share model, and the quantum financial values for 2024/25, as described in the Collaboration Agreement.
• The Strategy & Planning Workstream has proposed a 2024/25 work programme with a framework of principles to inform future strategic planning and resource prioritisation across the six ICBs. NHSE and the six ICB's will develop a strategy over the next few months with partners. Maintaining the status quo in year one is a key part of this, as ICBs will not be in a position to undertake significant pathway transformation work in 2024/25.
• Caveats that must be met before N&W ICB could accept delegation were fully supported by the ICB Board (Sept 2023) and have been adequately achieved.
• BLMK ICB confirmed as the host for the eastern region.
</td><td colspan="4">
Internal: Monitoring reports to Quality & Safety Committee and Finance Committee.

Report went to Audit Committee on 18/01/2023 and no specific concerns raised.

Two (optional) drop-in sessions have been arranged by NHSE and the dates were shared with N&W ICB Board members.

External: Monitoring meetings:

• Specialised Services Joint Commissioning Committee (SSJCC) which reports to the NHS EoE Regional Executive Team.

• Five workstreams that are managing the completion of the Safe Delegation Checklist.

• A weekly Huddle with the other five ICB's that is supported by programme management from NHSE and chaired by BLMK ICB.

• Monthly delegation programme Board, chaired by the programme director.
</td></tr>
</table>

• NHSE staff are not TUPE transferring to BLMK ICB until 1 April 2025, so they have stability and a confirmed employer. Their interim line management will be via BLMK ICB and the ICBs • BLMK ICB recruited a Finance Director and Programme Manager to lead the multi-ICB workstream on behalf of all ICBs. There is currently a Managing Director post out to advert to lead the spec comm programme of work on behalf of the eastern region ICB's from April 2024, employed by BLMK ICB at an Executive level. • Integrated Performance Reports are being produced monthly and shared with the ICBs, but the information is high level. • ICBs have been involved in reviewing draft documentation as it is produced including the Collaboration Agreement and the Delegation Agreement, both of which are recommended for signature at the March ICB Board meeting. • Arden & GEM CSU manage the BI functionality and this contract will remain with NHSE. • Data Protection Impact Assessment (DPIA) prepared for signing. • NHSE and ICB contract negotiations will be undertaken in step for 2024/25 with providers so there is one conversation	

Gaps in controls or assurances

- NHSE are not wholly assured that the arrangements for working together as described in the Collaboration Agreement will be adequate. This is to be tested out during 2024/25 as we begin to work together. NHSE are writing to the six ICB Accountable Officers with a recommendation to review the Collaboration Agreement mid-year.
- There is as yet no established relationship between N&W ICB and the acute Specialised Commissioning Provider Collaborative.
- There should be a national change made to all the ICB's Data Access Request Service agreements to reflect the spec com data to be processed by the ICB. To date we have not seen any further information on this, other than reference being made that this change is being done for us by NHSE.
- The ICB's are not well sighted yet on the issues that are being brought forward by Clinical Networks, and expectations need to be managed through the Strategy & Planning workstream.
- Budget for HCDs and Devices is staying with NHSE for 2024/25. The drugs spend is volatile and activity and HCD are inextricably linked – the ICB 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, the ICB will 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 fully understood, and the ICB does not have identified commissioner leadership to review this with the NHSE Commissioning lead.
- No commissioning team leadership in post yet to resolve issues and promote a positive culture to develop Spec Comm services, within the ICB, with the NHSE team and other partners.
- The operational working relationship with hospitals in Cambridgeshire and London will need to be developed / improved. The NHSE Specialised Commissioning Team will need to invest resource in establishing good relationships with London and Oxford Hospitals as this is a significant flow from the Essex and Herts ICB's.
- 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.
- N&W ICB is not yet well sighted on local Performance issues (e.g. RTT or Quality) but we have had an initial discussion about N&W issues and opportunities at the internal ICB Task & Finish group meeting on

13/02/2024. NHSE has confirmed that waiting lists for specialised services are not separated out by Providers. There is no data available for out of region providers in terms of waiting list size.

- There is a risk that the reduction in communications and engagement resource at NWICB will impact on our capacity to effectively communicate and engage with the local population in pathway changes and this is relevant in the context of developing a spec comm regional strategy and work plan.
- There has been discussion with quality, BI, finance and contracting colleagues within Providers but at the operational level there are further relationships to be developed.
- Matrix working across teams in the revised ICB structure is not yet established or understood – clarity regarding leadership and responsibilities needs to be developed.
- There is a financial risk of 8 (2 x 4) on the programme level risk register that the timescale for moving to the target allocations is too long. This is determined nationally and is tied in with the 2024/25 operational planning guidance which has not yet been received.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
01/12/23	The six ICB's and NHSE are listing out what the leadership roles and responsibilities are (ICB's will lead on these) and what the day-to-day commissioning role is (NHSE will continue to lead on this via BLMK hosted function) so there is transparency. These are now set out in the Collaboration Agreement.	G	29/02/2024
01/12/23	Proposed finance principles to support 2024/25 planning and provisional baselines have been shared with all ICB's. Aims and Principles of the delegated decision-making framework have been shared with all ICB's with the main feedback being that an escalation framework will need to be developed rather than using a vote. Both documents were discussed at N&W ICB EMT 18/12/23 and Spec Comm delegation / transition was on the Audit Committee agenda on 18/01/24. The finance principles have been agreed and are set out in the Collaboration Agreement and in the covering ICB Board report dated 26 March 2024.	G	29/02/2024
01/12/23	The Safe Delegation Checklist meetings have been superseded by five workstreams: Quality, Governance and Clinical Leadership, Strategy & Planning, Finance, Contracting & BI and Workforce & OD. These will oversee the completion of the Safe Delegation Checklist, but the focus is on safe transition rather than completion of the checklist as a task in itself.	G	31/03/2024
01/12/23	The Governance workstream has led the development of a bespoke Collaboration Agreement. This has been shared with the six ICB's for feedback by 12/01/24 ready for the next stage of discussions. The Collaboration Agreement has now been agreed, subject to sign off by ICB Board on 26 March.	G	15/01/2024
01/12/23	NHSE Programme Manager has developed a project plan of key dates and written up the current governance framework. This work has now been concluded.	G	29/12/2023

Visual Risk Score Tracker – 2023/24

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

BAF023

Risk Title	**System failure to meet access standards for cancer diagnosis and treatment.**
Risk Description	There is a risk that patients will come to harm due to the failure to meet access standards for cancer diagnosis and treatment.

Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Dr Frankie Swords	Quality & Safety	Sheila Glenn	22/11/2023	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

Controls: The system Cancer Programme Board works in partnership with the regional cancer Screening and Imms team and North EOE Cancer Alliance, to optimise uptake/coverage of screening, and support system transformation projects to expand diagnostic and treatment capacity/transform how care is delivered to improve timeliness and efficiency.

Unified prioritisation and harm review process for patients on waiting lists to ensure that elective capacity is used to deliver care to patients in order of clinical priority
Quarterly presentation of key themes from cancer significant incidents at the Cancer Programme Board to share learning.
Local communication plan in place to educate patients on worrying symptoms and encourage earlier presentation.
Range of partnership transformation projects to support raising awareness of the signs and symptoms of cancer in health inclusion groups and areas of deprivation.
Non-specific symptoms (NSS) pathway in place via the system cancer Rapid Diagnostic Service.
New cancer clinical decision support tool (C the Signs) in place to improve quality and reduce variation in urgent suspected cancer referrals.
Additional transformation resource allocated to address backlogs in challenged pathways. Alliance FDS project focused on supporting rapid improvement of these pathways.
Trusts have revised cancer recovery plans, transformation resource diverted to support additional breast activity.
Mutual Aid being negotiated for radiotherapy from other Centres.

Assurances on controls

There are particular concerns re skin, gynae prostate and colorectal cancer pathways, and there is concern that recent industrial action has potentially exacerbated this. Additional cancer transformation resource has been allocated to address backlogs in these pathways. The Alliance FDS project is focused on supporting the rapid improvement of these pathways.

Assurance on controls:
Assurance on controls: Internal: Bi-monthly trust updates re transformation and operational delivery into the system Cancer Programme Board. Monthly updates on Cancer Tiering to the ERB with escalation of performance issues to the system Performance Committee. Escalation of issues/challenges is to the Transformation Board. Fortnightly regional/national support meetings for cancer Tier 1 trust (NNUH) also attended by the EOE North Cancer Alliance. This risk links to ERB risk (BAF 08) re clinical harm reviews/reprioritisation. Escalation of oncology medical staffing to People Board re provider cancer specialty workforce development plans and to influence/improve funding arrangements to support introduction of proposed new skill mixes into trusts.
External controls: Oversight via PHE, NHS E and the NHSE Cancer Alliance.

Insignificant medical staff in oncology across whole system to meet demand for subsequent adjuvant treatments.

Gaps in controls or assurances

Surges in demand in urgent suspected cancer referrals, workforce resilience/capacity and ongoing industrial action continue to impact on reduction of backlogs. Administrative capacity/processes to safely manage backlogs and waiting lists, exacerbated by industrial action. . Little spare capacity to support mutual aid and complex surgery is provided by the NNUH as Cancer Centre which impacts on QEH and JPUH.
Insignificant medical staff in oncology across whole system to meet demand for subsequent adjuvant treatments: Oncology medical staffing agreed as highest priority for system cancer workforce plan. System workforce steering group in place to baseline medical staffing across the 3 trusts with Alliance support. Ongoing skill mix redesign projects for the non-medical workforce (cancer nursing, therapeutic radiography and pharmacy).

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**
22/11/23	System workforce steering group leading work to baseline medical staffing across the 3 trusts with Alliance support. Ongoing skill mix redesign projects for the non-medical workforce. New breast oncologist has been appointed to NNUH due to start imminently. Regional escalation for support re Mutual aid, remote clinics, and recruitment/retention. Work with quality team to ensure trusts prioritise patients approaching the end of the adjuvant treatment window to prevent harm occurring/patient support in place. NSS pathway and cancer Rapid Diagnostic Service funded via fixed term funding, awaiting prioritisation process for future commissioning	**R**	March 2024

Visual Risk Score Tracker – 2023/24												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score								16	16	16	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	6	6	6	6	
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	6	6	6	6	
BAF13	Personal data	Ian Riley	01/07/2022	31/03/2023	6	12	9	9	9	9	6	6	6	6	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**	**3**	**6**	**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 enabled for all ICB staff. • 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

- 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	Completed –Digital led project delivered MFA to ICB so rolled out to all active staff on NHS Mail in ICB as of 05/01/24 ahead of the target date of 31/03/24 Only 7 enforced entablements via NCHC IT service where needed.	G	31/03/24

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	6	6	6	6	
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**	**2**	**3**	**6**	**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. • MFA rolled out to all staff in ICB. • 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

- 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	**A**	15/01/24

	their credentials. The target date has been moved given the sensitivities of the staff consultation.		
01/03/23	Completed –Digital led project delivered MFA to ICB so rolled out to all active staff on NHS Mail in ICB as of 05/01/24 ahead of the target date of 31/03/24 Only 7 enforced entablements via NCHC IT service were needed.	G	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	6	6	6	6	
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 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.	G	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.	G	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	6	6	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	12	12	12	12	
BAF15	Staff Burnout	Ema Ojiako	01/07/22	31/03/23	4	12	12	12	12	12	12	16	16	16	16	16	
BAF16	The resilience of general practice	Mark Burgis	01/07/22	31/03/23	12	16	16	16	16	16	16	16	16	16	16	16	
BAF17	Financial Wellbeing	Ema Ojiako	01/08/22	Ongoing	12	12	12	12	12	12	12	12	12	Closed in M09			
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	20	20	20	20	
BAF20	Industrial action	Ema Ojiako	14/11/22	31/03/23	6	16	16	12	12	12	12	16	16	16	16	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 system finance meetings and the WDG. These themes will reduce workforce risks on implementation.	**A**	31/3/23

	• 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 portfolios.		
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**	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	12	12	12	12	
Change	→	→	→	→	→	→	→	→	→	→	→	

<table>
<tr><th colspan="9">BAF15</th></tr>
<tr><td>Risk Title</td><td colspan="8">Staff burnout</td></tr>
<tr><td>Risk Description</td><td colspan="8">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.</td></tr>
<tr><td>Risk Owner</td><td colspan="2">Responsible Committee</td><td colspan="2">Operational Lead</td><td colspan="2">Date Risk Identified</td><td colspan="2">Target Delivery Date</td></tr>
<tr><td>Ema Ojiako</td><td colspan="2">People and Culture</td><td colspan="2">Jo Catlin</td><td colspan="2">01/07/2022</td><td colspan="2">31/03/23</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>4</td><td>16</td><td>1</td><td>4</td><td>4</td></tr>
<tr><th colspan="4">Controls</th><th colspan="5">Assurances on controls</th></tr>
<tr><td colspan="4">• 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 year's staff survey which was open in Sep/October. Outcomes from the survey will be released in the new year by NHS England.</td><td colspan="5">Internal: SMT, EMT, ICB Board, Staff Involvement Group, Wellbeing Guardian

External: ICS Boards, NHSE/I</td></tr>
</table>

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	16	16	16	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. • Commencement of LMC General Practice Alert System sitreps	**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. Organisational change is impacting on support available due to vacancy controls.
- Continued reports of poor patient behaviour across practices, decrease in patient satisfaction with general practice through GP patient survey, consistent with national position.
- Progress on interface action planning process across Trusts impacted by ongoing pressures and national strike action.
- Reporting process for inappropriate transfers of workload from community and secondary care providers to general practice not yet fully utilised by practices, leading to 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.
- Pressure on primary care budgets due to the ICB's financial position impacting on our ability to support resilience and transformation in general practice

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion

Jan 2024	• £750k further winter funding for general practice was released in January, along with a further investment of £750k in ARI (acute respiratory infection) hubs. This funding remains available for investment during quarter 4. • A significant number of practices have reported challenges with the annual health checks requirement for people with a learning disability and have requested additional support. Appropriate support has been agreed with respective practices. • The LMC has launched their General Practice Alert System, designed to monitor the resilience of general practice in a similar way to the Opel system. Anonymous sitreps are being provided to the primary care team. • Work remains underway to improve the issues caused at the interface between primary and secondary care. A new reporting form is proposed for implementation to automate the process and reduce administrative burden for all providers, LMC and the ICB. QEH has launched ICE requesting for pathology and radiology and a working group has been set up at the NNUH to seek to progress the project there, including colleagues from JPUH. A plan will be developed for 2024/25 and agreed through the interface group. The additional Interface task and finish groups continue and are reported against on a monthly basis in terms of progress. • The primary care and locality teams continue to work with individual practices at resilience risk to support them to stabilise.		31.03.24
February 2024	• Good progress has been made with the practice visiting programme and, the first practice visit to Magdalene in Norwich was successfully completed in January 2024. Plans are underway for the next visit, which will take place in West Norfolk and dates are currently being discussed. There were no resilience concerns identified or reported at Magdalene practice during the visit. The practice benefits from stable partnership arrangements, stable workforce, and experienced practice manager. • An additional £357k resilience funding has been made available to practices. As a result, practices have submitted request for extra clinics including but not limited to enhancing support for learning disability annual health checks and asthma clinics. • Despite the changes in contractual arrangements in Norwich recently, the ICB continues to work with the new medical service provider to ensure continuity of service provision for patients. A proposal to change the current network arrangements has been received from Norwich practices, the ICB is working closely with PCN leadership to understand the proposal and the risk associated with the changes. • In February 38 practices requested and received Transition Cover Funding totalling £305,089 spread across the practices. Transition Cover Funding is available to support practices in moving into delivering via the Modern General Practice Access Model and N&W ICB are encouraging all practices to access this support. • The other 67 practices have been individually contacted with information on how to access the funding and how much is available to them. Practices must request this funding by the 11th of March to allow for payment before the end of March. • N&W ICB had 8 practices sign up to the final cohort of the GP Intermediate Support Programme run nationally – bringing our total		31.3.24

	practices who have engaged in the current phase of the GP improvement programme to 23 to date. • LD HC support to practices to improve the uptake and the quality of the annual LD HC continues with specific support with complex cases. • The GP contract letter was published on 28 February which is detailed on the March agenda. The financial settlement will be challenging for practices and we may well see further resilience issues as a result.		

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	16	16	16	16	
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**	**4**	**3**	**12**

Controls	**Assurances on 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 • Dental Data Review being updated to inform commissioning plans. • Primary care workforce and training team working closely with delegated commissioning team to ensure workforce retention programmes and training support is linked to the Dental Delivery Plans.	**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
Feb 2024	A small number of practices have been identified as being at higher risk of instability due to historical decisions about commissioning. Potential support is being discussed with them. A risk register relating to dental matters is being developed for Dental Services Delivery Group. A four-week engagement about the ICB's proposed Dental Long Term Plan proposals for next 2 years and beyond with members of the public and key stakeholders across Norfolk and Waveney, including the dental profession, was launched on 24 February 2024. Feedback will help inform ICB's plans due to be published Spring 2024.		31/03/2024
March 2024	ICB Engagement survey closed 21 February 2024 with over 2000 responses to be analysed for the Long-Term Dental Plan to be finalised for approval. NHS England Dental Recovery Plan 2024/2025 published 7 February 2024 (Faster, simpler and fairer: our plan to recover and reform NHS dentistry - GOV.UK (www.gov.uk)) and the ICB is working to mobilise the individual elements of the Plan as details are released and adapt ICB plans accordingly: • New patient premium to encourage dentists to see individuals who've not seen a dentist for more than two years, effective from 1 March 2024 • UDA uplift to £28 minimum. This is superseded by the ICB's agreed plan to uplift to £30 minimum UDA rate from 1 April 2024 • Mobilisation of a mobile dental van to improve access and oral health prevention schemes. • Golden Hello to retain dentists working in NHS services for 3 years. This is addition to the ICB initiative. 14 dentists have benefited from the ICB's workforce schemes to date. An early review of the Urgent Treatment Services pilot is underway to see if any learning can be applied to improve services going forward. The total patient appointments offered since November 2023 is 5339, and only 8 Did Not Attends. The average number of appointments offered per month to date is 1779.		30/04/2024

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	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 with 'hot debriefs' in place following each	**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

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 (i.e. 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	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	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
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	16	16	16	16	
Change	↑	→	↓	→	→	→	↑	→	→	→	→	

Agenda item: 14

Norfolk and Waveney
Integrated Care Board

Subject:	**Quality and Safety Committee Report**
Presented by:	**Aliona Derrett, Quality and Safety Committee Chair** **Tricia D'Orsi, Executive Director of Nursing**
Prepared by:	**Evelyn Kelly, Quality Governance & Delivery Manager**
Submitted to:	**Integrated Care Board Meeting**
Date:	**26 March 2024**

Purpose of Paper

To provide the Board with an update on the work of the Quality and Safety Committee for the period of 23 January 2024 to 26 March 2024.

Committee:	**Quality and Safety**
Committee Chair:	Aliona Derrett
Meetings since the previous update:	**01 February 2024,14:00 – 17:00** **07 March 2024,14:00 – 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:	**01 February 2024: regular meeting of the Committee covering all standing items plus the following focus areas:** • Ambulance Response Times • NHS Continuing Healthcare Update • Local Maternity & Neonatal System Update • Community Services Review • CYP Eating Disorder Provision • Norfolk & Waveney Bereavement Support Services • Infection Prevention & Control Update • Mental Health Transformation & Crisis Response Provision **07 March 2024: regular meeting of the Committee covering all standing items plus the following focus areas:** • CYP System Collaborative • Martha's Law and Fuller Report • Right Care NoW Programme and Voluntary Norfolk • Learning from Adverse Events and Complaints • Health Inequalities Framework for Action • Joint Public Health Norfolk and Suffolk Annual Update • Eye Care Transformation Update
BAF and any significant risks relevant / aligned to this Committee:	**Quality and Safety Committee BAF risks:** BAF03: Providers in CQC 'Inadequate' Special Measures 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) BAF23: Failure to Meet Cancer Access Standards **Quality and Safety Committee Significant Risks:** SR04: Surge Capacity to Support Local Acute Trusts SR05: Workforce Absence and Moral Injury SR06: Public Trust and Reputational Damage SR07: BCG Immunisation 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 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 SR51: Delegation of Specialised Commissioning Oversight SR52: Industrial Action Clinical Impact **NEW:** SR54: CYP Responsible and Approved Clinicians in NSFT **NEW:** TBC CYP Staff Competences in NSFT **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 NQ45 BPAS CQC Improvement Plan NQ46 Learning from Patient Safety Events System Go-Live LMNS05 Smoking in Pregnancy QICSGA29 Deprivation of Liberty Safeguards Backlog NQ47 Pharmacy Workforce **Committee <u>de-escalated</u> and closed the following risks:** SR03: EEAST Special Measures & Workforce Resilience SR45:12hr Decision to Admit Breaches: NOF 4 Exit Criteria CYP MH Delay to the Development of Castle Green LMNS04 Maternity & Neonatal Workforce
Key items for assurance/noting:	**<u>01 February 2024</u>** **Ambulance Response Times** Committee received an overview of learning from adverse incidents related to delayed ambulance conveyance and/or handover into hospital. Members responded to a theme around ReSPECT end of life planning and its significance when looking at patient and family experiences of emergency care. Opportunities were identified to link into system workstreams including Palliative Care Board. Work around interfacility transfers between hospitals both locally and regionally has progressed well, and Members also reflected on the improvement in time taken to reach suspected stroke calls since the implementation of C2 segmentation and the zero-tolerance approach to handover delays. Committee acknowledged the improvements in ambulance response times whilst also noting an associated increase in capacity pressures within the hospitals. **Quality in Care and NHS Continuing Care Update** Committee received an overview providing assurance on the quality oversight of care provision (residential and domiciliary); how the ICB works with the local authorities to ensure issues are identified early, to support the providers and to mitigate any risk to service.

	Committee were updated on the risk around local authority capacity to assess and authorise care plans for individuals residing in hospitals, care, nursing, or residential homes, that involve a deprivation of liberty under the Deprivation of Liberty Safeguards (DoLS). These delays are primarily due to the rising number of referrals and challenges related to staff capacity. The Regional Mental Capacity Act network recognises the delays in assessments and is developing a brief to share with Providers, recommending that professionals continue to make DoLS applications as required, to continue to follow the five principles of the Mental Capacity Act and to continue to review care arrangements regularly, ensuring the person's voice is at the center of their care, and all actions are in their best interests. Committee received an update on the Norfolk and Waveney self-assessment for its provision of NHS Continuing Healthcare (CHC), which has been rated as 'good'. Further work is to be undertaken to ensure there are underpinning Standard Operating Procedures, both procedural and for self-audit. Required evidence is now in place and actions required by NHS England are complete. **Local Maternity & Neonatal System (LMNS) Update** Committee received an update on LMNS safety and quality oversight of maternity and neonatal services and details of LMNS Maternity Transformation Programme. Committee were asked to note the work undertaken by the LMNS to support delivery of the Three-Year Delivery Plan for Maternity and Neonatal Services and to note the Quality & Safety Oversight undertaken by the LMNS Programme Team on behalf of the ICB. Smoking in pregnancy was noted as a significant clinical risk across the system and a smoking in pregnancy project is due to launch shortly. Members noted that the LMNS has recently completed a neonatal mortality morbidity review and smoking is reported as the overarching theme for stillbirths, neonatal deaths, and pre-term births. Vaping was discussed and while the current advice is that if you do not smoke, you should not start vaping, it is seen as a reasonable option to support smoking cessation in pregnancy and work is taking place with Public Health on the 'Swap to Stop' scheme. **Community Services Review** Committee received a briefing on the 2023 Tricordant Community Services Review which was commissioned to identify the optimal model needed to meet current and future need across Norfolk and Waveney. The result has been the creation of a framework to guide future planning, commissioning, and the delivery infrastructure of community health services in Norfolk and Waveney, built around four strategic impacts: 1) Proactive and personalised support from integrated teams. 2) Delivering more specialist care in the community. 3) Enabling health communities. 4) Meeting local urgent and emergency care needs. Through these impacts, community health services can make an important operational and strategic contribution to delivery of the Joint Forward Plan and system outcomes.

CYP Eating Disorder Provision
Committee received an overview of service improvements and pathway developments, overview of demand and waiting times, service user experience, and priorities and developments for the next financial year. The Norfolk and Waveney Children and Adolescent Eating Disorder Service offers evidence-based interventions in line with NICE recommendations. National and contractual standards are being met and service user feedback is positive. The expansion and development of service has increased access, improved patient outcomes, and delivered a wider range of services and support. Mental Health Practitioners have been embedded successfully in the Acute Hospital Children's Wards so that more acutely unwell patients can receive support whilst they receive medical stabilisation. GP attendees noted the positive impact of the introduction of a First Episode Rapid Early Intervention for Eating Disorders (FREED) pathway which focuses on early support.

Norfolk & Waveney Bereavement Support Services
At the meeting of Committee held in October 2023 a concern was raised regarding bereavement follow up available for families in Norfolk & Waveney, and the clarity of signposting and referral mechanism for NHS staff. A report was presented highlighting local bereavement services and Committee noted the breadth and diversity of the offer and the contribution that is being made by our VCSE sector in this space outside of statutory provision. Committee recommended that further work needs to take place to link up referral routes and understand how people can access and hear about these services, potentially via the Medical Examiner Offices.

Infection Prevention & Control Update
Committee received an update from the ICS Infection Prevention & Control and Antimicrobial Stewardship Partnership, which provides a forum for joined up collaborative working across the system. The following key issues were raised for escalation:

- Overall antibiotic prescribing remains above target in primary care but well below national averages in secondary care. Targeted work is ongoing by the ICB Medicines Optimisation Team to support Practices and PCNs with outlying prescribing rates.

- The latest C. difficile infection (CDI) data from December 2023 shows a positive improvement. Following the successful System CDI Workshop, the first joint site visits have taken place to a Practice that has the highest antibiotic prescribing data in combination with the highest CDI case rate.

- Gram Negative Blood Stream Infection (GNBSI) rates are above the East of England average. Workstreams are in place to address this.

- There continues to be an inequity of TB nurse provision across the ICS and options for increased resilience are being explored by Community providers.

The ICS Glove Reduction Programme has started to see a significant reduction in unnecessary non-sterile glove use, which has the potential to improve patient experience, reduce infections, reduce cost, and reduce environmental impact. The ICB has been asked to present this work to a national sustainability conference. The system Catheter Reduction Project is also progressing well with all Providers undertaking audits and some good examples of successful removal of inappropriate catheters.

Mental Health Transformation & Crisis Response Provision
Committee received an overview of the Mental Health Wellbeing and Crisis Hubs, designed to provide the Norfolk and Waveney population with an easily accessible, local, and safe space for mental health and crisis support, in the community. They are a key development in the transformation of community mental health services, however, Committee noted that the current usage of the Wellbeing Hubs is below expectation at around 26% of their available capacity. Members reflected on the challenges, including referral processes, service user acuity and Crisis Resolution and Home Treatment staffing capacity. It was recommended that the Quality & Safety Committee escalates the concerns and issues within the paper to the ICB/NSFT Service Performance Review Group (SPRG) due to the significant interdependencies between NSFT community services and that of the Wellbeing and Crisis Hubs. This will support the further development of the patient pathways.

07 March 2024

CYP System Collaborative
The CYP System Collaborative aim is to deepen and accelerate the partnership working in the children's space with the Strategic Alliance Board, FLOURISH ambitions and all the major partnerships across the health system and County Council working as a whole and across organisational boundaries to try to drive integrated working, integrated service models in the interests of children. Committee received an update on collaborative workstreams around early intervention and prevention, 'place' and community support, holistic needs assessment and community-led early help. Recent developments include a fully integrated 'front door' into children's services, a shared practice model and mental health support in schools. Well-established relationships across teams and a shared outcomes framework are driving collaborative work at pace, with real impact. Case studies and feedback from families are available which demonstrates that working together is making a significant difference.

Martha's Law and Fuller Report
Committee was briefed on the phased roll-out of the national Martha's Rule law, which gives all patients and families the legal right to seek a second opinion independent of the team treating the patient, by a team or clinician within the same hospital. The first phase during 2024/25 will focus on supporting participating provider sites to devise and agree a standardised approach, ahead of scale up to the remaining sites in England in the following years. Elements of Martha's Rule principles have already been adopted in Norfolk and

	Waveney by NNUH, QEHKL and NSFT. The ICB Executive Director of Nursing recommended to Committee that this is a piece of work for the Chief Nurses and Medical Directors to take forward consistently with the support of the communication strategy through the People and Communities Committee. Committee were also briefed on learning from the Fuller Report into primary care integration, with a focus around three essential offers; streamlining access to care and advice for people who get ill but only use health services infrequently, providing more choice about how they access care. Helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention. 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. **Right Care NoW Programme and Voluntary Norfolk** Committee received an update on the programme of work to streamline discharge processes, reducing the length of time people stay in hospital, decrease need for readmission and improve overall experience. Norfolk & Waveney Community Support Service (NWCSS) joined the session to provide a presentation on their community offer; bringing together the skills and experience of Voluntary Norfolk, Age UK, and the British Red Cross to avoid admissions and support discharged patients to return to the community safely. The service launched in September 2023 with initial referrals from the hospitals and adult social care, expanding to primary care and community referrals. The service offers short-term practical support, delivered by a combined team of staff and volunteers through a single point of referral and triage. The overarching aim is to link people into community groups and support networks. Members requested an update on discharge delay issues due to transport and heard that there is currently much better flow through the system, with better integration of the hospitals being able to have conversations directly with the transport providers. Delays in the dispensing of medication due to staffing resource issues in hospital pharmacies was discussed. Committee will continue to request regular updates on quality of care and patient wellbeing. **Learning from Adverse Events and Complaints** Committee heard that implementation of the national Patient Safety Incident Response Framework across the providers is progressing well, weekly touch point meetings are taking place and embedding well. Oversight of all adverse incidents is much approved with daily triage now taking place of all incidents within every provider, with strengthened reporting and governance processes. Committee noted a Never Event reported by NNUH in October 2023 and were given assurance around lessons learned. Members also received a briefing on learning from an inpatient fall at JPUH which highlighted patient management of NEWS2 score and deterioration. QEHKL have reported a small number of treatment delays in Gynaecology which are being investigated and followed up. IC24 reported an emerging theme around calls from people that are experiencing suicidal intent.

	Detailed work is taking place and will come back to Committee for oversight. Primary Care providers continue to report and investigate serious incidents according to the Serious Incident Framework 2015 with the support of the ICB's Nursing and Quality Team. Although PSIRF is not yet mandatory for this sector, there are system workshops planned to discuss the framework. The Nursing and Quality Team has also worked closely with an independent provider to support investigation and learning from a small number of post-surgical infections, with good engagement and positive findings from an Infection Prevention & Control visit which offered reassurance. **Health Inequalities Framework for Action** Committee was updated on the development of the Norfolk and Waveney ICS Health Inequality Strategic Framework for Action and the results of the systemwide stakeholder engagement exercise. The framework has a broad scope which includes action around the wider determinants of health and wellbeing and provides partners with a framework for action as opposed to another strategy, which commits to further engagement with a wide range of stakeholders, including our communities through community voices, health inequality conversations and focus groups with those of lived experience. The Committee Chair noted that feedback is still being invited on the framework until 15 March 2024, with final version to be published 1st April 2024. Members noted the progress that has been made to date. **Joint Public Health Norfolk and Suffolk Annual Update** A presentation was shared with Members from the Director of Public Health for Norfolk, covering key elements of the Public Health Strategic Plan which focuses on improving and safeguarding the health and well-being of the local population. This involves a wide range of activities and responsibilities aimed at promoting health, preventing disease, and addressing health inequalities. Public Health will continue to engage with system wide partners to promote the key messages in the strategic plan and collaborate on shared priorities to improve population health and wellbeing outcomes, including building the data and evidence base, implementing prevention interventions, and providing insight and training on how to influence and promote behaviour change. The ICB Executive Director of Nursing requested feedback on the interface between the local Public Health team and the UK Health Security Agency, particularly around outbreak management. It was noted that an MOU is currently being drafted to clarify roles and responsibilities. **Eye Care Transformation Update** Committee received a high-level progress report of implementation of the ICS Eye Care Transformation Plan 2023/24. As part of the Transformation Plan, the Eye Care Programme Team have developed the service specifications for a range of clinical services for use in a direct award process in line with the new Provider Selection Regime. Each specification has been carefully written to require providers to deliver a robust service offer for patients and pathways apply to all potential providers, whether Hospital Eye Services (HES) or Independent Sector Providers (ISP). Services include several areas

	that have experienced access challenges, including Glaucoma and Medical retina. The Eye Care Transformation Plan will close at the end of March 2024 with work than transferred onto the Commissioning and Contracts teams. The Committee Chair was encouraged to hear about the engagement exercise undertaken and how that may have influenced the service specifications. Positive responses have been received from groups such as the RNIB and Vision Norfolk. The Nursing & Quality Team will continue to oversee the quality element for Optometry and Ophthalmology and in particular these independent service providers, with introductory quality visits taking place.
Items for escalation to Board:	No additional escalations were requested. See risks and issues noted above.
Items requiring approval:	Committee approved the following report: • Norfolk and Suffolk Child Death Overview Panel Annual Report
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 February and March 2024 meetings were quorate, as defined above.

Key Risks	
Clinical and Quality:	This report highlights clinical quality and patient safety risks and mitigating actions.
Finance and Performance:	Finance and performance are intrinsically linked to quality, in relation to safe, effective, and sustainable commissioned services.
Impact Assessment (environmental and equalities):	N/A
Reputation:	See above.
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	The report supports the clinical quality and patient safety elements of the NHS Constitution.
Conflicts of Interest:	Committee member's interests are documented and managed according to ICB policy.

Norfolk and Waveney
Integrated Care Board

Agenda item: 15

Subject:	**Finance Committee Report**
Presented by:	**Hein van den Wildenberg, Non-executive Member, Finance Committee Chair**
Prepared by:	**Emma Kriehn-Morris, Director of Commissioning Finance**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**26 March 2024**

Purpose of paper:

To provide the Board with an update on the work of the Finance Committee up to including the 5th March 2024

Committee:	Finance Committee
Committee Chair:	Hein van den Wildenberg
Meetings since the previous update	Last update provided: 23.01.2024 Subsequent Meetings: 30.01.2024 & 05.03.2024
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 respectively.
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 January (Month 10) is a £18.6m deficit, which is £10.8m adverse against the plan. This is driven by the impacts of unfunded Industrial Action, Independent Sector activity costs, operational pressures and delays in Efficiency identification and/or delivery.

	The reported system forecast outturn for the year is a £ 5.7m deficit. However, the committee heard that a financial balance for the year was likely to be reported for next month, in part due to some funding received to address the impact of industrial action, and some upside for the Elective Recovery Fund. The ICB entity has reported a January year to date (Month 10) break-even position and forecasts a full year break even position 2. The Year-to-Date system CDEL (Capital) expenditure as at January (Month 10) was £57.3m, £14.5m behind plan, due to slippage/delays in project roll-out and RAAC schemes. For the financial year, the system is forecasting to underspend the financial plan by £ 3.4m. Work is underway to address this, as underspent monies cannot be retained by the system. 3. Due to the risk and pressures on N&W forecast outturn, the N&W ICS (NHS entities only) system continues to act under the self-imposed 'double lock' process for agreeing unplanned investment proposals that will negatively impact upon the system's forecast outturn. The 'double lock' means that for those expenditures, the relevant NHS organisation cannot make such decision by itself, but requires system level review and scrutiny. 4. Whilst the system will likely be in actual financial balance, the *underlying* deficit for the system will be some £ 200m. The ICB's part of that underlying deficit is some £ 100m. **<u>Emerging Plan 2024/25 (NHS entities in ICS)</u>** The committee took note of the status of the emerging plan for 2024/25. The above-mentioned *underlying* deficit of some £ 200m provides a challenging starting point. Unlike previous years, there is very little balance sheet flexibility to help turn the underlying deficit to a planned financial balance for the system. At the time of the last committee meeting, this emerging plan for 2024/25 showed a system deficit of over £100 m, with further work being undertaken by all system partners to reduce this a balanced position. The Board should be aware of significant risk profile to the mitigations that are needed.

	Arriving at a sustainable level of spending for the system will require close scrutiny what services are provided in what manner. **Spotlights** Several Spotlight topics were presented and discussed at the ICS Committee: - **Norfolk Community Health and Care (NCHC):** The CFO of NCHC provided the committee a deeper understanding of the drivers of NCHC's finances, and the emerging NCHC plan for 2024/25. In addition, committee heard on work done to successfully manage down the use of bank and agency staff, benchmarking analysis with other community trusts, and progress on the new 48-bed Willow unit in Norwich. - **EEAST (Ambulance Serice for East of England)**: EEAST's CFO provided the committee an overview of EEAST's operations, and how these drove their finances Whilst EEAST is best known for its 999 and Emergency services, other services are provided. The CFO drew attention on the marked improvement in ambulance handover, resulting from risk transfer to the acutes in Norfolk & Waveney. - **Norfolk County Council (NCC):** The NCC cabinet member for Finance, the section 151 officer (equivalent to CFO), Norfolk's director of Adult Social Care and Head of Finance provided an extended overview of NCC's finances. The pressures facing NCC were discussed and their impact on arriving at a balanced budget for 2024/25 as well as the medium-term challenges. The committee heard on how a Devolution deal may impact the longer term funding picture. The engagement was a strong reminder a) how intertwined local authorities, such as NCC, and NHS are in Norfolk & Waveney, and b) how similar many of the pressure points and financial challenges are. - **ICB**: The committee engaged on: o Mental Health Investment Standard (**MHIS**). The committee heard that the MHIS audit for 22/23 had concluded and signed off by the auditors with a good recommendations. The committee commended the team on achieving this important outcome. For the current year the committee heard

	representations made that the system was on plan meeting the standard for 23/24.
Items for escalation to Board:	1. For the current 23/24 financial year, the system will likely report a financial balance, as will the ICB unit. 2. As reported to the last Board meeting, the *underlying* deficit for NHS entities in the system for 23/24 is some £ 200m (ICB's share some £100 m). 3. The underlying deficit informs a particularly challenging backdrop for the emerging 24/25 plan. To meet expectations of producing a balanced plan, will require scrutiny by all system partners of what services are provided how. 4. Board is asked to note the spotlight sessions held, that provide valuable deeper understanding of system partners, seen through a financial lens.
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.

Norfolk and Waveney
Integrated Care Board

Agenda item: 16

Subject:	**Primary Care Commissioning Committee Report**
Presented by:	**Debbie Bartlett, Local Authority Member and Chair of PCCC**
Prepared by:	**Sadie Parker, Director of Primary Care**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**26 March 2024**

Purpose of paper:

To provide the Board with an update on the work of the Primary Care Commissioning Committee for the February and March committee meetings.

Committee:	Primary Care Commissioning Committee
Committee Chair:	Debbie Bartlett, Local Authority Member
Meetings since the previous update on 23 January 2024:	13 February 2024 12 March 2024 (There was no meeting in January 2024)
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	**BAF16 – the resilience of general practice** **Current mitigated score – 4x4=16**

relevant / aligned to this Committee:	There is a risk to the resilience of general practice due to several factors including 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:	**13 February 2024** • A progress update on the primary care ambition in the Joint Forward Plan was noted. Good progress was being made against the dental commitments and developing integrated neighbourhood working. The general practice work to develop our strategic approach had slipped due to capacity within the team necessitating the prioritisation of immediate resilience issues. • Reports from the dental and general practice delivery groups were noted. 98% of GP practices had met the contractual requirement to submit their e-declaration self-assessment. The remaining practices were being supported with resilience issues. There had been some national data discrepancy

	issues for learning disability health checks which had inflated the register size. This was expected to resolve before the end of the year. 91% of checks included a health action plan which was an improvement over last year. Alternative provision had been made available to support the uptake of checks. A number of dental contractual changes were approved to seek to maintain resilience in the practices affected and ensure stability of services for patients. • The finance report was noted, including the challenging position within the primary care budget. **12 March 2024** • A progress update was given against the implementation of the strategic workforce plan, with nearly all areas meeting or exceeding targets. In addition, Norfolk and Waveney was one of the best performing ICBs for GP retention. • The GP contract letter for 2024-25 was noted and the committee recognised the substantial financial challenges to the resilience of general practice with the uplift being provided. • The reports from the General Practice and Dental Delivery Groups were noted. 11 of 13 of the actions agreed to address the internal audit by TIAA had been completed. National changes to the Severe Mental Illness register to remove those people on lithium without a diagnosis were discussed. Further work would be undertaken to understand the risk. Two GP premises developments were approved to move to the next stage. A number of dental contractual changes were approved to seek to maintain resilience in the practices affected and ensure stability of services for patients. The draft areas of the long-term dental plan and an update on the patient engagement exercise were received. • The prescribing and finance reports were noted, and the challenging position within the primary care budget.
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 May. The resilience of dental services, summarised in BAF18 is of grave concern, with the short-term plan in implementation. The financial claw back of underperformance process has the potential to place struggling contractors at further resilience risk. The impact of ongoing vacancies on capacity in the locality and primary care teams due to the organisational change process is leading to delays in key areas of strategic work and necessitating a focus on short term resilience issues.
Items requiring approval:	**13 February 2024** • The two BAF risks set out above were reviewed and approved. • The committee received an application from Holt Medical Practice to close its branch surgery in Blakeney. Approval was given to defer the decision to enable further public involvement to be undertaken. A decision would be taken at a committee on 7 May 2024. • The committee approved a new branch surgery advice note (to support the provisions in the NHS England Policy Guidance Manual) where practices are seeking to change service provision in branch surgeries. **12 March 2024** • The two BAF risks set out above were reviewed and approved. Suggested changes following a recent advisory audit were noted. • Members approved a Dental Clawback Policy, which had received positive comments from the Local Dental Committee. The Policy aimed to support the resilience of dental services in considering how to claw back underperformance. • Revised terms of reference for the committee and the two delivery groups were presented. Subject to further minor amendments to wording on quality and involving the Public Health teams, approval was given.
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:

	13 February 2024 Debbie Bartlett, ICB Board local authority partner member and chair of the committee James Grainger (deputising for Steven Course, executive director of finance, ICB) Karen Watts, director of nursing and quality (deputising for Patricia D'Orsi, executive director of nursing) Hein van den Wildenberg, ICB Board non-executive member **12 March 2024** Debbie Bartlett, ICB Board local authority partner member and chair of the committee Steven Course, executive director of finance, ICB Patricia D'Orsi, executive director of nursing, ICB Hein van den Wildenberg, ICB Board non-executive member

Key Risks	
Clinical and Quality:	Care Quality Commission inspection reports are regularly reviewed. Quality responsibilities being clarified in the revised Terms of Reference.
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):	All papers considered include consideration of the ICB's duty to reduce health inequalities.
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: 17

Subject:	**Performance Committee Report**
Presented by:	**Dr Hilary Byrne**
Prepared by:	**Tessa Litherland**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**26 March 2024**

Purpose of paper:

To provide the Board with an update on the work of the Performance Committee for the period 23 January 2024 to 26 March 2024.

Committee:	Performance Committee
Committee Chair:	Dr Hilary Byrne. Deputy Chair – Andrew Palmer
Meetings since the previous update on 28 November 2023:	• 14 March 2024
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:	• Confirmed that the March meeting was the last Performance Committee in its current format. The performance of the system will in future come under the remit of the new Commissioning and Performance Committee, with the first meeting being held in May 2024. • Confirmation that the Norfolk and Waveney System has transitioned from level 4 to level 3 of the National Oversight Framework (NOF) and has therefore exited from the Recovery Support Programme. • Regular updates were received from: o Mental Health (MH) – Seeing an upturn in the number of 12hr breaches in A&E during the last few weeks, due to system pressures and availability of Out of Area placement beds. Norfolk Police has confirmed the pause of the launch of the Right Care Right Person initiative. o Children and Young People – Work ongoing to support awareness and delivery of recommendations of The Inbetweeners Review, which highlights the barriers and facilitators in the process of transition of children and young people with complex chronic health conditions into adult health services. o Elective, Cancer and Diagnostics – Elective waiting times continue to be an issue, with efforts to reduce the long waits across all providers, including offering patients alternative providers with shorter waits. Cancer 62 day backlog continues to reduce, with the Faster Diagnostic Standard improving towards the 77% target.

	Oncology medical staffing paper was presented to update the committee. Current mitigations are underway across the three trusts, and the issue has been logged on the Board Assurance Framework (via the Quality and Safety Committee. Diagnostic CT and MRI performance continues to cause concern. ○ Learning Disability and Autism – Improvement from 19 to 15 Transforming Care Patients, with commissioner oversight visits up to date. Contracts have been awarded from funding secured to reduce waiting lists for autism diagnosis; so will begin to see reductions in numbers and length of wait shortly. ○ Urgent and Emergency Care – whilst activity pressures remain intense, there have been improvements in A&E performance against the 4 hours wait standard. Revised governance framework and the UEC programme resource pressures were highlighted, with a paper going to the system executive team for approval. • Deep Dive area: ○ Community Wheelchair Service - The service has seen an increase in demand as well as complexity of patients needs. New ways of working and criteria for access is being explored, to be able to manage the demand and expectations. Additional resources are needed to tackle the waiting times and well as being innovative to staff recruitment issues.
Items for escalation to Board:	Items to note: • Acknowledgement of effort and commitment from staff across the system to exit the Recovery Support Programme. • Oncology medical staffing risk added to Board Assurance Framework (to be managed through the Quality and Safety Committee).
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: 18

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:	**26 March 2024**

Purpose of paper:

To provide the Board with an update on the work of the Patients and Communities Committee for the period to 22 January 2024

Committee:	Patients and Communities Committee
Committee Chair:	Aliona Derrett, Non-Executive Director
Meetings since the previous update on 30 May 2023	Monday 22 January 2024 Monday 22 March 2024 **the update from this meeting will be included in May'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:	**Spotlight on Planned Care and Cancer Activity Update:** Committee received an update on the work of the four sub teams within the Planned Care and Cancer Team – Cancer, Elective Access, Long Term Condition National Programmes and System Clinical Programmes. Committee noted the improvements against cancer targets and further noted the reasons why targets are not being met, which include increasing demand, and workforce and the reliance on a relatively small number of people to do the work. In relation to clinical programmes and links to primary care, committee heard that although good links have been established with local commissioning and primary care colleagues, Place could be better interlinked with programme boards, however Place doesn't currently have the capacity to do this. Committee heard how Core20 was being linked into clinical programmes via a programme board for each of the five areas highlighted nationally as most likely to underscore health inequalities. Committee sought reassurance the Knowledge NoW website (replacing Knowledge Anglia) would be much easier to navigate and update, and it would be tested thoroughly with patients. **Spotlight on Community Mental Health Transformation:** Committee received an overview of mental health pathways including the Norfolk and Waveney Mental Health Strategy and the six commitments. In terms of the equity of access approach, Committee noted the potential confusion for people trying to navigate pathways and entry points to services. There is much more work to do around developing a directory of services and people understanding how it works. Committee discussed health inequalities and the needs of individual populations, and how the strategy aims to be as bespoke as possible to support these, through working with experts by experience and community listeners.

	Committee also noted this is the last year of the community transformation work; much work has been achieved including the establishment of the primary care mental health teams. One of the last elements of the transformation work is around advice and guidance and keeping more people within primary care services. **Transformation Board Update:** In relation to the Joint Forward Plan (JFP) the Committee noted the excellent progress in several of the ambitions (Population Health Management, Prevention, Health Inequalities, and Children and Young People). However, progress has been more challenging in relation Primary Care, Urgent and Emergency Care and Elective Recovery due to the impact of industrial action, issues linked to workforce, and demand and capacity. The committee supported the proposed approach to the 2024/25 JFP refresh. Committee noted a new Commissioning and Performance Committee will replace the Transformation Board during spring 2024. Therefore, this was likely to be the last update from the Transformation Board in its current form. In relation to the Community Services Review the Committee sought reassurance that the new Commissioning and Performance Committee will focus on the impact of the new community services, to ensure they are making a difference to the Norfolk and Waveney Population. **ICS Mental Health Coproduction Strategy:** Committee received an update on the work being undertaken to develop and publish an all-age mental health coproduction strategy. Rethink Mental Illness were commissioned by the ICB to facilitate this work which had commenced in April 2023. The final strategy and toolkit will be published in April 2024. **Ageing Well Programme Board Update – Strategic Framework** Committee received and approved the Ageing Well Strategic Framework which is a key objective of the JFPs fifth ambition – Transforming Care in Later Life. Committee acknowledged the significant engagement, codesign and evidence that had been undertaken to develop the strategy. Committee discussed the importance of Public Health support in identifying older well people who can access the prevention phase. Older people are an asset to our system and Public Health is very excited to be supporting the framework. Committee also discuss governance and oversight arrangements to ensure the strategy is delivered. **Links Between Quality and Commissioning** Committee were informed about how the local commissioning and quality teams work together. Committee noted the local commission team is one of several commissioning teams across

	different specialties in the ICB, which can make it difficult to know where commissioning sits. However, in the new ICB structure there will be a central commissioning team which will address this issue. **Monitoring Mortality Rates Across the System and the Norfolk and Waveney Learning from Death (LFD) Forum:** Committee received insight into the monitoring of mortality rates across the system and the Norfolk and Waveney Death Forum, including how deaths are scrutinized and registered, and the systems duty to learn from the deaths of our patients. Committee noted the roll out of the Medical Examiner Service to include all deaths in the community in preparation for this becoming a statutory requirement. This will mean every single death occurring across our community (e.g. a community trust, a hospice, a mental health trust, an acute, or at home or elsewhere) will all have gone through either a medical examiner or the coroner from April 2024. Committee were advised the Medical Examiner Service is just for adults as there is already a robust process in place for children, however the children's process does go to the Learning from Deaths forum. **Healthwatch Suffolk Update:** Committee noted the update including: • The positive change in access for people into GP practices, with surgeries seeing an increase in patients 'though the door'. • The reintroduction of Phlebotomy into surgeries in Waveney (previously delivered by ECCH) and the continuing good feedback about this. • Support from Norfolk and Waveney ICB to resolve a situation whereby a service user had been provided with an inappropriately sized wheelchair. • The trial of 'AI robot' voice to text tech at Beccles practice, which will give patients who are waiting in the call queue the option to have AI fill in the 'patches' form over the phone. **Warm and Well Campaign Update:** Committee received a brief update on the Warm and Well Campaign and noted the campaign, which has been running for several years, is now led by Norfolk County Council (having taken over from the ICB last year). The ICS webpage is focused on finding the right health services, whilst the county council webpage is much more around living costs, utility bills and hardship, in particular the hardship scheme. Committee also received an update on the Healthcheck campaign which ran last year and aims to try and increase bookings in the areas of deprivation with low take. January

	would see the introduction of more outdoor adverts (e.g. on buses) and messaging will focus on social isolation, mental health and post-Chrismas hardships e.g. blue January. Leaflet door drops in targeted areas are also starting in January. In response to this the Committee advised there had been feedback from a health and wellbeing partnership working group about receiving information in hard copy rather than digitally, so it was good to have the two options.
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
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A

NHS Constitution:	The report supports the Patient and Communities elements of the NHS Constitution.
Conflicts of Interest:	Committee member's interests are documented and managed according to ICB policy.

Norfolk and Waveney
Integrated Care Board

Agenda item: 19

Subject:	**Audit and Risk Committee Report**
Presented by:	**David Holt, Non-executive Member**
Prepared by:	**Amanda Brown, Head of Corporate Governance**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**26 March 2024**

Purpose of paper:

To provide the Board with an update on the work of the Audit and Risk Committee for the period September 2023 to 16 January 2024.

Committee:	Audit and Risk Committee
Committee Chair:	David Holt, Non-executive Member
Meetings since the previous update on 28 November 2023	*Bullet pointed details of each committee meeting held since the last report to Board, including dates and times.* • *16 January 2024* • *20 March 2024 – will provide verbal update on any key issues as papers circulated prior to meeting taking place*
Overall objectives of the committee:	This Committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.
Main purpose of meeting:	Main purpose of this meeting was to report on key areas to the Committee providing information and assurance. The main items covered were: ***Freedom to Speak Up Update*** A verbal report was given to the committee by the Executive Director of People who advised that whilst one of the FTSU is leaving the organisation additional resources are being recruited to. There have been expressions of interest in the

	role and it was agreed that the FTSU will attend the meeting in March to provide a report to the committee. ***Staff Reorganisation*** This item confirmed that the executive team are working to consolidate all the feedback received following the consultation and that the final organisational structure and outcome of the consultation will be announced on 15 February 2024 to staff. Alongside this work is a readiness workstream that is looking at the implementation phase and delivery of the new model and managing transition. This will be a more operational stage and a senior responsible officer for this stage is being identified. The committee highlighted that it is the delivery of the new model and implication on services and system partners that Board will want assurances on. The risks include the unintended risks of not filling/recruiting to posts and having staff in post within the structure beyond their expected leave date at the end of March which will incur pay costs into the early part of 2024/25. The committee noted the length of time the reorganisation has taken and the impact this has had on staff. ***Specialised Commissioning*** The Executive Director of Strategy provided information on the forthcoming delegation of specialist services to the ICB. There will be 59 services where responsibility is transferring to the ICB with the six ICBs across the East of England working together to commission them. Bedfordshire, Luton & Milton Keynes ICB (BLMK) will host the specialised commissioning function with the existing NHS England team being TUPE'd to BLMK in April 2025. The legal Delegation Agreement that transfers the services from NHS England to the ICB will need to be signed by 31 March 2024. In addition, the Collaboration Agreement between the six East of England ICBs and NHS England will also need to be signed by this date. This is the agreement that sets out the arrangements for how the organisations will work together. The transfer of these 59 services will provide an opportunity to join up pathways locally with specialised services and create more local understanding of what is commissioned for the population. The meeting noted that not every region is going forward with delegation this year as some regions are having another year of joint commissioning with NHS England. There are three delegation categories for the transfer of services, and it is expected that the ICB will be in the first category with no delegated conditions

	Internal Audit Report Auditors confirmed that there were a number of reports in draft and that these would be presented at the next committee meeting. Further, that good progress has been made with respect to the outstanding recommendations. A concern was raised about the number of reports yet to start/be completed. It was recognised that this had been a challenging year to schedule audits and that the staff reorganisation had been taken into consideration which is why a number of audits have been scheduled for the last quarter of the year. Audits for 2024/25 have been scheduled to start earlier in the year. ***Counter Fraud Report*** The work on the counter fraud functional standards shows that there are currently 7 green and 5 amber rated components. It is anticipated that some of the amber rated components will be rated green by 31 March 2024 to reflect the work completed by the ICB and Grant Thornton (GT). An area to flag concerned fraud training. Counter fraud e-learning module has been produced by GT, but the level of compliance could be improved and the component is therefore rated amber. ***External Audit Update*** The meeting was advised that the team were in the process of completing planning procedures for the annual accounts with the audit plan being presented to the next meeting in March 2024. ***Approach for Annual Report and Accounts*** This item identified the key themes for inclusion in the annual report and accounts for 2023/24. The report covered urgent and emergency care, elective care, primary and community care, mental health, community services as well as the ICB and system finance and investments in buildings and technology. ***Losses and Special Payments*** The committee was advised that there were no bad debts sales invoices as at 31 December 2023. There are some long outstanding debts where all options are being considered to recover the monies. In addition there were a number of purchase invoices totalling under £5,000 that were recommended to be written off and which the committee approved. ***Audit and Risk Committee Self-Assessment*** Following the Committee's self-assessment of its effectiveness a paper was presented that included proposed actions. These were noted and accepted by the Committee. ***Information Governance and Senior Information Risk Officer Report***

	This report provided an update on the Data Security & Protection Toolkit as well as IG policies, and the Information Risk Register. The report also highlighted the IG work plan and provided a cyber security update. The Committee was advised that records retention is an area of potential risk and that the team are looking at long term solutions. The following IG Policies were approved: • Data Protection & Cyber Security Breach Management Policy • ICB Data Quality Policy • Information Risk Management Policy • Records Management Policy • Policy for External and Locally Commissioned Providers ○ **Items for information** The Committee also received updates on the following matters: ○ Conflicts of Interest Committee Update ○ Internal Audit Reports with reasonable assurance or above and advisory reports ○ Procurement update and Tender Waiver Briefing ○ Policies by Committee ○ Audit and Risk Committee Annual Plan ○ Report on any urgent Board decisions and non-compliance with the Standing Orders ○ Review other reports and policies as appropriate ○ Audit and Risk Committee ToR
BAF and any significant risks relevant / aligned to this Committee:	The risk management framework and BAF is reviewed by the Committee on a regular basis.
Key items for assurance/noting:	N/A
Items for escalation to Board:	N/A
Items requiring approval:	N/A
Confirmation that the meeting was quorate:	Yes

Note: Please add a level assurance on each topic covered in red, this should be rated as none, partial or full.

Key Risks	
Clinical and Quality:	Internal audit reports provide assurance on internal control processes
Finance and Performance:	The Committee monitors the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance.
Impact Assessment (environmental and equalities):	None
Reputation:	The Committee supports the ICB reputation by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.
Legal:	It is a statutory requirement for the ICB to have an audit and risk committee.
Information Governance:	This Committee provides assurance to the Board that there is an effective framework in place for the management of risks associated with IG.
Resource Required:	None
Reference document(s):	None
NHS Constitution:	N/A
Conflicts of Interest:	The Committee is responsible for satisfying itself that the ICB's policy, systems and processes for the management of conflicts (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

Norfolk and Waveney
Integrated Care Board

Agenda item: 20

Subject:	**Remuneration, People and Culture Committee Report**
Presented by:	**Cathy Armor, Non Executive Director and Chair of the Renumeration, People Culture Committee**
Prepared by:	**Andrew Jones – Interim Deputy Director of People**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**26th March 2024**

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 January 2024 to March 2024.

Committee:	**Remuneration, Culture and People Committee**
Committee Chair:	Cathy Amor
Meetings since the previous update on January 2024	23rd January 2024
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 • 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**
	• Further rounds of industrial action for Norfolk and Waveney took place in February with Junior Drs taking strike action
	• This resulted in cancellations of day and outpatient services, elective cancellations and a reduction in elective activity
	• Focus was given on patient safety through two lenses
	  • Admission avoidance – community response through community providers, IC24, EEAST, social care, VCSE
	  • Maintaining flow at front door – ambulance offloads and discharge
	• Reviews ongoing to manage impact going forward including impact on admin staff (sickness levels increasing), and how system can manage staff better on strike days
	
	ICB Change program
	• Consultation outcome paper published on 15th February 2024 with new directorate structures finalised.
	• Circa 140 members staff at risk of redundancy and in scope of the changes
	• £5.7m expected to be saved through process. C.£230k short of initial target with additional savings expected through efficiency programmes.
	• The ICB will seek to redeploy at risk staff, and retaining key skills as much as is possible.

	Organisational Development (OD) • Significant work continuing to support the ICB change programme • 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 **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 • Outline business case for NHSE has been approved and funding given to support programme **Workforce planning and Education** • Initial draft submission of the 2025 / 2026 workforce plan submitted February 2024 • Regional feedback concentrated on additional growth for both substantive and temporary staffing. • Providers have been asked to revise plans in line with feedback and 2nd draft to be submitted on 21st March 2024 • 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 **Agency Reduction Program** • Agency costs are £15m above plan YTD at M10 driven mainly by underperformance at QEHKL. • ICB are giving targeted support to QEHKL as a result of their current position

	• Agency KPI is currently 4.3% against a YTD planned KPI of 3.1% (and an NHSE target of 3.7%). Agency target will reduce to 3.2% in 24/25 • Long serving agency workers in system are being reviewed • NHSE Workforce productivity diagnostic tool to be sent out for Acute providers – review being undertaken on staffing growth vs temporary staffing usage. • Government budget in March 2024 announced expectation that all providers eliminate off-framework agency workers by July 2024. Plans in place across all providers. **EoE Productivity and Efficiency** • Region have set out a number of 'high impact actions' that all systems must look to deliver. • Plans are needed for how providers will eliminate Off-framework usage, will ensure price-cap compliance, develop a collaborative bank and review skill mixes • N&W are progressing work across each of them and feeding into the system oversight group
Items for escalation to Board:	N/a
Items requiring approval:	N/a
Confirmation that the meeting was quorate:	Yes

Key Risks	
Clinical and Quality:	N/a
Finance and Performance:	• HCA B2 / B3 review • 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