

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

Wed 22 May 2024, 13:30 - 15:30

## Agenda

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**13:30 - 13:30 Meeting agenda**

0 min

 00. 2024.05.22 NW ICB Public Meeting Agenda.pdf (3 pages)

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**13:30 - 13:30 1. Welcome and introductions - Apologies for absence**

0 min

**13:30 - 13:30 2. Minutes from previous meeting and matters arising**


0 min

 02. DRAFT NW ICB Board Part 1 Minutes 26032024.pdf (6 pages)

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**13:30 - 13:30 3. Declarations of interest**

0 min

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

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**13:30 - 13:30 4. Chair's Action Log**

0 min

 04. Chairs Action Log May 2024.pdf (1 pages)

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**13:30 - 13:30 5. Action log – things we have said we will do**

0 min

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

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**13:30 - 13:30 6. Chair and Chief Executive's Report**

0 min

 06. 2024-05-22 - Chair and Chief Executive's Board report - Final.pdf (5 pages)

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**13:30 - 13:30 7. Health Inequalities Strategy**

0 min

 07. ICB Board\_HI Framework.pdf (5 pages)


 07.1 N&W Health Inequalities Strategic Framework for Action.pdf (22 pages)


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**13:30 - 13:30 8. Norfolk All Age Autism Strategy for 2024 – 29**

0 min

 08. ICB Board Report May 24.pdf (3 pages)

 08.1 Summary Norfolk All Age Autism Strategy 2024 to 2029 - final draft.pdf (24 pages)

 08.2 Full version Norfolk All Age Autism Strategy 2024 to 2029 Final draft.pdf (41 pages)

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**13:30 - 13:30 9. Norfolk Learning Disability and Autism Review: Tricordant Report**

0 min

- 📄 09. Tricordant Report Board Cover Doc May 2024.pdf (4 pages)
- 📄 09.1 Norfolk LDA Review Stage 2 Final Report 231123.pdf (23 pages)

**13:30 - 13:30 10. Primary Care Recovery Plan Report**

0 min

- 📄 10. 24-05-14 PCARP Paper FINAL.pdf (23 pages)

**13:30 - 13:30 11. Financial Report for Month 11**

0 min

- 📄 11. ICB Finance Report - Month 11 - Board.pdf (9 pages)

**13:30 - 13:30 12. New financial year plan approval 2025/2026**

0 min

- 📄 12. 2024.25 System Wide Planning.pdf (9 pages)
- 📄 12.1 - ICB Financial Plan Update.pdf (7 pages)

**13:30 - 13:30 13. Board Assurance Framework**

0 min

- 📄 13. 2024.05.22-BAF Paper for ICB Board Part 1.pdf (3 pages)
- 📄 13. Appendix 1 - Board Assurance Framework-V9.pdf (51 pages)

**13:30 - 13:30 14. Report from the Quality and Safety Committee**

0 min

- 📄 14. Quality and Safety Committee Report to Board v1.0.pdf (6 pages)

**13:30 - 13:30 15. Report from the Finance Committee**

0 min

- 📄 15. Fin Com Chair Report to May24 Board ~ M11 Final.pdf (5 pages)

**13:30 - 13:30 16. Report from the Primary Care Commissioning Committee**

0 min

- 📄 16. 24-05-22 PCCC paper for Board.pdf (5 pages)

**13:30 - 13:30 17. Report from the Commissioning and Performance Committee**

0 min

- 📄 17. C&P Committee Report to Board.pdf (4 pages)

**13:30 - 13:30 18. Report from Patients and Communities**

0 min

- 📄 18. ICB Board - Patients and Communities Committee Update May 2024.pdf (5 pages)

**13:30 - 13:30 19. Report from the Remuneration, People and Culture Committee**

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- 📄 19. Remuneration People and Culture Committee Report.pdf (4 pages)

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**13:30 - 13:30 20. Report from the Conflicts of Interest Committee**

0 min

 20. COI Committee Update Report to Board.pdf (3 pages)

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**13:30 - 13:30 21. Questions from the Public**

0 min

**13:30 - 13:30 22. Any other business**

0 min

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

**Wednesday, 22 May 2024 1.30pm – 3.30pm**

**(In Public)**

**Virtual via Microsoft teams**

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

**Our goals:**

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

**Chair: Rt Hon. Patricia Hewitt**

<b>Item</b>	<b>Time</b>	<b>Agenda Item</b>	<b>Lead</b>
1.	1.30	<b>Welcome and introductions - Apologies for absence</b>	Chair
2.		<b>Minutes from previous meeting and matters arising</b> To approve the part 1 public minutes of the previous Board meeting.	Chair
3.		<b>Declarations of interest</b> 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.		<b>Chair's Action Log</b> To receive an update from the Chair on actions taken since the last meeting.	Chair
5.		<b>Action log – things we have said we will do</b> 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	<b>Chair and Chief Executive's Report</b> 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
<b>Items for Sharing and Board Consideration</b>			

Item	Time	Agenda Item	Lead
7.	1.40	<b>Health Inequalities Strategy</b> To present the 'Norfolk & Waveney ICS Health Inequalities Strategic Framework for Action'.	Mark Burgis Tracy Williams Stuart Lines
8.	2.00	<b>Norfolk All Age Autism Strategy for 2024 – 29</b> To share the Norfolk All Age Autism Strategy for 2024 to 2029. and agree ways of working with the Norfolk Autism Partnership Board to develop a delivery plan.	Tricia D'Orsi Karen Dures Tracey Walton
9.	2.10	<b>Norfolk Learning Disability and Autism Review: Tricordant Report</b> To share the outcome of the commissioned review from Tricordant exploring outcomes for people with learning disabilities and/or autism (LD&A) in Norfolk.	Tricia D'Orsi Jo Yellon
10.	2.20	<b>Primary Care Recovery Plan Report</b> To update on progress of the system capacity and access recovery plan in response to the Delivery Plan for Recovering Access to Primary Care.	Sadie Parker Mark Burgis
<b>Finance and Corporate Affairs</b>			
11.	2.35	<b>Financial Report for Month 11</b> To receive a summary of the financial position as at month 11	Steven Course
12.	2.45	<b>New financial year plan approval 2024/2025</b> To receive a summary of the financial year plan 2024/2025 for approval.	Steven Course
13.	3.05	<b>Board Assurance Framework</b> A review of the risks (things that might go wrong and how we can alleviate them) within the Integrated Care system.	Karen Barker
<b>Committees Updates and Questions from the Public</b>			
14.	3.10	<b>Report from the Quality and Safety Committee</b>	Aliona Derrett
15.		<b>Report from the Finance Committee</b>	Hein Van Den Wildenberg
16.		<b>Report from the Primary Care Commissioning Committee</b>	Debbie Bartlett
17.		<b>Report from the Commissioning and Performance Committee</b>	Hein Van Den Wildenberg
18.		<b>Report from Patients and Communities</b>	Aliona Derrett
19.		<b>Report from the Remuneration, People and Culture Committee</b>	Cathy Armor
20.		<b>Report from the Conflicts of Interest Committee</b>	David Holt
21.		<b>Questions from the Public.</b> Where questions in advance relate to items on the agenda.	Chair

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Item	Time	Agenda Item	Lead
		Any other business	Chair
Date, time and venue of next meeting: 1.30 – 3.30 Wednesday 17 July 2024 Priscilla Bacon Lodge, Century Place, Colney, Norwich, NR4 7YA (Conference Room)			
Any queries or items for the next agenda please contact: <a href="mailto:nwccg.corporateaffairs@nhs.net">nwccg.corporateaffairs@nhs.net</a>			

### Some explanations of terms used in this Agenda.

Please see further terms defined on our website [www.improvinglivesnw.org.uk](http://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 1<sup>st</sup> 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.

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**NHS Norfolk and Waveney Integrated Care Board**  
**DRAFT Minutes of the meeting on Tuesday, 26 March 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 Borett (BB), Chair, Norfolk Health and Wellbeing Board, and Chair, Norfolk and Waveney ICP (from 2.17pm)
- 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
- Emma Ratzer (ER), Voluntary, Community and Social Enterprise Sector Board 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
- Mark Burgis (MB), Executive Director of Patients and Communities, 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
- Ema Ojiako (EO), Executive Director of People, NHS Norfolk and Waveney ICB

**Attending to support the meeting:**

- Chris Williams (CW), Senior Support Manager, NHS Norfolk and Waveney ICB (Minutes)

<b>1.</b>	<b>Welcome and introductions - apologies for absence</b>	
	The Chair welcomed everyone to the meeting.	
	Apologies were received from the following Board members: <ul style="list-style-type: none"> <li>• Caroline Donovan (CD), Partner Member – NHS Trusts</li> </ul>	

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<b>2.</b>	<b>Minutes from previous meeting and matters arising</b>	
	<p><b>Agreed:</b> The draft minutes from the meeting held on 23 January 2024 were approved as an accurate record of the meeting.</p>	
<b>3.</b>	<b>Declarations of interest</b>	
	The Chair noted that declarations of interest were kept up-to-date and were available on the ICS's website.	
<b>4.</b>	<b>Chair's action log</b>	
	There were no Chair's actions.	
<b>5.</b>	<b>Action log</b>	
	The report was noted.	
<b>6.</b>	<b>Chair and Chief Executive's Report</b>	
	<p>TB introduced the item by highlighting key points from the report.</p> <p>Questions and comments from Board members:</p> <ul style="list-style-type: none"> <li>• FS explained that NHS Norfolk and Waveney was the only ICB in country that was an innovation site.</li> <li>• The Chair highlighted the important work of the health innovation networks and that through innovation and transformation we would improve the care, support and health of the population.</li> </ul> <p>The report was noted.</p>	
<b>Learning from people, staff, and communities</b>		
<b>7.</b>	<b>Primary care support for people with diabetes</b>	
	<p>PD'O introduced the item and the Board watched a video about the work the system was doing to improve care and support for people with diabetes.</p> <p>Questions and comments from Board members:</p> <ul style="list-style-type: none"> <li>• DH asked what was being done to identify and support people who had diabetes, but who hadn't been diagnosed with the condition.</li> <li>• FS explained that the health checks programme, done in partnership with public health, was important for identifying this group of people and that clinicians also watch out for people reporting symptoms. She added that education was important for helping to prevent diabetes and to improve outcomes for those who have it.</li> <li>• The Chair asked how local levels of diagnosis compare with other parts of the country.</li> <li>• FS explained that in Suffolk rates of diagnosis were lower than would be expected, but that Suffolk and Norfolk perform well in terms of health checks. She added that the system needed to target areas where there was more likely to be a higher incidence.</li> <li>• HB explained that patients who were at risk of developing diabetes were monitored.</li> <li>• MB commented that the Wellness on Wheels bus does reached out to communities.</li> </ul>	

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	<ul style="list-style-type: none"> <li>• PD'O noted that this item showed the strength of relationships between patients and professionals in primary care, as well as the importance of healthy living. She added that the system needed to look at how existing resources could be used differently to support people and that diabetes was one of a number of long-term conditions that patients needed support with and care for.</li> </ul> <p>The report was noted.</p>	
<b>Items for Sharing and Board Consideration</b>		
<b>8.</b>	<b>Delegated Specialised Commissioning Update</b>	
	<p>AP introduced the item by highlighting key points from the report and thanking colleagues for the work they had done on this.</p> <p>Questions and comments from Board members:</p> <ul style="list-style-type: none"> <li>• AD asked if there were any challenges foreseen with the collaboration.</li> <li>• AP explained that the systems had been working together on this for a while and so no problems were anticipated, adding that more complex services were to follow which may bring challenges. He highlighted that this was an opportunity to join-up services for people though and this should outweigh potential issues.</li> </ul> <p><b>Agreed:</b> The ICB Board:</p> <ul style="list-style-type: none"> <li>• Approved the delegation of 59 specialised services and authorised the signing of the Delegation Agreement between the ICB and NHS England.</li> <li>• Noted than an updated Delegation Agreement was being produced by NHS England with minor amendments and authorised the signing of the final version of the Delegation Agreement/contract variation as appropriate.</li> <li>• Approved 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.</li> <li>• Agreed that the ICB would 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.</li> </ul>	
<b>9.</b>	<b>Joint Forward Plan Refresh for Approval</b>	
	<p>AP introduced the item by highlighting key points from the report and thanking colleagues for the work done to refresh the plan.</p> <p>BB joined the meeting at this point.</p> <p>Questions and comments from Board members:</p>	

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	<ul style="list-style-type: none"> <li>• The Chair highlighted that although the JFP had been developed primarily by the NHS part of system, it was an important piece of work and was informed by the wider system.</li> <li>• CA commented that the JFP showed the positive work the system was doing and asked what AP was most pleased with.</li> <li>• AP explained that he was pleased the system had made progress on all of the eight ambitions in the JFP and that the system had done well in terms of delivery. He added it was nice to be able to look forward and to contribute towards the priorities in the system's Integrated Care Strategy.</li> <li>• JB commented that it was an important document, but that the work didn't end with its publication, the aims and ambitions flowed into provider organisations and place boards and added value to what the system does.</li> <li>• PD'O highlighted the diagram on page 24 which showed people's outcomes along the life course and commented that it helped to bring the plan to life.</li> </ul> <p><b>Agreed:</b> The ICB Board approved the refreshed five-year Joint Forward Plan for 2024/25 to 2028/29, subject to any minor drafting corrections.</p>	
<b>Finance and Corporate Affairs</b>		
<b>10.</b>	<b>Financial Report for Month 10</b>	
	<p>SC introduced the item, noting that the forecast outturn position for the ICB for the year remained a break-even position in line with our plan. He explained that the forecast outturn position for the Integrated Care System was a £5.7m deficit, and noted that a paper would be taken to the next Finance Committee that would include a route to get to break-even for the system. 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.</p> <p>The report was noted.</p>	
<b>11.</b>	<b>Fit and Proper Persons Test Report</b>	
	<p>KB introduced the item by highlighting key points from the report.</p> <p>The Chair thanked colleagues for their work on this. She noted that the deadline had been extended to the end of June and that systems had been asked to do more work on it.</p> <p><b>Agreed:</b> The ICB Board approved the work done so far and noted there was an extension to the deadline and additional work to be done.</p>	
<b>12.</b>	<b>Governance Handbook</b>	
	<p>KB introduced the item by highlighting key points from the report.</p>	

	<p><b>Agreed:</b> The ICB Board approved the changes to the Governance Handbook detailed in the report.</p>	
<b>13.</b>	<p><b>Board Assurance Framework</b></p> <p>KB introduced the item by highlighting key points from the report.</p> <p>The Board received and reviewed the risks presented on the Board Assurance Framework.</p>	
<b>Committees update and questions from the public</b>		
<b>15.</b>	<p><b>Report from the Quality and Safety Committee</b></p> <p>AD noted that the committee had discussed the changes made to ambulance handovers and their impact, RightCareNow and changes to discharge, improvements made in children and young people's eating disorder services, and the implementation of the new patient safety incident framework.</p> <p>The report was noted.</p>	
<b>16.</b>	<p><b>Report from the Finance Committee</b></p> <p>HvdW noted that the committee had discussed the work that was in progress for the next financial year, noting that was challenging, but progress was being made.</p> <p>The report was noted.</p>	
<b>17.</b>	<p><b>Report from the Primary Care Commissioning Committee</b></p> <p>DB noted that the committee had discussed access to care and dentistry.</p> <p>The report was noted.</p>	
<b>18.</b>	<p><b>Report from the Performance Committee</b></p> <p>HB noted that the committee had discussed the system's transition out of National Oversight Framework level 4, community wheelchair provision and workforce. She also noted that from May 2024 the committee would be replaced by the new Commissioning and Performance Committee.</p> <p>The report was noted.</p>	
<b>19.</b>	<p><b>Report from the Patients and Communities Committee</b></p> <p>AD noted that the committee had discussed community mental health transformation, the monitoring of mortality reports, the learning from deaths forum and the medical examiner changes.</p> <p>The report was noted.</p>	
<b>20.</b>	<p><b>Report from the Audit and Risk Committee</b></p> <p>DB noted that the committee had discussed key risks on the Board Assurance Framework and that it was relooking at the process for how</p>	

	those risks were escalated. The committee had also discussed freedom to speak up and the chairs of the system's audit and risk committees had discussed how to get a better oversight of risks as a system.  The report was noted.	
<b>21.</b>	<b>Report from the Remuneration, People and Culture Committee</b>	
	CA noted that the committee had discussed the ICB's organisational review and restructure and the workforce plan for 2024/25, as well as freedom to speak up.  The report was noted.	
<b>22.</b>	<b>Report from the Conflicts of Interest Committee</b>	
	DH noted that good progress had been made with conflicts of interest and that there was a high level of returns about people's interest. He added that the committee was thinking about how far the ICB should go beyond its own staff due to the number of people from other organisations on the ICB's committees. He confirmed there had been no breaches in last 12 months.  <b>Action: PD'O to discuss freedom to speak up with DH in the context of the quality agenda, the implications of Martha's rule and the Lucy Letby case.</b>  The report was noted.	PD'O
<b>23.</b>	<b>Questions from the public</b>	
	There were no questions from the public.	
<b>24.</b>	<b>Any other business</b>	
	No other business was raised.	
<b>Date, time and venue of next meeting: Wednesday, 22 May 2024, 1.30pm – 3.30pm, via MS Teams</b>		
<b>Any queries or items for the next agenda please contact: <a href="mailto:nwccg.corporateaffairs@nhs.net">nwccg.corporateaffairs@nhs.net</a></b>		

**Minutes agreed as accurate record of meeting:**

Signed: .....  
Chair

Date: .....

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**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

Davey Hewitt  
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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.

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16/05/2024 08:56:24

**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 Rätzer	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

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NORFOLK & WAVENEY ICB Chairs Action Log - Wednesday 22 May 2024

Date	Matter	Details of discussion	Decision	Date Reported to ICB Board
29-apr	Operating Plan submissions for 2024 - 2025	<p>The ICB Board were not quorate with only 9 members present therefore under section 4.9.4 of the Standing Orders set out in the Constitution the Chair took the following actions:</p> <ul style="list-style-type: none"> <li>•Approve the ICB's 2024/25 Operating Plan submissions.</li> <li>•Approve the system's 2024/25 Operating Plan submissions.</li> <li>•Approve the letter of support for the Full Business Case for the Norfolk and Waveney Acute Trusts' Electronic Patient Record.</li> </ul> <p>The Chief Executive was also present at the meeting and agreed the actions.</p>	<ul style="list-style-type: none"> <li>• Approved the ICB's 2024/25 Operating Plan submissions.</li> <li>•Approved the system's 2024/25 Operating Plan submissions.</li> <li>•Approved the letter of support for the Full Business Case for the Norfolk and Waveney Acute Trusts' Electronic Patient Record.</li> </ul>	22-mai-24

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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
25	26-mar-24	Freedom to Speak Up in the context of the quality agenda.	PD'O to discuss freedom to speak up with DH in the context of the quality agenda, the implications of Martha's rule and the Lucy Letby case.	PD'O	mai-24	Action to be updated at the meeting 22.05.24.	Open

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Agenda item: 6

<b>Subject:</b>	<b>Chair and Chief Executive's report</b>
<b>Presented by:</b>	<b>Rt Hon. Patricia Hewitt, Chair, NHS Norfolk and Waveney ICB Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney ICB</b>
<b>Prepared by:</b>	<b>Rt Hon. Patricia Hewitt, Chair, NHS Norfolk and Waveney ICB Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney ICB</b>
<b>Submitted to:</b>	<b>ICB Board</b>
<b>Date:</b>	<b>22 May 2024</b>

**Purpose of paper:**

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

**Executive Summary:**

The report covers the following:

- A. System finances
- B. Major boost for mental health services
- C. Our Long-Term Dental Plan
- D. Using data to improve people's health and care
- E. Benjamin Court
- F. Meetings and visits

Davey, Heidi  
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## Report

### A. System finances

We may be six weeks into the new financial year, however it is really important that we take a moment to pause and reflect on breaking-even last year. Delivering the balanced budget we had set ourselves was very challenging – our budget included £116.2m of efficiencies and the industrial action put additional pressure on our finances.

Importantly, we broke-even while also making significant improvements to services, for example the improvements to ambulance handovers and response times. We must continue to do this and ensure we are using every pound we have as effectively as possible.

This financial year will be incredibly challenging. It's important to recognise that there is significant pressure on the budgets of our partners too, including local authorities and the voluntary sector, with the NHS having had relatively larger increases than they have had in recent years. Only by working together will the NHS and the wider public sector be able to deliver the required efficiencies and productivity increases, whilst also maintaining and improving outcomes.

### B. Major boost for mental health services

We continue to invest in improving mental health services. From September, people in Norfolk and Waveney experiencing anxiety and depression will benefit from an enhanced new NHS Talking Therapies service providing tailored care and support as close to their home or place of work as possible.

The new service, which has been shaped by service users, families, carers and clinicians together, will see support offered from more than double the existing number of locations across Norfolk and Waveney, bringing personalised care and support closer to those who need it.

The new multi-partnership approach brings together voluntary, community, social enterprise and statutory organisations and will ensure people in Norfolk and Waveney can get quick and easy access to talking therapies services, enabling them to live their lives with improved mental health.

We look forward to working with the partners over the next few months and years to ensure people across Norfolk and Waveney have access to high quality, safe and efficient mental health services.

More information about the new NHS Talking Therapies service, known locally as the Wellbeing Service, can be found here: <https://improvinglivesnw.org.uk/major-boost-for-mental-health-services-in-norfolk-and-waveney-with-announcement-of-new-nhs-talking-therapies-service/>.

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## C. Our Long-Term Dental Plan

We took on responsibility for dental services a year ago and since then we have made progress. We published our short-term dental plan in September and allocated £2.3m of funding to implement it. We have focused on improving access for patients needing urgent treatment. We have 23 practices offering up to 450 urgent appointments per week and the service is now treating c1,800 patients per month.

We have also increased the amount we pay dentists to provide NHS care, to a minimum of £30 per Unit of Dental Activity (UDA), higher than the nationally recommended value of £28 per UDA. We have funded local dental providers to undertake children's oral health initiatives using £600,000 of funding. And we have put in place recruitment and retention plans to support dental practices using a further £600,000 of funding.

We know that dental services continue to be very challenged though. We are making progress, but long-term sustainable change is going to take time. We are very grateful for the 2,000 people who over the past few months have contributed to the development of our new long-term dental plan.

This year we will be investing £7million in dental services as we start to implement our new plan. Over the next five years we want to build stability and resilience across NHS dental services, improve access to oral health care and reduce health inequalities.

There are three things we will be focusing on:

- Building capacity by working with system partners to improve recruitment and retention of the dental workforce.
- Improving access for children and young people, and those living in more deprived areas.
- Empowering and supporting residents to manage their own oral health, working with local Public Health teams and system partners.

## D. Using data to improve people's health and care

We have recently published our Population Health Management Strategy, which sets-out how we will use data-driven approaches to improve people's health and care. This involves identifying variations in people's access to care and health outcomes, and then putting in place interventions to address them, often by trying to prevent problems from arising in the first place or by treating them early before they become more serious. This work is vitally important for addressing health inequalities, as well as driving-up quality.

Here are a few examples from the last year that show how this is helping people across Norfolk and Waveney:

### **NHS Diabetes Prevention Programme**

We identified individuals with non-diabetic hyperglycaemia and contacted them all proactively to encourage and support them to participate in the Diabetes Prevention Programme. This led to a massive increase in programme uptake, particularly

among people in previously low-referring practices and our more deprived areas. Through this initiative, an additional 1,800 people have completed the programme so far.

### **Digital Weight Management Programme**

In this project we identified people with obesity and pre-existing hypertension or diabetes, targeting low referring practices and those living in more deprived areas of Norfolk and Waveney. In June 2023, only 10% of our referral target had been met, but we are now the highest ranked ICB in the East of England with over 5,200 high risk residents referred onto the programme.

### **Active NoW**

This initiative aims to boost physical activity levels and as a result positively impact on people's physical and mental health. The Active NoW programme is not new, but we know that it has been underused, particularly by those amongst high-risk and deprived populations. So using Population Health Management techniques we identified those who might benefit most and our support team contacted and supported individuals to join the scheme. Among the 4,632 participants, 72% were from the lowest quintiles of deprivation, with 69% experiencing increased activity, 79% reporting improved mental health, and 88% reporting enhanced general health after six months.

You can read our Population Health Management Strategy here:

<https://improvinglivesnw.org.uk/norfolk-and-waveney-5-year-joint-forward-plan/strategic-frameworks/>.

### **E. Benjamin Court**

As the Board will know, Benjamin Court in Cromer has been used to provide a range of health and care services in the past. It is made-up of two buildings, however one of these has largely been empty since last June. We are considering what should happen with the building that is largely empty and as part of this we are currently asking people to share their ideas about how it could be used in future.

There are a range of ways that people can get involved – online, in person and over the phone. There is more information about the engagement exercise and how people can get involved here: <https://improvinglivesnw.org.uk/have-your-say-on-how-benjamin-court-could-be-used-in-future/>.

### **F. 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:

- I attended the regular NHS Confed Chairs Group, as well as a joint NHS Providers/NHS Confederation session on the NHS oversight framework with NHS England.

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- I went to the Milken Institute's Advisory Council Roundtable on Preventative Health. It was really interesting to discuss new approaches to funding and financing innovation in preventative healthcare.
- ICB colleagues and I had a very constructive meeting with Emma Rutzer to talk through progress with and the future of our VCSE Assembly.
- As part of the follow-up to a meeting with Minister Maria Caulfield MP earlier in the year, Tracey, colleagues from NSFT, NHS Suffolk and North East Essex and I met with Norfolk and Suffolk MPs to discuss NSFT's Improvement Plan.
- Tracey and I also separately briefed MPs from Norfolk and Waveney on other matters, including dentistry, pharmacy services, general practice, urgent and emergency care, and system finances.
- I attended a workshop organised by the Norfolk Public Sector Leaders Board to discuss how the board's work should develop in preparation for a Directly Elected Leader of Norfolk County Council in May 2025.

As Chief Executive, 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 have met with regional NHS England colleagues to discuss progress with and next steps for the New Hospitals Programme. We also had our quarterly ICB review meeting with NHS England.
- We held an East of England Learning Disabilities and Autism Share and Learn Webinar, which was a great way for us to talk about some of the good work we are doing in Norfolk and Waveney, as well as a chance to learn from others.
- I attended a national event about the Enhance Programme, which is all about the importance of generalist skills. I was part of panel with Professor Sir Chris Whitty, Sam Illingworth and Dr Geoff Smith where I talked about the system level benefits from a workforce who are better equipped with generalist skills.
- Carers Voice Norfolk and Waveney held an excellent session on developing an All Age Carers Strategy for Norfolk and Waveney.
- I thoroughly enjoyed the Healthwatch Norfolk Annual Partners meeting, it was a great opportunity to hear about the work they have been doing over the last year and what they are working on now and next.
- 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.

Davey Heidi  
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Agenda item: 07

<b>Subject:</b>	<b>Norfolk &amp; Waveney ICS Health Inequalities Framework</b>
<b>Presented by:</b>	<b>Mark Burgis, Exec Director Patient &amp; Communities Tracy Williams, Clinical Lead Health Inequalities &amp; Inclusion Health Stuart Lines, Director of Public Health, Norfolk County Council</b>
<b>Prepared by:</b>	<b>Shelley Ames, Acting Head of Health Inequalities &amp; VCSE</b>
<b>Submitted to:</b>	<b>Norfolk &amp; Waveney Integrated Care Board</b>
<b>Date:</b>	<b>22 May 2024</b>

**Purpose of paper:**

To present to the ICB Board the 'Norfolk & Waveney ICS Health Inequalities Strategic Framework for Action'. This is for information and to request that the Board endorse and support its implementation by undertaking the Board self-assessment by the end of July 2024. This has been produced by NHS Providers and will inform a baseline position from which to target and implement work on the Healthcare Inequalities programme.

**Executive Summary:**

The Norfolk and Waveney ICS Health Inequalities Strategic Framework for Action has been developed with extensive input from stakeholders across all sectors and those with lived experience of health inequalities. The Framework sets out the actions we want to take as partners of our Integrated Care System to tackle health inequalities, as shaped by our 'Health Inequalities Conversation'.

There are 10 clear actions for the first year and discussions are underway with the Integrated Care Partnership to ensure clear accountability and governance structures to drive the initial actions and those in the future.

The Integrated Care Board is tasked with leading Healthcare Inequalities 'building block', aligned to the legal duties and requirements of the NHS and the NHSE Statement on Information on Health Inequalities. This will require a whole-system response and will be overseen by our Health Inequalities Oversight Group (HIOG) and our Population Health and Inequalities Board. Our 5 Place Boards are integral to development and implementation of our action plan.

We are asking organisations, as one of the 10 actions, to undertake baseline and self-assessments, so that we can be clear on our start position and the areas for improvement, both as individual organisations and a system. We ask the Integrated Care Board to undertake the Board self-assessment for health inequalities developed by NHS Providers.

Davy White  
 16/05/2024

## Report

The Norfolk and Waveney ICS Health Inequalities Strategic Framework for Action has been developed with extensive input from over 100 stakeholders and those with lived experience of health inequalities. The Framework responds to an objective set out in the Joint Forward Plan to develop a health inequalities strategy. The Framework sets out the actions we want to take as a system to tackle health inequalities, as shaped by our 'Health Inequalities Conversation'.

The Framework sets a clear vision for our system, provides clarity around *who* is impacted by health inequalities (our Core20plus populations) and establishes guiding principles to underpin implementation. It sets out what we need to do to strengthen our foundation to create the conditions for success, as well as how we might create better building blocks for health related to three key areas; Living and Working Conditions, Lifestyle Factors and Healthcare Inequalities.

There are 10 clear actions for the first year, and discussions are underway with the Integrated Care Partnership to ensure our Integrated Care System has clear accountability and governance structures to drive the initial actions and those in the future. These actions include:

- Developing and rolling out an organisational pledge programme for health inequalities.
- Continued engagement with communities that experience health inequalities, with emphasis on our Community Voices programme.
- Developing a network of leaders, organisational leads and HI champions and ensure clear accountability and governance.
- Undertaking self-assessments to assess where we are and what we need to do next.
- Develop action plans for each of our building blocks, including Healthcare Inequalities.
- Developing a suite of tools and training to support organisational and workforce development.
- Implementation of our Population Health Management strategy.
- Mapping the flow of health inequalities resources and spend across our system to further develop our business case for investment.

The NHS contributes to tackling inequalities in health in three distinct ways:

**1. Influencing multi-agency action to address social and wider determinants of health.**

The role of Integrated Care Systems (ICSs) working with local authorities and local communities is particularly critical here.

**2. The NHS as a significant economic actor in its own right.**

The choices we make as an employer, a purchaser and a local 'anchor organisation' can help moderate inequalities.

**3. Tackling inequalities in healthcare provision.**

This is our direct responsibility and must be the prime focus of our action. The enduring mission of the NHS is high quality care for all. That means tackling the relative disparities in access to services, patient experience and healthcare outcomes.

Given the above the ICB has a significant role to play in supporting multi-agency action, particularly with our partners in Public Health, to drive implementation of the overall Framework. As an Anchor organisation and with increasing responsibilities around the

Davey, Heidi  
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prevention agenda, we must play our part in the tackling health behaviours (lifestyle) and wider determinant (living and working conditions) outcomes.

The ICB is tasked with leading the Healthcare Inequalities building block, given our sphere of influence and legal duties and requirements. There are clear requirements set out by NHS England that will need to be considered in developing our action plan, which will be led by the new Health Inequalities & VCSE team in the Patient and Communities directorate alongside colleagues in Place teams and across the organisation as appropriate. The work programme will be overseen by the Health Inequalities Oversight Group (HIOG) which is chaired by our Clinical Lead for Health Inequalities & Inclusion Health. These requirements include:

- The priorities set out in the [NHSE Statement on Information on Healthcare Inequalities](#)
- The Core20plus5 health improvement framework for [adults](#) and for [children and young people](#)
- The [NHS Inclusion Health Framework](#)
- [NHS Anchor recommendations](#)
- The NHSE 5 priority actions for health inequalities:
  - o Restoring NHS services inclusively
  - o Mitigating against digital exclusion ([Digital Inclusion Framework](#))
  - o Ensuring datasets are timely and complete
  - o Accelerating preventative programmes
  - o Strengthening leadership and accountability

It is important that we understand our start position and have a baseline, so that we can develop our actions plans with improvement in mind, and so that we can articulate our impact at a later stage. NHS Providers have developed a [Reducing Health Inequalities: A guide for NHS trust board](#) members as well as [a self-assessment tool for Trust Boards](#), which we are asking our ICS partners to undertake. We are asking all partners to undertake a self-assessment. Whilst this is directed at Trusts, the questions asked are relevant to the Integrated Care Board and we request that our Board consider undertaking this assessment so that we might get an organisational view on the steps we need to take to improve our maturity in this agenda. This exercise will be supported by the Health Inequalities & VCSE team.

We will combine our ICB results with those of the system and through a new NHS Anchors Group we are establishing to report to HIOG, we will work together with other NHS bodies to drive improvements efficiently and effectively.

#### **Recommendation to the Board:**

The ICB Board is asked to:

- Endorse the Health Inequalities Strategic Framework for Action.
- Support its implementation by undertaking the health inequalities board assessment by end July 2024.

If approved the ICB Board will receive updates on the progress of this and the Healthcare Inequalities work programme.

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<b>Key Risks</b>	
<b>Clinical and Quality:</b>	Unfair and avoidable differences in access to care, quality and experience of care within our Core20plus communities and those with protected characteristics. This will impact on outcomes for individuals and contribute to system pressures.
<b>Finance and Performance:</b>	N/A
<b>Impact Assessment (environmental and equalities):</b>	N/A
<b>Reputation:</b>	
<b>Legal:</b>	The NHS has legal duties that relate to health inequalities as outlined in the NHSE Statement on Information on Health Inequalities. These include to: <ul style="list-style-type: none"> <li>- Arrange services to meet reasonable needs</li> <li>- Have regard to reducing inequalities in access and outcomes.</li> <li>- To improvement in quality of services.</li> <li>- To promote integration.</li> <li>- To consider effects of wider decisions on inequalities.</li> <li>- Include consideration for inequalities in annual plans, joint forward plans, performance assessments and annual reports.</li> </ul>
<b>Information Governance:</b>	N/A
<b>Resource Required:</b>	N/A
<b>Reference document(s):</b>	Norfolk & Waveney ICS Health Inequalities Strategic Framework for Action
<b>NHS Constitution:</b>	<ol style="list-style-type: none"> <li>1. The NHS provides a comprehensive service, available to all</li> <li>3. The NHS aspires to the highest standards of excellence and professionalism</li> <li>4. The patient will be at the heart of everything the NHS does</li> <li>5. The NHS works across organisational boundaries</li> <li>6. The NHS is committed to providing best value for taxpayers' money</li> <li>7. The NHS is accountable to the public, communities, and patients that it serves</li> </ol>
<b>Conflicts of Interest:</b>	N/A
<b>Reference to relevant risk on the Board Assurance Framework</b>	BAF06

### **Governance**

<b>Process/Committee approval with date(s)</b> (as appropriate)	Patient and Communities Committee approval received 20.5.24
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	Integrated Care Partnership approval being sought June 2024
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Improving lives **together**

Norfolk and Waveney Integrated Care System

Norfolk and Waveney Integrated Care System

# Health Inequalities Strategic Framework for Action

2024 - 2034

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16/05/2024 08:56:24

## Foreword

Norfolk and Waveney is generally a healthy and safe place to live. We are fortunate that life expectancy locally is higher than the national average for both men and women.

However, there are significant differences between different parts of Norfolk and Waveney, as well as between groups of people. Right now, some people in Norfolk and Waveney are dying a decade younger than they should. This is just one of many statistics that show the avoidable differences in the health of our residents.

Too many people are living for years in poor health; too many families have lost a loved one too soon. Changing this is what is driving us to do better.

Addressing health inequalities is everybody's business. This is because our physical and mental health depends upon so many things, not just health and care services, but economic factors, such as whether we have decent work or enough money, our environment, if we have close family and friends, and of course our own lifestyles.

This is why our Integrated Care Systems is so important, as it includes such a wide range of partners, from the voluntary, community and social enterprise sector and our many residential and domiciliary social care providers, to local government, the NHS and other statutory organisations.

There are many people and organisations in Norfolk and Waveney who are already doing excellent work every day to address health inequalities, despite the financial constraints that affect us all. This important new framework will enable us to have a much greater impact than we currently are. We know that by working more closely together we can achieve so much more: this framework gives us all the common vision, purpose and plan that we need.

Over 100 organisations and hundreds of people were involved in developing this framework. We are really grateful to everyone for contributing their time, energy, skills and experience – we will need the same commitment as we work together to change things, not just for the next 12 months, but for the years ahead.

By working together we can create a healthier Norfolk and Waveney for all our residents.

**Councillor Bill Borrett, Chair, Norfolk and Waveney Integrated Care Partnership**

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



## A clinical view

As a nurse, I have seen first-hand the impact that health inequalities have on people, families, communities and patients I have cared for. There are many health and care professionals, as well as people who choose to volunteer their time and energy, who work tirelessly to address inequalities which are unfair, unjust and avoidable. I am so pleased with our strategic framework for action because it provides us with a stronger foundation from which we can all work together more effectively to change things for the better for our communities and future generations.

The COVID-19 pandemic played out against a backdrop of multiple inequalities, driven by a range of factors, including levels of poverty and deprivation, systemic discrimination, access to safe and healthy housing, education, employment, healthy food and green spaces. The pandemic highlighted these issues, we cannot now forget about them. We must continue to focus on inclusion, exposing and addressing the stark differences that excluded, minority and vulnerable groups experience.

It's our duty to understand and overcome the root causes of health inequalities, ensuring that the health and care services we offer are inclusive and welcoming to everyone. We must eliminate barriers, bias and discrimination wherever they are identified, with compassion and openness, and by gaining the trust of our communities. We know that this will take time and that it will be challenging, but it is the right thing to do.

This strategy holds at its heart the values of our Integrated Care System. It will build a culture of collective responsibility for the delivery of inclusive and equitable care for all. It will move our care beyond the current boundaries. And it will enhance the experience of our communities, patients and our staff, as we strive to improve the quality of life for all.

**Tracy Williams, Queen's Nurse and Clinical Lead for Health Inequalities and Inclusion Health**



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## Introduction

Right now, some people are dying a decade younger than they should. Lives are being cut short because of where someone lives and works, how they are treated and because they might not be able to access services.

This framework for action is designed to change that, to help individuals, families, communities and organisations tackle these issues. Nationally, and locally, we know where and what the causes are, but no one organisation can address it alone. That is why this framework will try and map actions and develop tools and commitments so we can act **together** now.

Many people who are passionate about making a difference have contributed to the ideas and information presented within this framework. Our Health Inequalities Conversations have taken place across Norfolk & Waveney and have helped to shape this framework.

There are many people and organisations in Norfolk & Waveney who are working to address health inequalities every day. Action around health inequalities is not new, but the whole Integrated Care System recognising our key issues and coming together under a common purpose and framework is.

The spotlight on those individuals and communities who have been most affected during the pandemic has meant that we all want to do things differently. Now is the time to act, the creation of our Integrated Care System, and the national drive for change has contributed to the urgency and determination to come together with a common vision, language and goals.

We are focused on our **'building blocks'** for good health, alongside how we strengthen our foundation to **create the conditions for success**.

This is a ten-year framework, which contains within it a requirement to create annual action plans that are to be reviewed every year. Our initial actions detailed in this framework are the **first steps** towards a whole-system approach, and will be valid for our first 12 months of implementation.

### Norfolk and Waveney Vision

We will come together to tackle unfair and avoidable differences in health outcomes. We will do this by listening to communities, prioritising prevention, and taking action together, making health inequalities everybody's business.

## What are health inequalities?

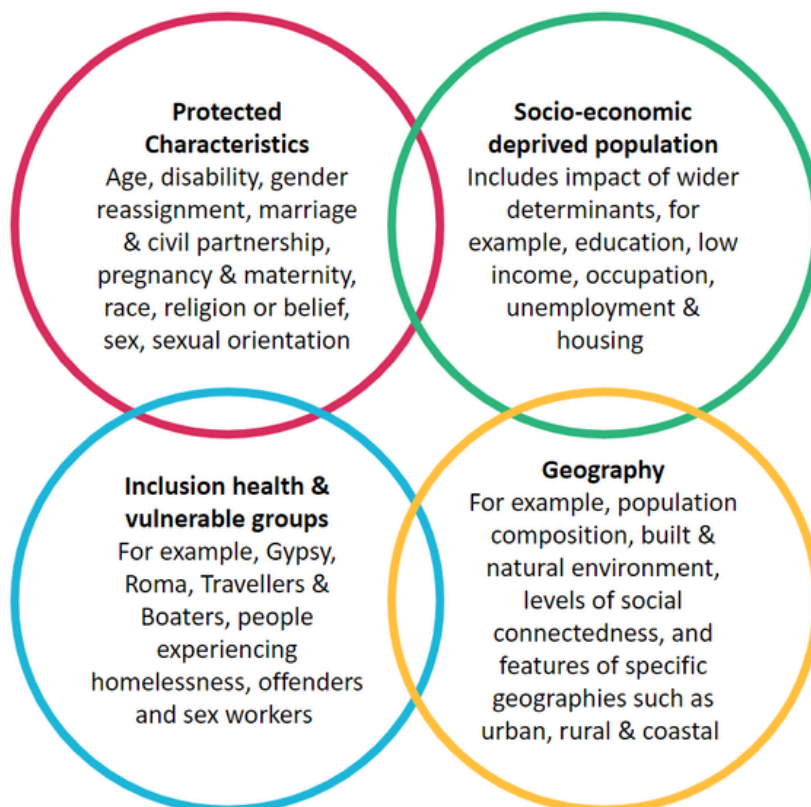
Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing. The effects of inequality are multiplied for those who have more than one type of disadvantage. (Kings Fund)

### Inequalities of what?

This can involve differences in outcomes and in known contributing factors to health:

- **Health status** e.g. life expectancy and prevalence of health conditions
- **Access to care** and non-clinical services e.g. availability or waiting times for treatments, take-up of services, access to information
- **Quality and experience of care**, e.g. levels of patient satisfaction, feeling involved
- **Behavioural risks** to health, e.g. smoking rates
- **Mental wellbeing** and exposure to stressors and adversities (or protective factors)
- **Social economic and environmental conditions** that are 'wider determinants' of health e.g. cost of living, housing quality, community life, discrimination

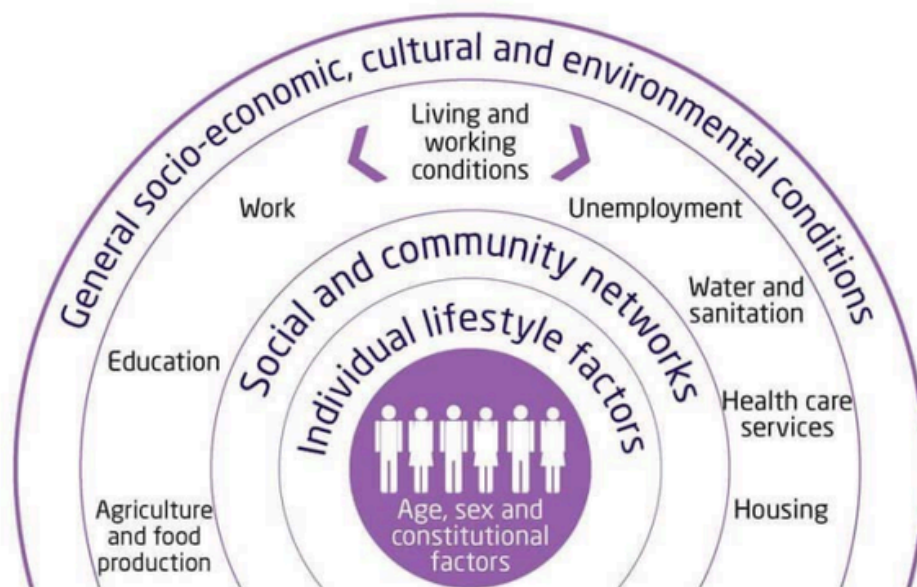
### Inequalities between who?



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## Keeping healthier for longer

There are lots of studies that show us that where we live and work influence our behaviour, as does how we spend our time and who we spend it with. The chart below is a good starting point for understanding all the factors that make up our health and decisions on our health, as well as those things we can't influence on our own.



Key areas that impact the health and wellbeing of our most vulnerable residents include good work, healthy communities and places, having the best start in life, tackling racism, discrimination and its outcomes, and environmental sustainability (Marmot, 2024).

In the Norfolk and Waveney area, there has been an emphasis on place-based approaches, and the need to address the socio-economic factors and geography outlined in the chart above (Figure 1). These are described locally as **Living and Working Conditions**.

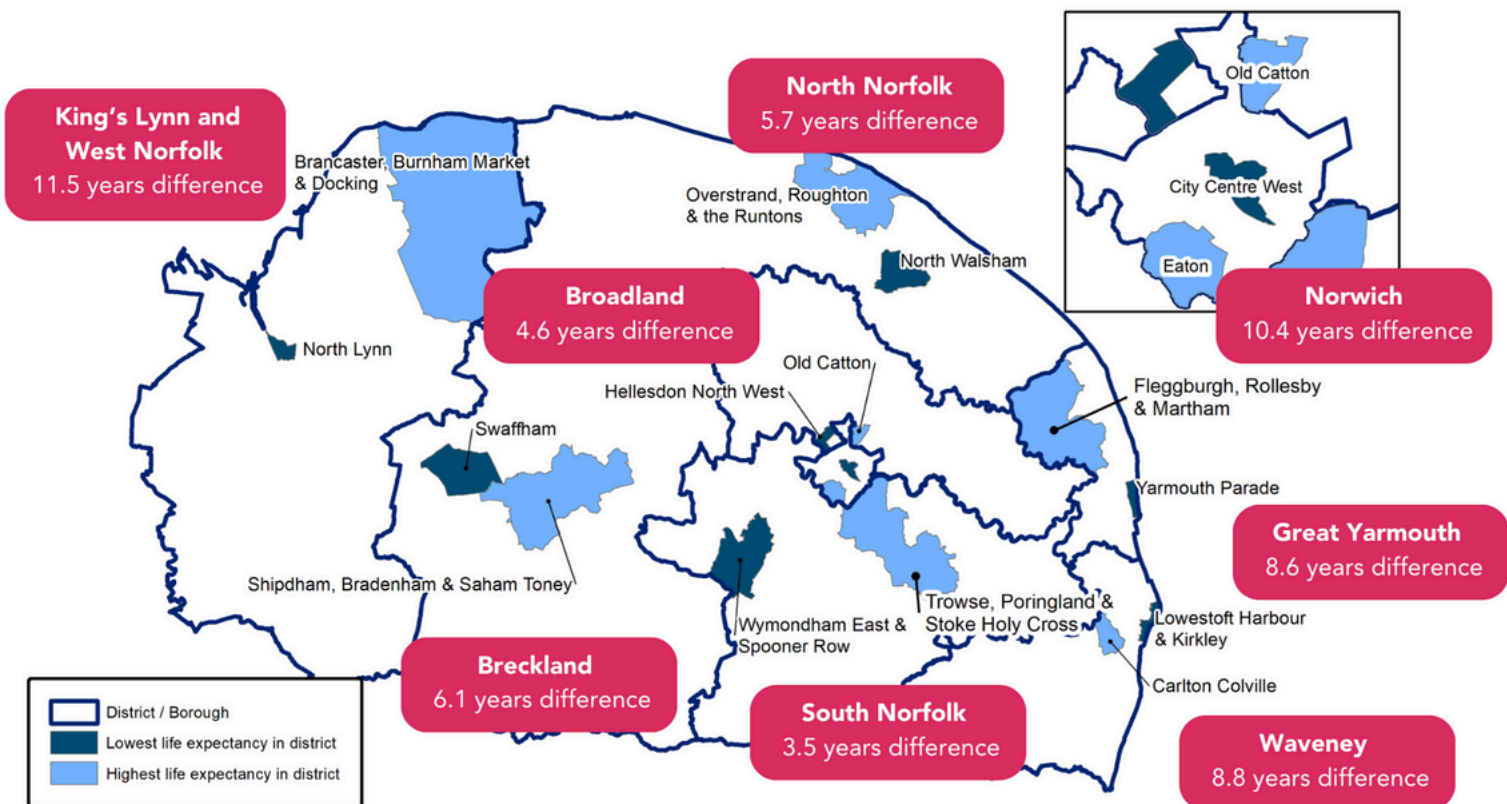
All of us can make a difference to our own health and wellbeing by making good, healthy choices, but sometimes this is not easy to do, especially when faced with a disadvantage because of where you live or if you face discrimination. We have described this as **Lifestyle Factors**.

And of course, when we need help, being able to access services early, and quickly, the same as anyone else with similar issues, but recognising the way in which the services are delivered might need to be different. For example, a person with autism accessing mental health services, someone with a mental health condition accessing stop smoking services, or someone attending a hospital appointment when English is not their first language. We describe this as **Healthcare Inequalities**.

# Why are we doing this?

Health equity means everyone should be able to reach their full potential for health and well-being, with fair and just opportunity to do so. Right now, we know this is not happening as some people are dying earlier than we would expect.

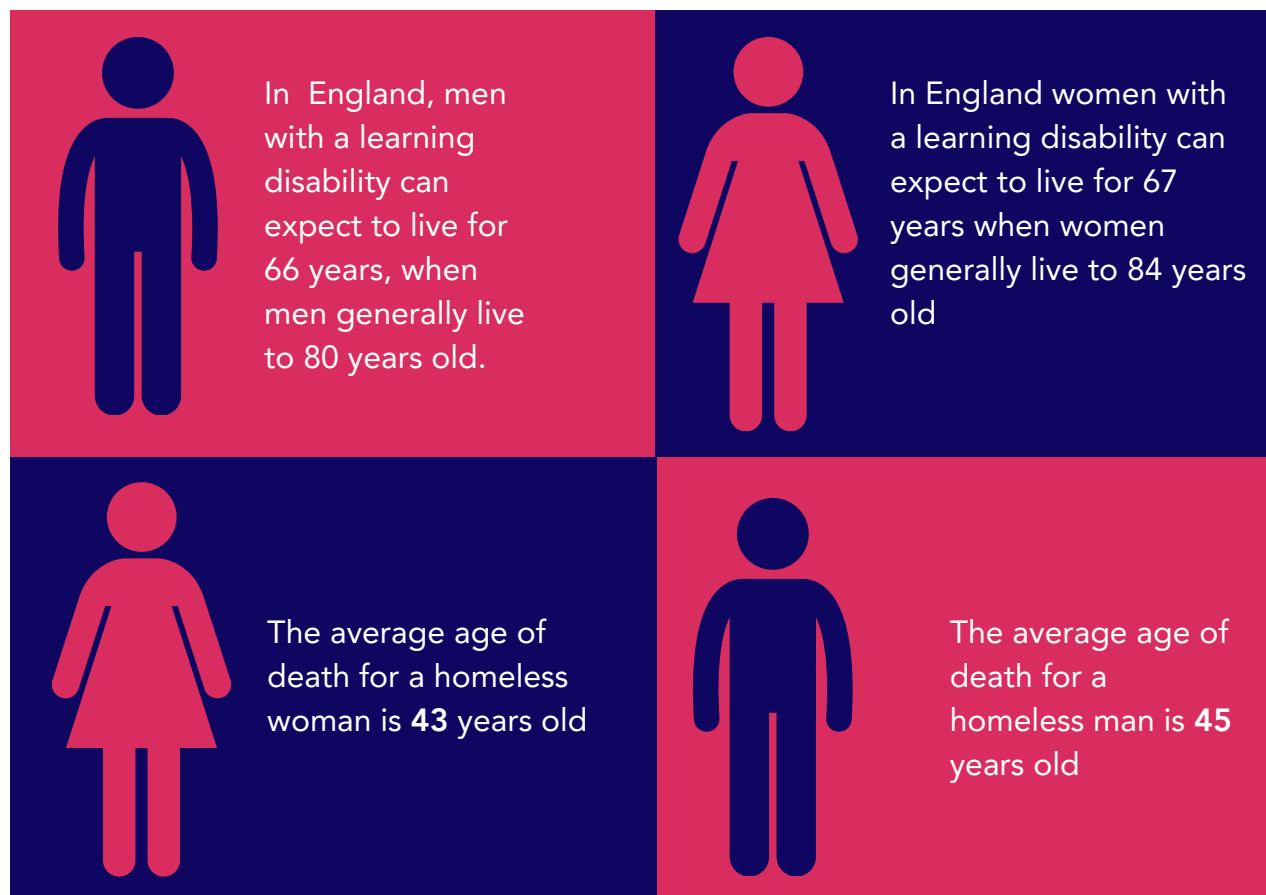
The map below shows that people are dying much earlier in some parts of Norfolk & Waveney than others, for reasons that can be prevented. The difference in average life expectancy between residents in one place compared to another is the kind of gap we want to close.



Across Norfolk & Waveney differences in life expectancy can be seen in each district footprint. There is a 11.9 year age gap between the lowest life expectancy in Norfolk and Waveney (72.2 years as seen in North Lynn & Yarmouth Parade) and the highest (84.1 years seen in Eaton).

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This gap in life expectancy is even bigger for some groups, such as those who are homeless, or with a learning disability.



**Norfolk insight** is our local data hub where anyone can look online at local data about the population of Norfolk and Waveney. We know who lives in poor health, who dies earlier from preventable illnesses, who has worse health outcomes, where they live and much of the time, why they have worse outcomes.

We know that people are dying earlier from preventable illnesses in some communities, with around half (men) to a third (women) of these due to circulatory diseases and cancer in Norfolk.

You can find more data relating to health inequalities by [clicking here](#).

We have also been speaking to our communities that experience inequalities to better understand the barriers and build a rich picture to help close the health gap between groups.

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## Who will we reach?

Although we have a lot of data telling us about the different outcomes in our communities, we also want to make sure that we are listening to those who are seldom heard, and that people are able to speak for themselves. To help write this framework, we have asked people who experience health inequalities directly, what the issues are that affect them the most.

## Community Voices

### Using your feedback to improve care

We have targeted these conversations towards the groups that experience the greatest differences in health outcomes, working with our trusted communicators across sectors through our Community Voices programme.

These conversations highlight how important it is to understand how residents who experience health inequalities live and work, those factors that influence their health behaviours and what makes it difficult or possible to access services.

The summary below highlights some of what we have heard and more information can be found in our [summary reports here](#).

"Living in poor housing adds to (my) health issues and stress"

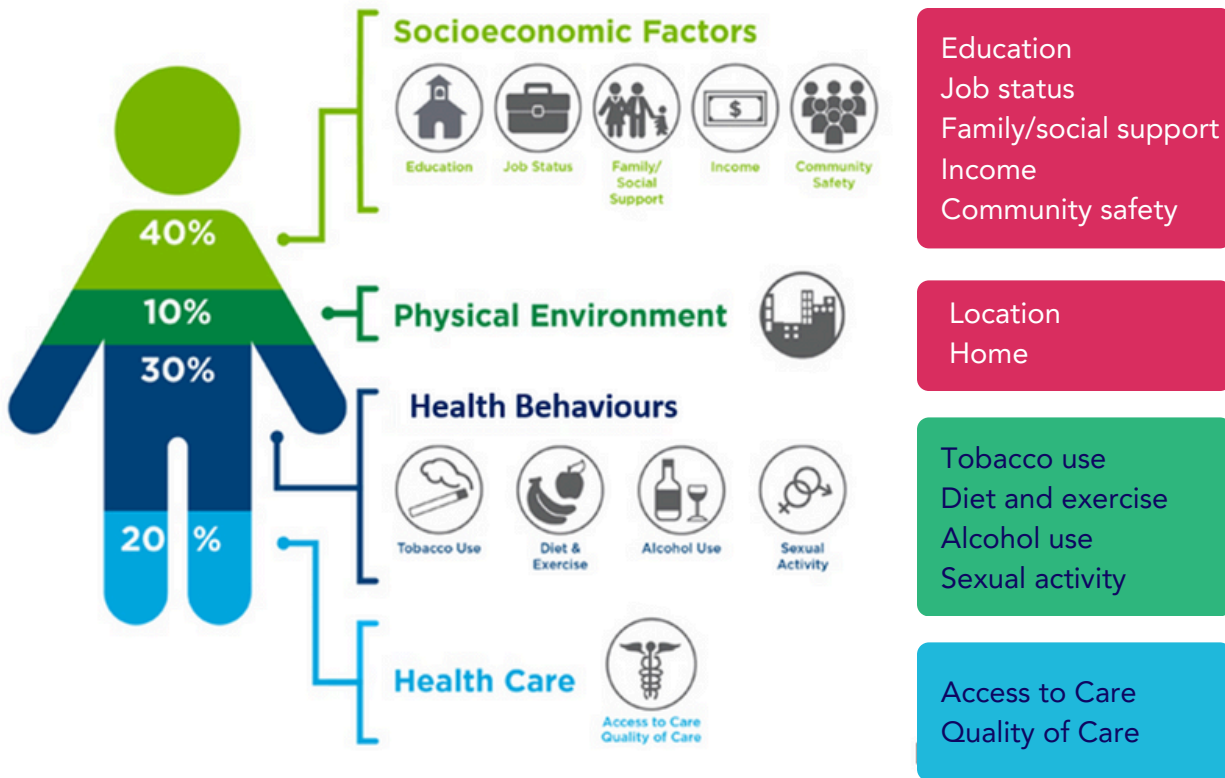
"Gp has told them they must quit (smoking) due to heart condition. Has tried vapes and tablets (chamix) . Finds current living condition very stressful and feels that quitting now would be a huge stress 'on top of everything'..... Has anti social neighbours and black mould caused by an issue with leak in flat above. Doesn't feel in 'right place mentally' to quit"

"Some residents have concerns they are treated differently due to being a migrant or having a language barrier. Many report a lack of trust in the NHS, often stemming from miscommunications or feeling unheard"

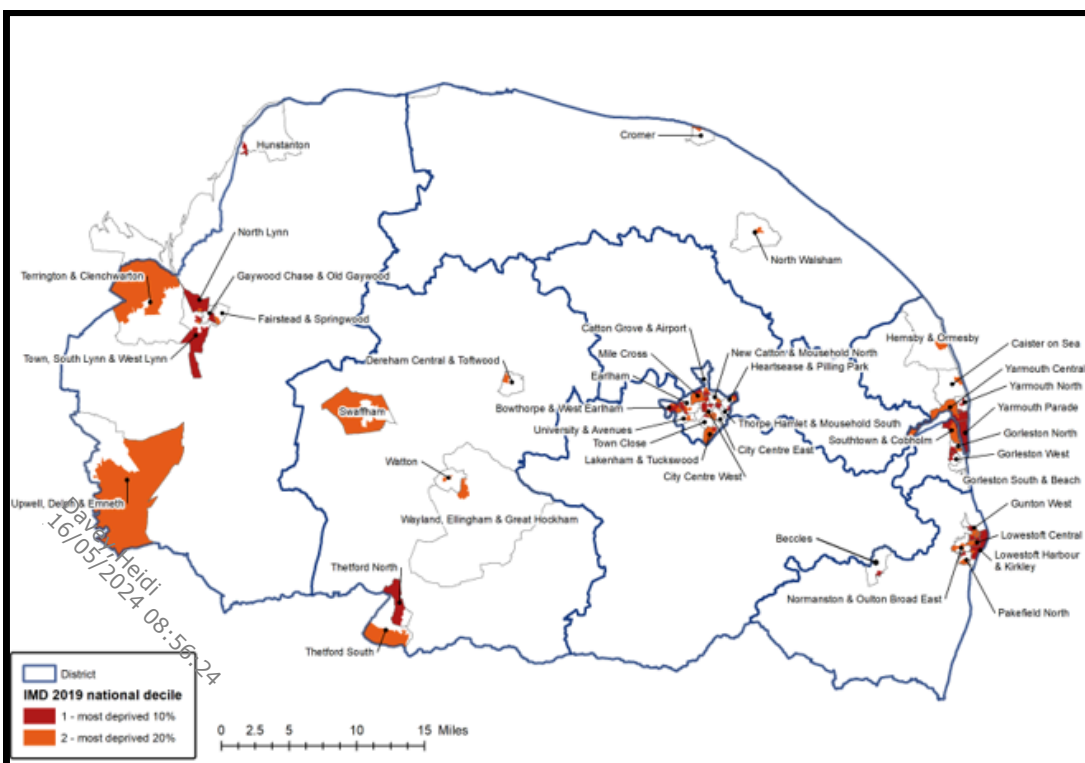
[recently left prison] he has not been able to sort his benefits for the last 5 months and is living on a very limited budget for food which is also playing a big part in his illness [diabetes] and feels he cannot afford to spend what little money he has on a nutritious diet that he needs to try and keep healthy"


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Our Community Voices conversations highlight why action should not be limited to health services alone. The causes of disease begin long before someone sees a health professional as outlined below. This image clearly shows the 'building blocks' for good health.



The NHS has identified the communities and groups we should focus on as the 'Core20plus' communities. These are the people living in the most deprived areas and vulnerable people in the local area, who are referred to as the 'plus groups'. Our most deprived 'Core20' communities are highlighted in the map below - we have 42 of these in Norfolk & Waveney.





The Norfolk & Waveney 'plus' groups have been locally defined and agreed. These are:



- Ethnic minority communities
- Inclusion health groups
  - People experiencing homelessness
  - Drug & alcohol dependence
  - Vulnerable migrants
  - Gypsy, Roma and Traveller communities
  - Sex workers
  - People in contact with the justice system
  - Victims of modern slavery
- People with a learning disability, neurodiversity and autistic people
- People living in coastal and rural communities
- Young carers and looked after children
- Armed forces community

We have produced some fact sheets which give more information about each of our plus groups, [which you can find here.](#)

Health services have a clear call to action outlined via the Core20plus5 health equality improvement frameworks, which map where the inequalities are nationally, and what the NHS should focus on locally. The frameworks also include 5 clinical priority areas, and there is a framework for adults and a framework for children and young people. You can find out more information about the [adult framework here](#) and more about the [children and young people framework here](#).

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## What difference will we make?

**Residents** who face the worst health outcomes will:

- Be able to access the right services more easily and get the right support to improve their health and wellbeing.
- Have more say about services, especially feedback on whether they are working well.
- Live longer, healthier, happier lives.

**Organisations** involved in improving the health of residents will:

- Commit to working together more effectively to tackle the causes of health inequalities.
- Have a common language and purpose and commit to improving outcomes for residents experiencing inequalities.
- Recognise and respond to risk for specific groups, with good quality information and understanding of need and be supported to enable this.
- Detect and manage need early, targeting resources based on preventing further ill health.
- Increase their effectiveness through a healthy and diverse workforce.
- Understand that not taking action early has a negative financial impact on organisations, and worse health outcomes for residents.

## Existing commitments



Our organisations and leadership are not new to trying to prevent unfair and avoidable differences in experiences and early deaths from preventable illness. Listed below are the ICS strategies and approaches that include commitments relating to health inequalities. This framework will help to deliver them and a summary of their existing objectives [can be found here.](#)

## Our Guiding Principles

Through our Health Inequalities Conversation we have developed the following guiding principles that we ask our partner organisations to adopt. These are guidelines for decision making.

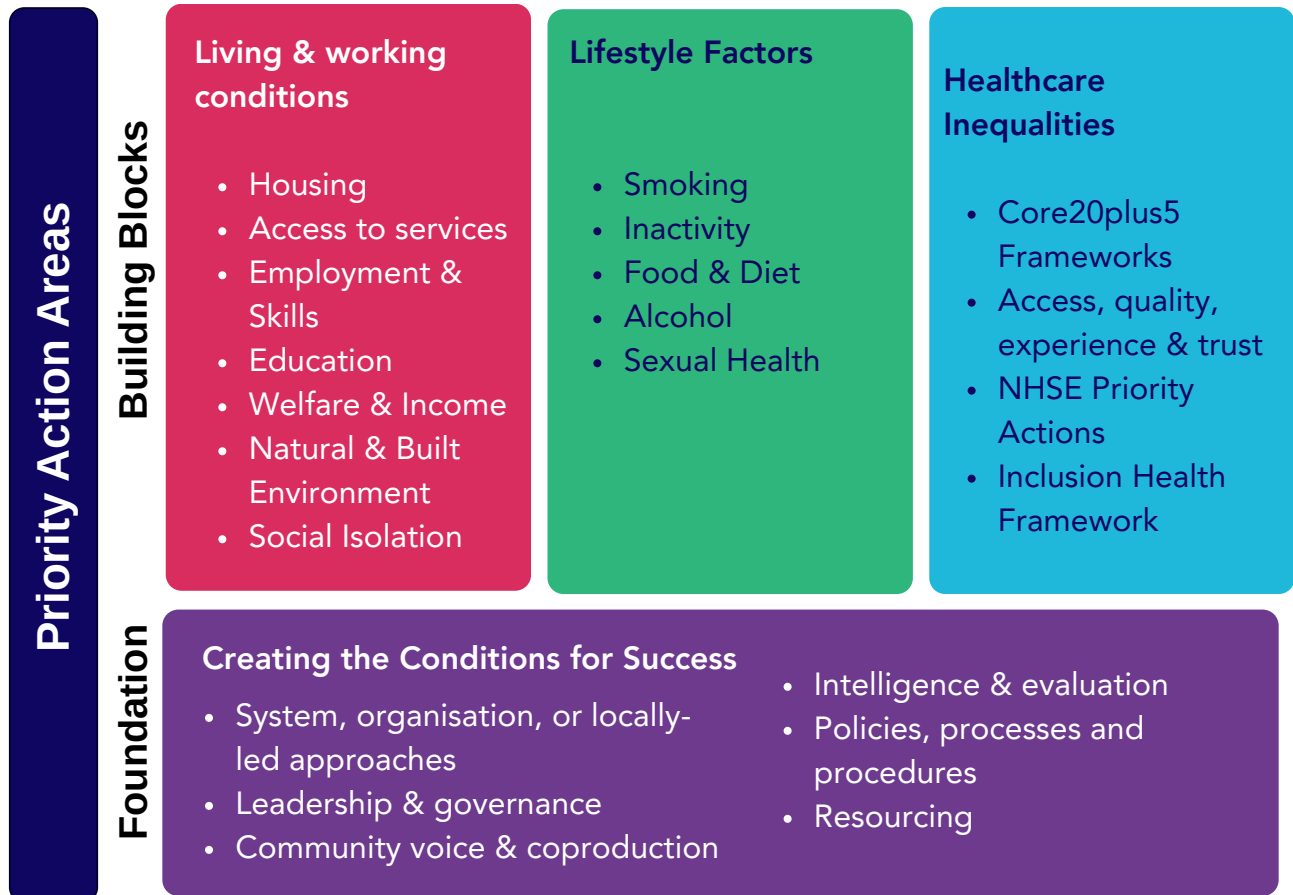
- **Everyone needs something, some people need more.**
- **We know we can make a difference, and this is a long-term commitment.**
- **Enabling communities to have a voice is key and requires creativity and persistence.**
- **We will work as close to people and communities as possible.**
- **Our approach must be personalised to ensure the right action at the right time for the right individual.**
- **We will ensure accessible services for those in greatest need.**
- **We will take an approach that includes consideration for families and all stages of life.**
- **Leading for change requires shared responsibility, collaboration and enduring focus.**
- **We will understand who is accessing our services, who isn't and why in order to act.**
- **Recognising the building blocks for good health & wellbeing are not just in health services.**
- **Building fairer services means supporting change in our organisations.**

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## Our priority areas for action

Through our Health Inequalities Conversation we have determined our priority areas for action, as described below. We refer to these as our **'building blocks'** and our **'foundation'**.



### Living and working conditions

The well-being of a community depends on many things, including education, housing, employment, and access to good healthcare. These factors can affect a person's health throughout their life and can also contribute to health inequalities. (Marmot, 2010). They are also often linked. For example, someone who is unemployed may have a harder time finding good housing and may not have access to healthy food or green spaces.

To address these issues, we need to focus on spending money where it is needed most, to make sure everyone has the same chance at good health. This means investing in the root causes of health inequalities and making sure resources are distributed where there is need. (The King's Fund, 2022).

This may very well be at place level in order to meet local need, and be delivered by organisations and people who know the place and community best.

## Lifestyle factors

The choices we make in living our lives impact our health and wellbeing. The impact of smoking, choosing unhealthy foods to eat, not getting enough exercise, and too much alcohol are known as behavioural risk factors. These are a major challenge for health and social care for all residents, not only those communities that experience inequalities in outcomes.

These factors increase our chances of developing chronic conditions like heart disease, cancer or diabetes and can lead to early death. Health inequalities increase the risk of becoming ill and living in poor health among some groups in society and can be seen and measured as a result.

## Health and care services

Health and care services are there to maintain and improve our health. The original focus of the NHS was the diagnosis and treatment of disease. Now it plays more of a part in both preventing ill health and improving the physical and mental health of the population.

Health and care services are structured to meet *everyone's* need which at times makes it difficult for some groups or people to get access. This can be due to examples like services not being available, adjustments not being made for disability, people having challenges being understood because of language barriers, or discrimination.

The NHS has legal duties relating to health inequalities, and there are 5 Urgent Actions that are identified in NHS operational planning guidance, which will require a partnership approach to implement. [More information about these duties to address health inequalities can be found here.](#)

Please go to the ICS health inequalities webpages for case studies that give examples of the work underway in Norfolk and Waveney by [clicking here.](#)

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## Creating the Conditions for Success

This framework for action is ambitious. We have to work together building on our successes so far, sharing our knowledge, tools and resources to drive change. If we are going to make a difference to health outcomes, so people have a fairer chance to live longer and healthier lives, we have to change the way we work within our organisations and together and with our communities.

Navigating our different duties, relationships, structures and priorities is going to be difficult. However, this is the chance to work more closely with communities, understanding better how we can do differently, and leading more effectively.

## Leadership & Governance

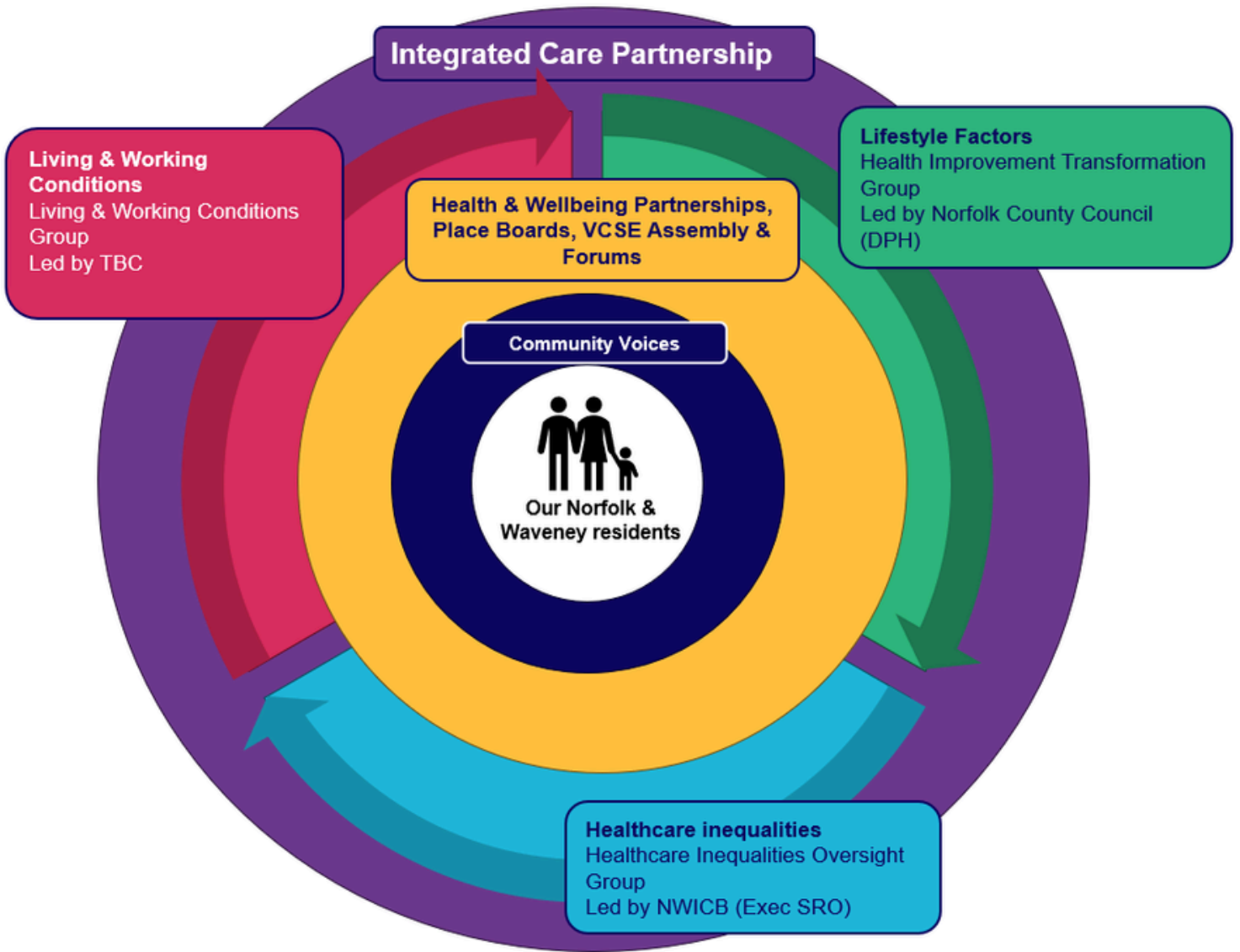
We recommend a leadership and governance structure for health inequalities that maximises our existing resources and expertise and responds to the benefits of working locally.

This proposed structure enables us to share, learn and scale what works and understand what doesn't. This is about what we can do together and all parts of our Integrated Care System have a role to play - this includes our district, city, borough and county councils, Voluntary Community & Social Enterprise (VCSE) sector, the NHS and the independent sector.

Our Norfolk & Waveney Integrated Care Partnership brings together health and social care providers, local government, the VCSE sector and other partners. It will provide oversight and ensure the Health Inequalities Framework is delivered.

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# How we will organise ourselves



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## Action within our organisations

Our organisations already make a huge difference to the wellbeing of people living in Norfolk and Waveney right now. Closing the gap so that everyone has a fair chance; stopping the early deaths of vulnerable people, will mean doing some things differently. Organisations involved have a number of ways to make this happen, for example:

- By embedding these guiding principles in their organisational action plans and ways of working
- As 'anchor institutions' working locally to lead by example as an employer and estate owner, as well as through buying power (see below diagram).
- Through good quality equality impact assessments, complaints procedures or by embedding a requirement for social value in contracts.
- A commitment to training and learning.
- Through sharing good practice and intelligence to inform action
- Through a commitment to actively listening to people, especially the most vulnerable
- Through robust data collection and sharing

This isn't everything we can do, and we have outlined below what some of this might look like. UCL Partners, an organisation working alongside NHSE, have produced a useful toolkit that you can [find here](#), which helps anchor organisations understand 'how strong is your anchor' currently.

## Anchor Institutions

First developed in the United States, the term anchor institutions refers to large, typically non-profit, public sector organisations whose long-term sustainability is tied to the wellbeing of the populations they serve.



**Purchasing more locally  
and for social benefit**



**Using our buildings and spaces  
to support communities**



**Work more closely  
with local partners**



**Widen access  
to quality work**



**Reduce our environmental impact**

As anchor institutions we can influence the health and wellbeing of communities simply by being there. But by choosing to invest in and work with others locally and responsibly we can have an even greater impact on the wider factors that make us healthy.

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## Acting as close to communities as possible

Organisations often come together around a 'place'. This might be a few streets, a neighbourhood, a council footprint or a health system boundary. Local services and people have a good idea of what works for them, and how it is best to go about making change happen. There are ways in which people in communities and organisations can plan their place together, that helps identify where the greatest need is, and what the best approach is for that place. This might not be the same everywhere as every place is different.

Place-based partnerships are an important vehicle for tackling health inequalities. They bring together organisations at a local level, including district councils, VCSE organisations and health and care services, to enable greater understanding, connectivity and collaboration.

Place-based partnerships will be supported to close the gaps between groups, through the update and production of tools and guides. Place-based structures will play a key role in developing the action plans for each of the building blocks, with the **Health & Wellbeing Partnerships** coordinating action relating to **Living & Working Conditions** and **Lifestyle Factors**, and **Place Boards** coordinating action relating to **Healthcare Inequalities and Creating the Conditions for Success**.

## Empowering communities

The Voluntary, Community & Social Enterprise (VCSE) sector plays an important role in addressing health inequalities.

The VCSE sector is a vibrant and creative sector that can lead the way to finding solutions to local health issues. Rooted in communities with established relationships in place, the sector has long been acting as 'trusted communicators' highlighting community need and assets. The sector offers the opportunity for better connection to those who experience the worst health disadvantage. The Covid 19 Pandemic response also reinforced that the VCSE sector is able to shift focus, respond quickly and help meet immediate need.

The VCSE sector are powerful partners needed to succeed in transforming health inequalities, promoting community wellbeing and ensuring equitable access to healthcare. In order to do this successfully more needs to be done to empower organisations in the sector. Therefore, this framework for action commits member organisations to the development of a VCSE partnering work programme, as well as the continued development of a VCSE Assembly that complements what is already in place.

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## Acting together as a 'system'

The word system has different meaning for different people. Simply put it means organisations coming together to tackle a common goal, considering the desired outcome rather than individual organisational interests.

We need to better coordinate our action to tackle health inequalities as a 'whole system' , so that we can join up and coordinate our existing work, share best practice, scale what works and understand better what doesn't.

Our proposed structure will establish and further develop three groups all of which are to be representative of our Integrated Care System, that will drive further action relating to our building blocks:

- Living & Working Conditions Group to drive action relating to **Living and Working Conditions**
- Health Improvement Transformation Group to drive action relating to **Lifestyle Factors**
- Population Health & inequalities Board to drive action relating to **Healthcare Inequalities**

Further to these groups we will seek to establish a Health Inequalities Coordination Group overseen by a Strategic Steering Group and made up of system partners that will drive implementation of the overall strategy with particular emphasis on **Creating the Conditions for Success.**

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## Summary of key actions

We have set out here what actions we think need to take place first so that people across all organisations are confident they can tackle local health inequalities. These are based on our Health Inequalities Conversations - what we need to do to make this commitment happen.

We plan to take these **10** actions in the first **12** months of implementation, by 1 June 2025. The Taskforce will be responsible for making sure these actions happen.

<p><b>Communications &amp; Pledges</b></p> <p>We will continue our 'Health Inequalities Conversation' and roll out a programme which includes commitments and accountability.</p>	<p><b>Governance</b></p> <p>We will identify named Senior Responsible Officers/Leaders, Organisational Leads, Clinical leads and Health inequalities champions.</p>	<p><b>VCSE Integration</b></p> <p>We will further develop the VCSE Assembly, integrate the VCSE sector into all parts of our planning &amp; decision making and support volunteering.</p>
<p><b>Action Plans</b></p> <p>We will produce action plans for each of our building blocks, using existing assets and with our place and system structures working closely together.</p>	<p><b>Self Assessment</b></p> <p>We will assess where we are, what good looks like, what we need to do next. We will include actions for anchor institutions.</p>	<p><b>Organisational Development</b></p> <p>Including a suite of tools and training, a learning centre to share good practice and case studies, and a health inequalities champions network.</p>
<p><b>Resources</b></p> <p>Mapping the flow of health inequalities resources &amp; spend across organisations to further develop the business case for investment.</p>	<p><b>Intelligence</b></p> <p>Implement our Population Health Management Strategy, so that we get better at collecting and using data and insights</p>	<p><b>Monitoring</b></p> <p>A Health Inequalities Outcomes Framework developed with clear metrics and targets identified to keep us on track</p>

<p><b>Participation</b></p> <p>Develop a common approach to engaging our communities that experience health inequalities to enable access to services and ensure voices are heard with equity. We will ensure coproduction with experts by experience.</p>
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## Key commitments

### Short term actions (year 1)

- Focus on our foundation – improving our ways of working to create the conditions for success
- Strengthen our leadership, governance and partnership working
- Understand our baseline - map and coordinate existing activity and identify gaps
- Clarifying the actions required around our building blocks to further our impact

### Medium term actions (2-5 years)

- Implementing our action plans, and understanding our impact
- Organisations taking action utilising the tools provided
- Aligning the action between our building blocks - creating a Health Equity focus
- Measurable differences in our ways of working – improvements on our baseline

### Long term actions (5 – 10 years)

- Tackling health inequalities part of our 'business as usual' via a confident and competent workforce
- Demonstrable impact on the metrics within our outcomes framework

Davey, Heidi  
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Agenda item: 08

<b>Subject:</b>	<b>Norfolk All Age Autism Strategy 2024 to 2029</b>
<b>Presented by:</b>	<b>Tracey Walton - Autism Commissioning Manager Karen Dures - Strategic Business Lead - Autism</b>
<b>Prepared by:</b>	<b>Tracey Walton - Autism Commissioning Manager Karen Dures - Strategic Business Lead - Autism</b>
<b>Submitted to:</b>	<b>ICB Board Meeting</b>
<b>Date:</b>	<b>22 May 2024</b>

**Purpose of paper:**

**Purpose of paper:**

To ask the ICB Board to endorse the refreshed Norfolk All Age Autism Strategy for 2024 to 2029 and agree that the ICB will work with the Norfolk Autism Partnership Board to develop a delivery plan.

**Executive Summary:**

**Background:**

There is a requirement under the Autism Act 2009 for local areas to develop and implement an autism strategy. Through a co-produced approach, the Norfolk Autism Partnership Board has refreshed the Norfolk All Age Autism Strategy for the next five years.

**Report**

The refreshed Norfolk All Age Autism Strategy 2024 to 2029 (see attached), builds on and replaces the Norfolk All Age Autism Strategy 2019 to 2024, [‘My Autism, Our Lives, Our Norfolk’](#).

The refreshed Strategy meets the requirement under the statutory guidance for the Autism Act 2009 for local areas to develop and implement an autism strategy. It also takes account of the [national all age autism strategy](#) and local strategies which may be relevant for autistic people, such as the learning disability, SEND and alternative provision, carers, suicide prevention and eating disorders strategies.

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To co-produce the strategy, the Norfolk Autism Partnership Board (NAPB) set up an Autism Strategy Reference Group. This group included autistic people, members of the NAPB and statutory bodies working together to oversee the refresh of the strategy. This group then obtained the views of autistic people, parents/carers and those who work with autistic people. The strategy sets out what autistic people, their parents/carers and those supporting them have told us is important to them, and the changes that are needed to improve the lives of autistic people in Norfolk.

The strategy shares the NAPB’s vision for improving the lives of autistic people in Norfolk, and the priorities which partner organisations will work on over the next five years, to achieve this vision.

A summary of the Norfolk All Age Autism Strategy (see attached) has also been developed.

The NAPB is asking the ICB Board and other partner organisations to endorse the strategy and agree to work with the NAPB to develop a delivery plan.

Following endorsement of the strategy, the NAPB will publish the final version and will start work with partners to develop the plan. The plan will set out the key actions that partner organisations will take towards achieving the priorities of the strategy. It will be updated each year from 2025 to 2029 and will be monitored by the NAPB. By January 2029, the NAPB will start work to refresh this strategy for 2030 onwards.

**Recommendation to the Board:**

- The ICB Public Board is asked to:
- a) Endorse the refreshed Norfolk All Age Autism Strategy for 2024 to 2029.
  - b) Agree that the ICB will work with the [Norfolk Autism Partnership Board](#) to develop a delivery plan.

<b>Key Risks</b>	
<b>Clinical and Quality:</b>	N/A
<b>Finance and Performance:</b>	N/A
<b>Impact Assessment (environmental and equalities):</b>	N/A
<b>Reputation:</b>	
<b>Legal:</b>	
<b>Information Governance:</b>	N/A
<b>Resource Required:</b>	N/A
<b>Reference document(s):</b>	
<b>NHS Constitution:</b>	N/A
<b>Conflicts of Interest:</b>	N/A

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<b>Reference to relevant risk on the Board Assurance Framework</b>	N/A
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**Governance**

<b>Process/Committee approval with date(s)</b> (as appropriate)	
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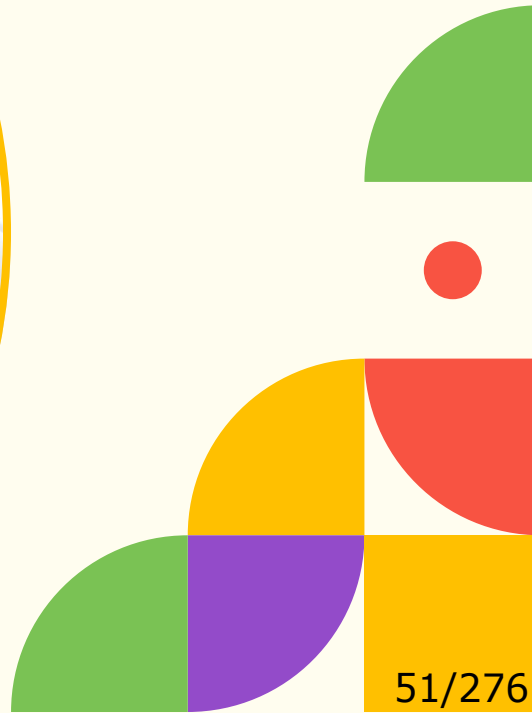


NORFOLK  
AUTISM  
PARTNERSHIP

# NORFOLK'S ALL AGE AUTISM STRATEGY

## JUNE 2024 TO 2029

### SUMMARY





# NORFOLK AUTISM PARTNERSHIP



**A partnership of autistic people, parents, carers, and voluntary and statutory organisations working together to achieve an autism-friendly Norfolk.**

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# Foreword

**This is a summary of the refreshed strategy.**

**It builds on and replaces the Norfolk All Age Autism Strategy for 2019 to 2024, 'My Autism, Our Lives, Our Norfolk'.**

**This strategy is for autistic people of all ages, their parents, carers and families, those supporting them and anyone who has an interest in autism in Norfolk.**

**This refreshed strategy builds on 'My Autism, Our Lives, Our Norfolk' which was a five-year strategy from 2019 to 2024.**

**This strategy reflects the improvements that have happened since 2019, and the changes that autistic people in Norfolk have told us they want to see over the next five years, from 2024 to 2029.**

**The refreshed strategy also reflects changes in national guidance and policies, so that our local priorities and actions can be as effective as possible. It takes account of other local strategies that may be relevant for autistic people.**

**700,000 autistic adults and children in the UK  
1 in 100 people are autistic**



# Introduction and vision

**'My Autism, Our Lives, Our Norfolk' and this refreshed strategy set out a vision for the future.**

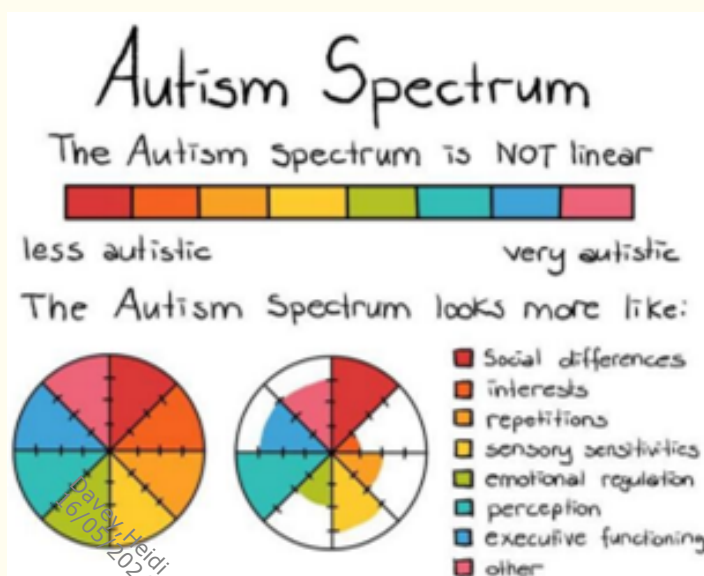


## Our Vision

**All autistic people, their parents/carers are accepted, understood and treated as equal members of the community.**

**That there is a greater awareness and understanding of autism by people that live and work in Norfolk.**

**That this understanding will enable autistic people to have the same opportunities as everyone else to live a fulfilling and rewarding life and achieve their life's ambitions.**



**This strategy uses the term 'autistic people'. Autistic members of the NAPB said that they prefer 'identity first' language ('autistic people' rather than 'people with autism'). Identity first language reflects the view of many autistic people that their autism is part of who they are, not something separate.**

**Autism is a lifelong condition that affects how people communicate and how they experience the world around them.**

# The priorities

These are the areas the Norfolk Autism Partnership will work on to achieve the vision.

This summary includes the key themes that people said are important to them, for each of these priorities.

**1** Improve understanding and inclusion of autism

**2** Improve access to education and support transitions into adulthood

**3** Support adults into employment

**4** Tackle health inequalities for autistic people

**5** Build the right support in the community

**6** Improve support within the criminal and youth justice system

To find out more information you can read the full version of the strategy.

This says more about what is happening nationally and locally, and what people said is important.

Davey Hill  
16/05/2024 09:56:24



**1**

**Improve understanding and inclusion of autism**

**21% of Norfolk autistic people felt more included in their communities compared to 2019**

**24% of autistic adults in the UK think public understanding has improved**

Davey Hill  
16/05/2024 08:56:24

**By 2029, we want Norfolk to be a much more autism-inclusive county, where Norfolk's autistic population are included in society, feel safe and welcome.**

**We want to improve understanding of autism within the general public, and among those providing support and services to autistic people.**

**Awareness seems to have increased, but I don't feel like it has translated to real inclusion.**  
**Norfolk Resident**

**I note there is in general, a shift (for the better) in people's awareness and understanding of the needs of autistic people and there are more considerations in services (i.e. supermarkets, cinemas, etc) of how to adjust to meet the needs of autistic people.**  
**Norfolk Resident**

**People said these themes are important to them:**



**Better understanding of autism within society**



**Better understanding of autism within public services**



**A Norfolk autism directory of support**



**Autistic people fully involved in planning, delivery and monitoring of the strategy**



**Independent advocacy available**



**A quiet space available within communities and hospitals**



**2**

**Improve access to education  
and support transitions into  
adulthood**

**2 new autism schools and  
13 autism specialist  
resource bases**

**Fewer autistic  
children access a specialist  
resource base compared  
to other local  
authorities**

Heidi  
18/05/2024 08:56:24

**By 2029, we want autistic children and young people to get the right support so that they can flourish in education.**

**We want transitions into adulthood to improve so that young people can live well in their communities, find work or continue in education.**

“  
My son has no idea how to move forward after college and is very stressed about what the future may bring.  
”

Norfolk Resident

“  
Better planning for this transition period, thinking about aspirations, developing independence skills and access to mental health support/ support with creating and maintaining healthy relationships.  
”

Norfolk Resident

**People said these themes are important to them:**



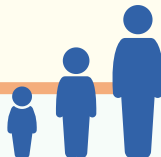
**Support in schools, colleges and other education settings**



**Listening to parents, children and young people**



**Support for home educating families and young people who are not in school**



**More support for transition to adulthood**

Davey, Heidi  
16/05/2024 08:56:24

A woman wearing a blue hard hat and a high-visibility yellow safety jacket is focused on operating a yellow surveying instrument mounted on an orange tripod. The background is a blurred outdoor construction site.

**3**

**Support adults into  
employment**

**3 in 10  
autistic people of working  
age are employed  
nationally**

**10,000  
autistic people of working  
age living in Norfolk are  
estimated to not be in  
employment**

**By 2029, we want more autistic adults to be in employment.**

**We want autistic people's experience of being in work to have improved, and for employers to be more confident about hiring and supporting autistic workers.**

“  
Many autistic people find themselves stuck in volunteering or unhealthy work environments. I think a priority needs to be to support us to find paid, sustainable employment...  
”

Norfolk Resident

“  
... support for adults when they are already in employment...  
”

Norfolk Resident

**People said these themes are important to them:**



**Support to get a job**



**Support to keep a job**



**Support for employers**



**Routes into employment and education for adults**

Davey, Heidi  
16/05/2024 08:56:24

**4**

## Tackle health inequalities for autistic people

**954**

**adults are waiting for an autism assessment in Norfolk**

**9290**

**children and young people are waiting for a neurodevelopmental assessment in Norfolk and Waveney**

*Daisy Heidi  
16/05/2024 09:56:24*

**By 2029, we want autistic people to be able to access the health support they need to live healthier lives.**

**We want to see improved health outcomes and a reduction in the gap in life expectancy that currently exists for autistic people.**

“  
ASD affects the whole experience of healthcare, and the long wait times and difficulty getting diagnosed is a significant barrier to accessing the correct healthcare and resources.  
”

Norfolk Resident

“  
People are waiting too long for a diagnosis that can put people off a diagnosis when it is needed.  
”

Norfolk Resident

**People said these themes are important to them:**



**Reduce the waiting time for a diagnosis, and provide more information and support**



**Better access to health services, through annual health checks, health passports and specialist services**



**Better access to mental health services and support to prevent people going into crisis**

Davey Jaidi  
16/05/2024 08:56:24

# 5

## Build the right support in the community



**By 2029, we want autistic people to be able to live well in their communities.**

**We want improvements in support to mean that fewer autistic people reach crisis point.**

**When autistic people spend time in hospital, we want them to be able to return home or move to suitable accommodation with the right support as soon as they are ready.**

“  
Life at home, relationships - support for neurodiverse spectrum couples and help to have a healthy relationship and family life.

Norfolk Resident  
”

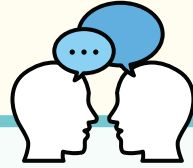
“  
More support directed towards autistic adults. Not everyone will seek out the support.

Norfolk Resident  
”

**People said these themes are important to them:**



**Early intervention such as more autism social groups, support to understand yourself and peer support**



**Support for autistic people such as a drop-in service and autism friendly guidance and advice**



**Improve social care support for autistic people**



**Support to develop independent living skills and information about housing options**

Davey Heidi  
16/05/2024 08:56:24



6

## Improve support within the criminal and youth justice system

**By 2029, we want autistic people who come into contact with the criminal and youth justice system to get the support that they need.**

**Through early intervention, we want fewer autistic people to become victims of crime or to be convicted of a crime.**

**We want those who have been convicted of a crime to get the support they need to fully engage with their sentence and rehabilitation.**

More awareness and support for reoffending programmes tailored for autistic people. Ensuring probation staff are trained to stop recall being the first option when someone with autism is struggling and can instead support them better.

Norfolk Resident

Some autistic people are coerced into criminal activity due to a variety of factors that is not a deliberate intention or awareness of hurting others, with lack of autism awareness from professionals.

Norfolk Resident

**People said these themes are important to them:**



**Early intervention  
and support to  
prevent situations  
from getting worse**



**Support in police  
stations and courts**



**Support while in  
prison**



**Support on release  
from prison**

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16/05/2024 08:56:24



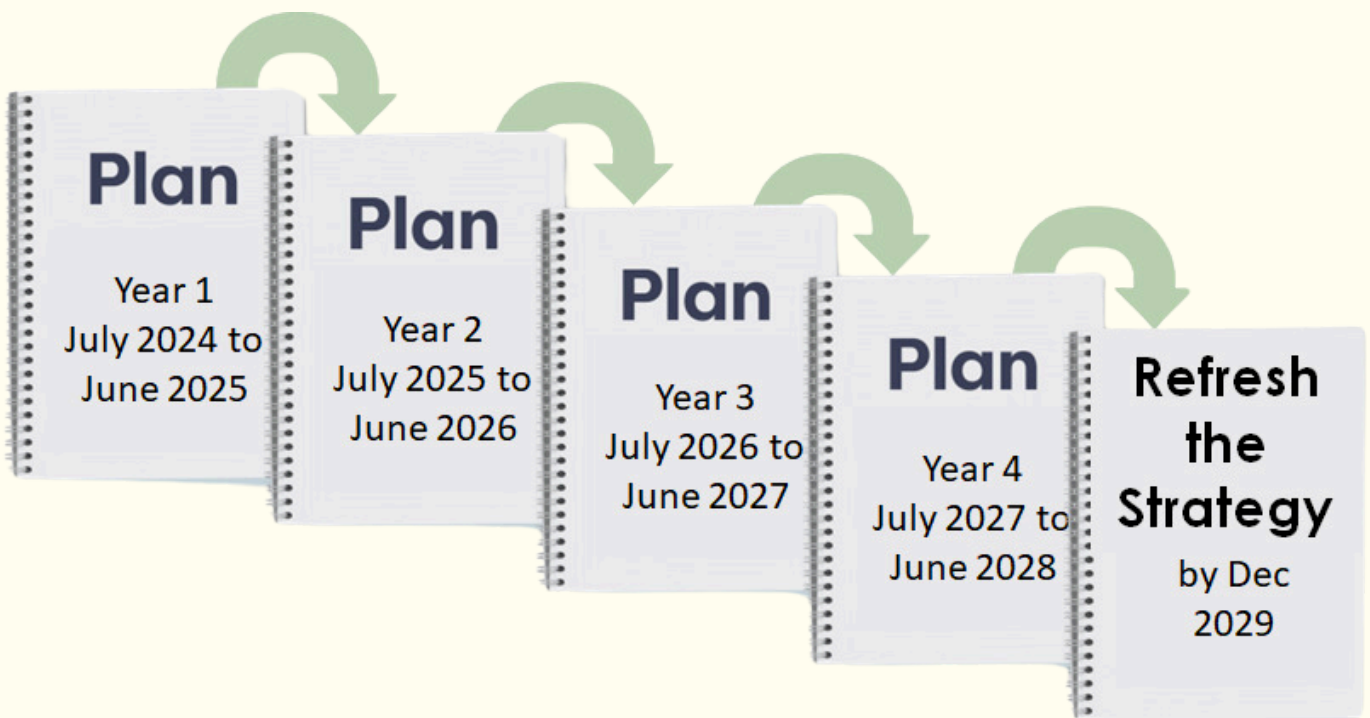
Davey Reid  
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# Putting the strategy into action

The plan sets out the key actions that we will take towards achieving the priorities of the strategy.

A new plan will be agreed each year.

The NAPB will monitor the plan and whether partner organisations are doing what they have said they will do.



To find out how this strategy will be put into practice, you can read the plan.

Will there be visibility on how funding is spent?

Norfolk Resident

Who will monitor how and when the strategy is implemented?

Norfolk Resident

Davey, Heidi  
16/05/2024 08:56:24

# How we refreshed the strategy

**This strategy is co-produced by the Norfolk Autism Partnership Board (NAPB), which includes people with lived experience of autism of all ages, including parents/carers.**

## July to Dec 2023

Set up an Autism Strategy Group made up of autistic people to oversee the refresh of the strategy

## Oct to Nov 2023

Documents, questionnaire and workbook available through the Norfolk Autism Partnership website

## July to Sept 2023

Autism Strategy Group designed and tested

- a document, animation and easy reads to share what the strategy achieved over the last 5 years and what partners plan to do over the next 5 years
- an online questionnaire and workbook, to find out what is important to people
- a webpage to share the communications
- a plan of how to encourage people to take part

Davey Heidi  
16/05/2024 08:56:24

“  
**Being part of the Autism Strategy Reference Group enabled me to feel part of a caring community dedicated to making positive change for autistic people in Norfolk.**

**Autism Strategy Group Member**  
”

**Mar to Apr 2024**

Autism Strategy Group analysed the feedback to agree the Norfolk All Age Autism Strategy's key priorities and wrote the strategy and plan

**Jan to Feb 2024**

Autism Strategy Group arranged activities to share and understand better what people said is important and check if anything is missing

**May to June 2024**

Shared the strategy with Board members and partners

Davey Heidi  
16/05/2024 08:56:24

# Who was involved?

**574 individual comments were recorded and analysed from those people who completed the questionnaire in October 2024, and those who took part in online and face to face sessions held in January and February 2024.**

The questionnaire was completed by 137 people:

- 76 autistic adults (blue)
- 2 autistic young people - aged under 18 (yellow)
- 35 parents/carers or family members (green)
- 24 professionals/other respondents (orange)

69 people took part in individual and group sessions:

- 43 people through an online session (gold)
- 20 people through a library session (grey)
- 6 people in a workshop for autistic prisoners at Norwich Prison (purple)

Davey Heidi  
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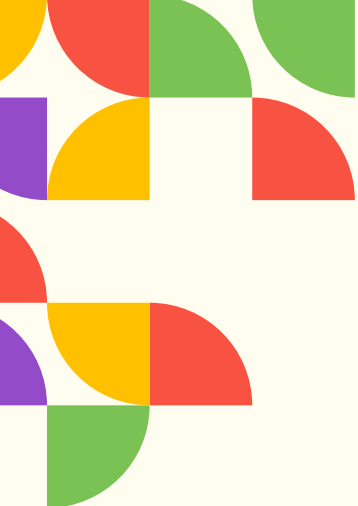
# Acknowledgements

## Acknowledgement and special thanks to the following:

- **The Autism Strategy Reference Group members for their hard work to develop this strategy and their creativity and innovative thinking.**
- **All members of the NAPB, past and present, who give their time, skills and experience. Their valuable contribution to improving services and support for autistic people of all ages is acknowledged.**
- **Those who completed the autism strategy questionnaire or attended a group or forum to refresh the strategy. All those who took part have had a major impact on this strategy by sharing their experiences and ideas.**



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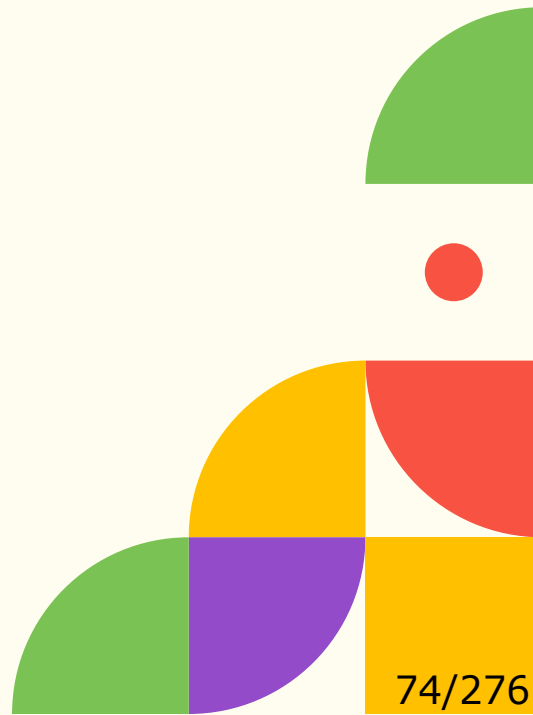
**NORFOLK  
AUTISM  
PARTNERSHIP**

# **NORFOLK'S ALL AGE AUTISM STRATEGY SUMMARY DOCUMENT JUNE 2024 TO 2029**



**A partnership of autistic people, parents, carers, voluntary and statutory organisations working together to achieve an autism-friendly Norfolk.**

*Davey Heidi  
16/05/2024 08:56:24*



# Norfolk's All Age Autism Strategy

## June 2024 to 2029



**NORFOLK  
AUTISM  
PARTNERSHIP**

Norfolk All Age Autism Partnership



A partnership of autistic people, parents, carers, voluntary and statutory organisations working together to achieve an autism-friendly Norfolk.

LOGOS WILL BE ADDED HERE

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16/05/2024 08:56:24

**DRAFT**

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Davey Heidi  
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## Foreword and acknowledgements

This is Norfolk's refreshed strategy for improving the lives of autistic people living in Norfolk. It builds on and replaces the Norfolk All Age Autism Strategy for 2019 to 2024, 'My Autism, Our Lives, Our Norfolk'.

['My Autism, Our Lives, Our Norfolk'](#) called for a greater understanding of autism, so that autistic people can live fulfilling and rewarding lives. The Norfolk Autism Partnership Board (NAPB) works to improve services and support for autistic people of all ages. In 2019 the NAPB was facilitated by Norfolk County Council, but it is now supported by an independent organisation, giving it greater autonomy. We have seen some real improvements in Norfolk since 2019, such as autism awareness training available to everyone, which was co-produced by autistic people. And the [NAPB's website](#) is expanding all the time and is a valuable source of information for autistic people and their families.

The Covid pandemic had a major impact on many autistic people, making it harder for people to get support.<sup>1</sup> But we also learned some valuable lessons from the pandemic, such as the benefits of flexible working and new ways of providing support online.

Much more needs to be done to improve autistic people's lives in Norfolk. Autistic people and their families have told us that understanding of autism still needs to improve in society and across public services. They told us that improvements are particularly needed within mental health and other health services. Autism is not a mental illness, but it is estimated that 70 to 80% of autistic people experience mental ill health, and suicide is one of the leading causes of death.<sup>2</sup> Waiting times for an autism assessment have increased, with people waiting too long for an assessment. Autistic people and their families tell us that they are not getting the support they need due to the inequalities in services they experience. We also know that an inability to record and report accurate autism data both nationally and locally creates a real challenge to effective planning of appropriate services and support for those with a primary need of autism.

<sup>1</sup> [Left stranded: our new report into the impact of coronavirus \(autism.org.uk\)](#)

<sup>2</sup> [Autism and mental health.](#)

**DRAFT**

This strategy aims to build on the ambitions of 'My Autism, Our Lives, Our Norfolk'. It sets out what autistic people, their parents/carers and those supporting them have told us is important to them, and the changes that are needed to improve the lives of autistic people in Norfolk. It is co-produced by the NAPB, which includes people of all ages with lived experience of autism, including parents/carers. It also includes people from a wide variety of partner organisations such as individuals working in healthcare, social care, education, voluntary organisations, the police and Healthwatch. Everyone involved with the NAPB is committed to improving the life opportunities of all autistic people living in Norfolk.

This strategy uses the term 'autistic people'. This is because autistic members of the NAPB said that they prefer 'identity first' language ('autistic people' rather than 'people with autism'). Identity first language reflects the view of many autistic people that their autism is part of who they are, not something separate. However we recognise that there is no single way of describing autism that is universally accepted and preferred by everyone.<sup>3</sup>

### **Acknowledgement and special thanks to the following:**

- The Autism Strategy Reference Group members for their hard work to develop this strategy and their creativity and innovative thinking.
- All members of the NAPB, past and present, who give their time, skills and experience. Their valuable contribution to improving services and support for autistic people of all ages is acknowledged.
- Those who completed the autism strategy questionnaire or attended a group or forum to refresh the strategy. All those who took part have had a major impact on this strategy by sharing their experiences and ideas.

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<sup>3</sup>Which term should be used to describe autism?

## Our vision

'My Autism, Our Lives, Our Norfolk' and this refreshed strategy set out a vision for the future:

### Our Vision:

**All autistic people, their parents/carers are accepted, understood and treated as equal members of the community. That there is a greater awareness and understanding of autism by people that live and work in Norfolk. That this understanding will enable autistic people to have the same opportunities as everyone else to live a fulfilling and rewarding life and achieve their life's ambitions.**

This refreshed strategy sets out the areas which the Norfolk Autism Partnership will work on over the next five years, from 2024 to 2029 to achieve this vision. We will do this by working together to achieve the six priorities that autistic people have told us are important:



These six priorities are linked to the priorities of the [national strategy for autistic children, young people and adults: 2021 to 2026](#). The national strategy sets out the government's vision of the changes needed at a national level to improve autistic people's lives.

**DRAFT**

**1** Improve understanding and inclusion of autism

By 2029, we want Norfolk to be a much more autism inclusive county, where Norfolk's autistic population are included in society, and feel safe and welcomed. We want to improve the understanding of autism within the general public, and among those providing support and services to autistic people.

**2** Improve access to education and support transitions into adulthood

By 2029, we want autistic children and young people to get the right support so that every child and young person in Norfolk can flourish. We want transitions into adulthood to improve so that young people can live well in their communities, find work or continue in education.

**3** Support adults into employment

By 2029, we want more autistic adults to be in employment. We want autistic people's experience of being in work to have improved, and for employers to be more confident about hiring and supporting autistic workers.

**4** Tackle health inequalities for autistic people

By 2029, we want autistic people to be able to access the health support they need to live healthier lives. We want to see improved health outcomes and a reduction in the gap in life expectancy that currently exists for autistic people.

**5** Build the right support in the community

By 2029, we want autistic people to be able to live well in their communities. We want improvements in support to mean that fewer autistic people reach crisis point. When autistic people spend time in hospital, we want them to be able to return home or move to suitable accommodation with the right support as soon as they are ready.

**6** Improve support within the criminal and youth justice system

By 2029, we want autistic people who come into contact with the criminal and youth justice system to get the support that they need. Through early intervention, we want fewer autistic people to become victims of crime or to be convicted of a crime. We also want those who have been convicted of a crime to get the additional support they may need to fully engage with their sentence and rehabilitation.

## Background

### Why do we need a new autism strategy?

'[My Autism, Our Lives, Our Norfolk](#)' was a five year strategy from 2019 to 2024. The Norfolk Autism Partnership Board (NAPB) started work to refresh the strategy in June 2023. We want this refreshed strategy to build on 'My Autism, Our Lives, Our Norfolk'. It reflects the improvements that have happened since 2019, and the changes that autistic people in Norfolk have told us they want to see over the next five years, from 2024 to 2029. We also want to make sure that the refreshed strategy reflects changes in national guidance and policies, so that our local priorities and actions can be as effective as possible.

The Autism Act (2009) was the first national legislation and guidance specifically aimed at autistic people. In 2015, the government provided statutory guidance on implementing the Autism Act.<sup>4</sup> This set out local authorities' and NHS organisations' duties to support autistic adults, and to have a local Autism Partnership Board in place. This led to the Norfolk Autism Partnership Board being set up in November 2017.

The statutory guidance also placed a duty on the government to produce and regularly review a national autism strategy to meet the needs of autistic adults in England. The most recent national strategy includes children and young people for the first time, as well as adults.<sup>5</sup> This national strategy reflects many of the priority areas that were included in 'My Autism, Our Lives, Our Norfolk', such as employment, transitions, better community services and the justice system.

In refreshing this strategy, we also need to take account of other local strategies which may be relevant for autistic people. These strategies include the [learning disability](#), SEND and alternative provision, [carers](#), suicide prevention and [eating disorders](#) strategies. Some of these local strategies are also in the process of being refreshed, so we have talked to people working on these other strategies. We talked to them to make sure that we are all working together to achieve the same priorities.

Davey Heidi  
16/05/2024 09:35

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<sup>4</sup>Statutory guidance for Local Authorities and NHS organisations to support implementation of the Adult Autism Strategy ([publishing.service.gov.uk](https://publishing.service.gov.uk))

<sup>5</sup>National strategy for autistic children young people and adults 2021 to 2026 - GOV.UK ([www.gov.uk](http://www.gov.uk))

**DRAFT**

## Who is this strategy for?

This strategy is for autistic people of all ages, their parents, carers and families, those supporting them and anyone who has an interest in autism in Norfolk.

Autism is a lifelong developmental difference that affects how people communicate and how they experience the world around them.<sup>6</sup> While autistic people share some similar characteristics, it is important to understand that everyone is unique, and autistic people have a variety of strengths as well as needs. Autism is not a learning disability or mental health condition, but autistic people can have co-occurring conditions such as a learning disability or health condition. Some autistic people are able to live independent lives, while others require specialist care and support.

The National Strategy reports that about one in 100 people are autistic, and that there are around 700,000 autistic adults and children in the UK.<sup>7</sup> However, a recent study by researchers at University College London suggest that a more realistic estimate is that between 1 to 3% of people are autistic, and that there are over 1.2 million autistic people in the UK.<sup>8</sup> This means, based on Norfolk's population there could be about 27,400 autistic people living in Norfolk.<sup>9</sup> And based on the birthrate in 2021, there could be 237 autistic babies born each year in Norfolk.<sup>10</sup>

## Approach to refresh the strategy

In June 2023, the Norfolk Autism Partnership Board (NAPB) set up an Autism Strategy Reference Group (the Strategy Group). This group included autistic people, members of the NAPB and statutory bodies working together to oversee the refresh of the strategy.

“  
Being part of the Autism Strategy Reference Group enabled me to feel part of a caring community dedicated to making positive change for autistic people in Norfolk.  
Autism Strategy Group Member  
”

<sup>6</sup><https://www.autism.org.uk/advice-and-guidance/what-is-autism>

<sup>7</sup>The national strategy for autistic children, young people and adults: 2021 to 2026 - GOV.UK ([www.gov.uk](http://www.gov.uk))

<sup>8</sup><https://www.ucl.ac.uk/news/2023/jun/number-autistic-people-england-may-be-twice-high-previously-thought>

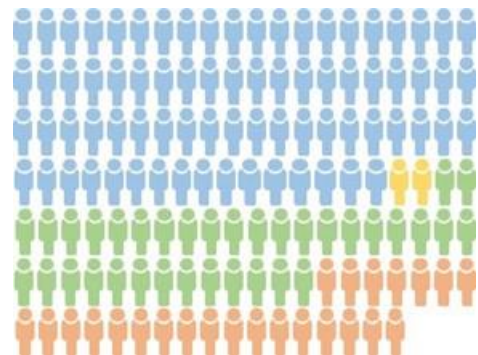
<sup>9</sup>[https://www.norfolkinsight.org.uk/wp-content/uploads/2023/08/Norfolk\\_Population\\_Overview\\_August\\_2023.pdf](https://www.norfolkinsight.org.uk/wp-content/uploads/2023/08/Norfolk_Population_Overview_August_2023.pdf)

<sup>10</sup>[Norfolk Population Overview \(norfolkinsight.org.uk\)](http://www.norfolkinsight.org.uk)

The Strategy Group designed a 'You Said, We Did' document. This explained what has changed since 2019 in response to 'My Autism, Our Lives, Our Norfolk'. It also explained what partner organisations already plan to do to improve the lives of autistic people beyond 2024. An autistic member of the Strategy Group created [an animation](#) to provide this information in a different format, and an Easy Read version was also created. The Strategy Group designed and tested a questionnaire, to find out what is important to autistic people, their parents/carers and supporters. All of these communications were checked against the [Autism Friendly Top Tips guide](#) to make sure they were autism friendly.

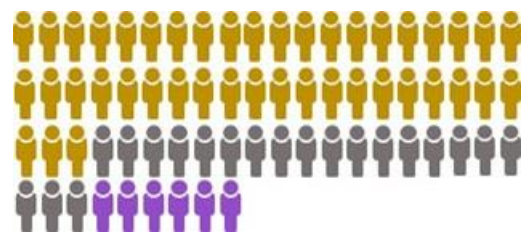
The Norfolk Autism Partnership (NAP) hosted a webpage to share the 'You Said, We Did' communications and the questionnaire, which could be completed online or as a workbook. They wrote to all members of the NAP to encourage people to take part, and shared details through partner organisations, voluntary groups and libraries across Norfolk. The questionnaire was completed by 137 people in total:

76 autistic adults (blue),  
2 autistic young people (aged under 18) (yellow),  
35 parents/carers or family members (green), and  
24 professionals/other respondents (orange).



The Strategy Group arranged further activities in January and February 2024, to give people the opportunity to say more about what is important to them. A mix of online sessions and in-person sessions in Norfolk libraries were held. 69 people took part:

43 people through an online session (gold),  
20 people through a library session (grey), and  
6 people in a workshop for autistic prisoners at Norwich Prison (purple).



The views we gathered through the questionnaire and the sessions led to the six priorities listed on page 6. 574 individual comments were noted from the questionnaire and sessions and were grouped into key themes. These key themes are reflected throughout this strategy in the sections headed 'What is important to people?'

Daisy Heidi  
17/05/2024 08:56:24

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Davey, Heidi  
16/05/2024 08:56:24

BACKGROUND

# 1

## Improve understanding and inclusion of autism

By 2029, we want Norfolk to be a much more autism inclusive county, where Norfolk's autistic population are included in society, and feel safe and welcomed. We want to improve the understanding of autism within the general public, and among those providing support and services to autistic people.

### What we know nationally

The national strategy reports that awareness of autism has increased, since the introduction of the Autism Act in 2009. It is estimated that 99.5% of the public are now aware of autism.<sup>11</sup> Although there is more awareness, there is still a significant lack of understanding about autism among the public, including what it means to be autistic and the diversity of autism. Just 24% of autistic adults and 26% of family members think public understanding has improved since the introduction of the Autism Act.<sup>12</sup>

The Equality Act 2010 places a legal requirement on public services to eliminate discrimination and advance equality of opportunities for disabled people. It also requires service providers, employers and businesses to provide reasonable adjustments for disabled people. This includes autistic people, with or without a diagnosis, provided that their autism has a substantial effect on their ability to carry out day to day activities.<sup>13</sup>

Many public sector services and other organisations are taking steps to become more autism inclusive. However, autistic people still face stigma and prejudice when accessing services or just going about their daily lives.<sup>14</sup> Many autistic people feel excluded from public spaces because these can be overwhelming, busy or noisy and because staff or the public may react negatively to autistic people. The national strategy also identifies that transport is a key issue and is central to autistic people and their families being included in their community and being able to find employment. Many autistic people find public transport inaccessible because of how anxiety-inducing, noisy and busy it can be.

<sup>11</sup>[The national strategy for autistic children, young people and adults: 2021 to 2026 - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/90422/national_strategy_for_autistic_children_young_people_and_adults_2021_to_2026.pdf)

<sup>12</sup>[APPGA Autism-Act-Inquiry-Report.pdf \(pearfoundation.org.uk\)](https://www.pearfoundation.org.uk/wp-content/uploads/2019/05/APPGA-Autism-Act-Inquiry-Report.pdf)

<sup>13</sup>[Check if you're protected from disability discrimination - Citizens Advice](https://www.citizensadvice.org.uk/disability-and-health/autism/autism-act-2009/check-if-youre-protected-from-disability-discrimination/)

<sup>14</sup>[The Autistica Attitudes Index | Autistica](https://www.autistica.org.uk/autistica-attitudes-index/)

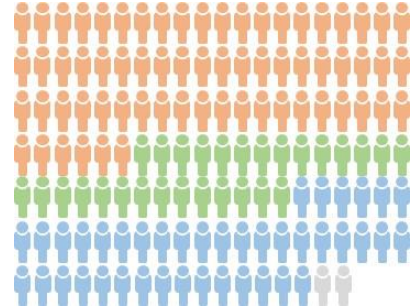
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## What we know in Norfolk

'My Autism, Our Lives, Our Norfolk' included autism awareness as a priority for 2019 to 2024. Our new priority for this strategy reflects the need to move on from awareness to better understanding and inclusion.

Our questionnaire asked people whether they thought that autistic people are more included within their communities now, compared with 2019.

48% said they were unsure (orange),  
21% said they are more included (green),  
30% said they are not more included (blue),  
1% did not answer the question (grey).



Autism awareness e-learning is available free of charge to anyone via the Norfolk Autism Partnership website. There is also a more detailed one day 'Understanding Autism' course. The Norfolk Autism Partnership co-produced, designed and created both courses with the help of Norfolk County Council and Norfolk and Suffolk NHS Foundation Trust. The courses have been quality checked and endorsed by the University of East Anglia and are annually updated.

People told us that although there is more awareness of autism, there is still a lot to be done to improve the understanding of autism within society, and in public services. In particular, autistic people raised concerns about the lack of autism awareness among staff in primary care, including GP surgeries, and the need for mandatory training to address this. They also talked about the need for better understanding among employers, as well as in schools and a wide range of other settings.

People said that there is a need for clear information about support for autistic people in Norfolk. They also told us about the importance of autistic people working with services to create information and training, and of advocacy to support people when needed. And they told us that safe spaces are needed in the community and in hospitals.

Davey Heidi  
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## What is important to people

I note there is in general, a shift (for the better) in people's awareness and understanding of the needs of autistic people and there are more considerations in services (i.e. supermarkets, cinemas, etc) of how to adjust to meet the needs of autistic people. Norfolk Resident

Awareness seems to have increased, but I don't feel like it has translated to real inclusion. Norfolk Resident

## Better understanding of autism in society

- Many people said that autism training for employers or for those providing services in community such as opticians, solicitors and hairdressers is needed. Training could also help family members of autistic people.
- People said there needs to be more understanding of autism among the general public. This includes understanding of meltdowns and shutdowns, so that people respond in a way that is helpful.
- People said that autism should be recognised as a different way of thinking to break down stereotypes.
- People said that autism should be celebrated in society. This includes having positive role models and using celebrities.
- People said that leisure services and social groups which are open to everyone (such as Scouts and Brownies) need to make adjustments so that autistic people can take part more easily.
- People said that autism friendly transport needs to be widely available, so that autistic people can get out and about, particularly if they live in rural areas.
- People said that autism alert cards should be promoted, so that autistic people can choose to use them, and the general public have a better understanding of what they can do to support autistic people.

Danny Heidi  
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- People said there could be a kitemark scheme to recognise organisations which are supporting autistic people well.

### Understanding of autism in public services

- Many people said that more training is needed for staff in settings such as schools, the police, job centres and prisons, to improve the understanding of autism. This includes making sure that staff put training into practice, and that training is mandatory. This will make sure that all staff who work with autistic people have the right skills and knowledge.
- Many people said that it is important to make reasonable adjustments based on the needs of the autistic person, regardless of whether they have a diagnosis. For example, providing a quiet place in hospitals and allowing more time to explain things. People said that reasonable adjustments should be made in schools based on the child's needs, rather than requiring a diagnosis.
- Many people said that there should be more training for staff in health and social care services. They said it is important that clinical and administrative staff in hospitals, GP surgeries, dentists and mental health services undertake the right level of training for their role.
- People said that it is important that professionals understand sensory differences (such as different ways of perceiving pain), and that they understand demand avoidance and the impact of previous trauma.
- People said there are examples of good practice in healthcare settings and schools. This good practice should be shared widely so that other services can learn from them.

### Information and Resources

- Many people said that a Norfolk directory of autism support should be created, so that autistic people and their families know what is available, and how to access it.

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## Co-production

- People said that co-production is important. They said that information for autistic people should be co-produced, and that autistic people should be fully involved in creating the plan to deliver this strategy and monitoring it. They also said that autistic people should be involved in creating training courses (such as the [free autism awareness e-learning](#)) and that it is important for autism training to be co-presented by autistic people.
- People said that the Norfolk Autism Partnership Board should reach out to younger people, to make sure that they are represented on the Board.

## Advocacy

- People said that independent advocacy should be available whenever autistic people need it. This could be to support them when accessing services such as health and social care or when applying for benefits.

## Safe spaces

- People said there is a need for safe places in the community and in hospitals. These could also provide a quiet place for autistic people when they need it.

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IMPROVE UNDERSTANDING  
AND INCLUSION OF AUTISM

## 2

## Improve access to education and support transitions into adulthood

By 2029, we want autistic children and young people to get the right support so that every child and young person in Norfolk can flourish. We want transitions into adulthood to improve so that young people can live well in their communities, find work or continue in education.

### What we know nationally

The national strategy tells us that a growing number of children and young people are being diagnosed as autistic, with special educational needs data suggesting that 1.8% of all pupils in England now have an autism diagnosis.<sup>15</sup> In spite of this, many autistic children and young people are still having poor experiences at school and are struggling in the transition to adult life. The national strategy highlights evidence that autistic children and young people often struggle to get support they need through the Special Educational Needs and Disabilities (SEND) system, including being able to access support early enough from health and social care, as well as education. In addition, staff often lack the skills needed to put in place the right plans and support for autistic young people.<sup>16</sup>

### What we know in Norfolk

The Norfolk Joint Strategic Needs Assessment for children and young people with SEND published in May 2022 found that 49% of children and young people (1267 children) on the Norfolk Register of Disabled Children in 2019 were autistic.<sup>17</sup> The JSNA also identified that the most common primary need for children in special schools is Autistic Spectrum Disorder, although the proportion is lower than the national figure (28.7% of special school pupils in Norfolk, compared to 32.4% in England).

Norfolk now has two specialist autism schools: The Wherry School in Norwich which opened in 2017, and the Duke of Lancaster school in Fakenham which opened in January 2022. Two new specialist schools are planned for 2026: a school for children with communication and interaction needs in Downham Market, and a school for children with complex needs in Great Yarmouth. Norfolk also has 13 autism specialist resource bases (SRBs) attached to mainstream schools, but the JSNA found that there are not enough places available for autistic children and young people and that the proportion of young people accessing an SRB is lower than the average in other local authorities.

<sup>15</sup>Special educational needs in England, Academic year 2022/23 – Explore education statistics – GOV.UK ([explore-education-statistics.service.gov.uk](https://explore-education-statistics.service.gov.uk))

<sup>16</sup>The national strategy for autistic children, young people and adults: 2021 to 2026 - GOV.UK ([www.gov.uk](https://www.gov.uk))

<sup>17</sup>Norfolk Joint Strategic Needs Assessment for children and young people with SEND

Norfolk County Council set up a [Preparing for Adult Life team](#) in 2020 to support young people who are likely to need support from Adult Social Services. The proportion of young people turning 18 and supported by the team whose primary need is autism has increased each year, rising from 13% in 2021 to 2022 to 26% in 2023 to 2024.<sup>18</sup>

People told us that the support for autistic children and young people in education settings needs to be improved, along with better communication with families. They also said that better support is needed for those who are not in school as some parents are not home educating through choice, but because a school cannot meet their child's needs. And people said that improvements need to be made for the transition into adulthood.

Our plans to achieve this priority need to reflect the SEND and Alternative Provision Strategy. We will identify where actions planned as a result of that strategy will help us to achieve the priorities within this refreshed strategy.

### What is important to people

Better planning for this transition period, thinking about aspirations, developing independence skills and access to mental health support/support with creating and maintaining healthy relationships.  
Norfolk Resident

My son has no idea how to move forward after college and is very stressed about what the future may bring. Norfolk Resident

### Support in schools, colleges and other education settings

- People said that good quality support in mainstream schools, colleges and universities is important. This includes support continuing from one setting to another (for example, primary to secondary school). It also includes understanding of autistic young people's mental health and sensory needs, and support for those with lower level needs, not just those with complex needs.
- People said that better resources are needed to enable teachers to support autistic students. These should also be shared with parents for a consistent approach.

<sup>18</sup>Data provided by Norfolk County Council.

- People said that schools and colleges could learn from each other by sharing good practice.
- People said that it can be very difficult to access an Education Health and Care Plan (EHCP) for those who need it, and the wait to get an EHCP should be reduced. People said that schools and colleges should be held to account if they do not provide the support listed in an EHCP.
- People said that more specialist schools for autistic students are needed, as well as better access to remote learning for those who are struggling to attend school. People said that more flexibility could enable young people to access college courses when they are ready for them, rather than being limited by their age.
- People said that autistic children and young people should get support in schools to enable them to make and keep friends. People also said that bullying within schools needs to be better addressed.

### Communication

- People said that the voices of parents and children needs to be heard in education settings, as parents can feel that they are not listened to.
- People said that autistic young people need more support to learn to speak for themselves as they become adults. They said families need better information about how they can support their child to make their own decisions, and what happens if the young person is not able to make a decision for themselves.

### Support for home educating families, and young people who are not in school

- People said it would be helpful if resources used by schools could be shared with families, so that they can use them as well.

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## Transitions into adulthood

- People said autistic young people need support to make the transition from school to college, and from education to work. This includes schools and colleges knowing about options for young people to move on to.
- People said that careers advice should focus on the autistic young person's strengths and their hopes for the future.
- People said that planning for the transition into adulthood should start in Year 9 for all autistic young people, not just those with an EHCP.
- People said that continuity is important in transitions within health care, social care and education, so that autistic young people do not suddenly lose support, or find they are being supported in a very different way.
- People said that waiting times for support from the Preparing for Adult Life Team need to be reduced, so that they can get involved earlier.

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## 3

## Support adults into employment

By 2029, we want more autistic adults to be in employment. We want autistic people's experience of being in work to have improved, and for employers to be more confident about hiring and supporting autistic workers.

### What we know nationally

The national strategy tells us that there is a significant employment gap for autistic people. The Buckland Review of Autism Employment (published in February 2024) identified that only around 3 in 10 working age autistic people are in employment.<sup>19</sup> This compares with around 5 in 10 for all disabled people and 8 in 10 for non-disabled people. Autistic people also face the largest pay gap of all disability groups, receiving a third less than non-disabled people on average. Autistic graduates are twice as likely to be unemployed after 15 months than non-disabled graduates and are more likely to be overqualified for the job they have.

Barriers to work for autistic people identified by the Buckland Review include poor preparation by employers, unfair hiring practices, unclear processes and outdated attitudes. Once in a job, many autistic people do not receive the support or adjustments they need. Only around 35% of autistic employees are fully open about being autistic at work, and the most common time for employees to disclose their autism is after starting a job. This highlights a persistent and well-founded fear of discrimination during the recruitment process.

### What we know in Norfolk

Using the estimated figures for the number of autistic people in Norfolk referred to [above](#), there could be about 14,200 autistic people aged 18 to 64 in Norfolk.<sup>20</sup> If only 3 in 10 autistic people of working age are employed, then there could be almost 10,000 autistic people of working age who are not in employment in Norfolk.

New employment schemes to support people with long-term conditions, including autistic people, have been established since 2019. These include the [Local Supported Employment](#) programme (available from late 2022 until March 2025) and [Working Well Norfolk](#). There is also the [Norfolk Employment Service](#) for people supported by Adult Social Services. In addition, the [Universal Support Scheme](#), funded by the Department of Work and Pensions, is currently being rolled out across the country. This is likely to come to Norfolk in late 2024 or early 2025.

<sup>19</sup>[Buckland Review of Autism Employment](#)

<sup>20</sup>Data shared by Norfolk County Council

People have told us that more needs to be done to support autistic people to get and keep a job and to support employers of autistic people. They also told us that there need to be more routes into employment and education for autistic adults.

### What is important to people

“ Many autistic people find themselves stuck in volunteering or unhealthy work environments. I think a priority needs to be to support us to find paid, sustainable employment...  
Norfolk Resident ”

“ ... support for adults when they are already in employment...  
Norfolk Resident ”

### Getting a job

- People said that autistic people need support to access employment based on their strengths and interests.
- People said that there are many alternatives to traditional employment which could be considered. These include apprenticeships, supported internships, self-employment, part-time or flexible working, and paid peer support roles. Being able to work or study from home also creates more opportunities for some autistic people.
- People said that recruitment processes should be adapted so that they are based on autistic people's strengths and an understanding of the challenges they experience. For example, doing a job trial rather than a traditional interview.

### Keeping a job

- People said that employers could provide a mentor for autistic employees when appropriate. Having one person to go to would make it easier for many autistic people to maintain their job.
- People said that more support should be given to autistic employees to help them to manage stress and issues at work. Autistic people sometimes feel that Human Resources processes around absence do not recognise their needs.

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- People said that autism friendly information on employment rights would be helpful. This would help autistic employees to know what support they can expect their employer to provide, and what their employer is legally required to do.
- People said that bullying in the workplace should be addressed.
- People said that autistic people should be made aware of the support available through the [Access to Work](#) scheme.

### Support for employers

- People said that there should be more information and support available to employers to help them recruit and support autistic employees.
- People said employers could share good practice with each other and be encouraged to sign up to the [Disability Confident](#) scheme. The needs of autistic people could be specifically considered, for example as a separate kitemark.

### Routes into employment and education for adults

- People said that there should be more supported employment settings for autistic people who need a higher level of support.
- People said that volunteering and work experience could provide more routes into work for autistic people.
- People said there should be more targeted support for autistic people who are on benefits, to support them to get into work.
- People said that support should be available to enable autistic adults to access education throughout their life.

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SUPPORT ADULTS INTO  
EMPLOYMENT

## 4

## Tackle health inequalities for autistic people

By 2029, we want autistic people to be able to access the health support they need to live healthier lives. We want to see improved health outcomes and a reduction in the gap in life expectancy that currently exists for autistic people.

### What we know nationally

The national strategy highlights that many people are waiting a long time for an autism diagnostic assessment. NHS data shows that in December 2023 over 170,000 people were waiting for an autism assessment in England, a 47% increase from the previous year.<sup>21</sup>

The national strategy also tells us that autistic people have poorer physical health outcomes and a lower life expectancy than the general population.<sup>22</sup> Many possible reasons for this gap have been suggested, including poor understanding of autism among health and care staff, which can lead to signs of illness being overlooked. Without the right understanding, autistic people can miss out on adjustments needed for them to engage in medical appointments, which can lead to distressing experiences and avoiding seeking medical attention.

It is estimated that 70 to 80% of autistic people experience mental ill health. This could include anxiety, depression, eating disorders or psychosis.<sup>23</sup> It is recognised that there are not enough of the right type of community services, and not enough mental health professionals who properly understand autism.<sup>24</sup>

Autism annual health checks are currently being piloted in other parts of England, to tackle the causes of poor health in autistic people and improve their physical and mental health.<sup>25</sup> These health checks already exist for people with learning disabilities, and there is evidence that they can improve health outcomes.<sup>26</sup> They are not yet available for autistic people who do not have a learning disability in Norfolk. Autistica is working with NHS England to carry out research into the effectiveness of these checks for autistic people and has created a [Health Checks Plan](#) to ensure every autistic person is offered an annual health check by 2030.

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<sup>21</sup>News item [Autism assessment waiting times](#)

<sup>22</sup>[Premature death of autistic people in the UK investigated for the first time | UCL News - UCL – University College London](#)

<sup>23</sup>[Challenges autistic people face | Autistica](#)

<sup>24</sup>[Mental Health \(autism.org.uk\)](#)

<sup>25</sup>[Autistica releases plan to ensure every autistic adult is offered a yearly, tailored health check by 2030 | Autistica](#)

<sup>26</sup>[Better Health and Care for All \(nhr.ac.uk\)](#)

**DRAFT**

The [learning from lives and deaths – people with a learning disability and autistic people \(LeDeR\)](#) programme was expanded in January 2022 to include autistic adults who do not have a learning disability. The number of LeDeR reviews for autistic people without a learning disability completed in 2022 was small, and awareness of the programme needs to be increased. The annual report found that suicide was the leading cause of death for autistic adults referred for a review.<sup>27</sup> [The national suicide prevention in England: 5-year cross-sector strategy](#) identifies autistic people as a priority group, reflecting the evidence that autistic people are up to seven times more likely to die by suicide than others, with a need for action to address this.<sup>28</sup>

## What we know in Norfolk

People have told us that more needs to be done to tackle health inequalities in Norfolk.

The NHS publishes statistics relating to waiting times for autism assessments on the [NHS Digital website](#). However, not all diagnostic services report in this way, meaning that this data is not always accurate for Norfolk. While improvements to the accuracy of the NHS Digital data are being made, commissioners report statistics to the NAPB. In January 2024, it was reported that there were 9290 children (aged under 18) waiting for a neurodevelopmental assessment in Norfolk and Waveney. And there were 954 adults in Norfolk waiting for an autism diagnostic assessment.

Norfolk's situation mirrors that across England, with waiting lists at unsustainable levels. Diagnostic services for both adults and children are unable to meet the NICE guidance stating that no one should wait longer than 13 weeks for their first appointment,<sup>29</sup> or the NHS 18 week 'Referral to Treatment' target.<sup>30</sup> Actions to reduce the waiting time for an adult autism assessment were taken in 2022 to 2023, using one off funding to complete 1119 assessments. Similar funding has been allocated for children's neurodevelopmental assessments, and this work is underway. This one off funding has helped temporarily, but increasing numbers of people being referred for assessment means that waiting times are increasing. If referrals continue at their present rate and action is not taken, the waiting times will continue to increase each month.

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<sup>27</sup>[Learning from Lives and Deaths - people with a learning disability and autistic people \(LeDeR\) - King's College London \(kcl.ac.uk\)](#)

<sup>28</sup>[Suicide and autism | Autistica](#)

<sup>29</sup>[Autism assessment waiting times](#)

<sup>30</sup>[NHS England » Referral to treatment](#)

In most cases, people have a right to choose an alternative service to complete their autism assessment, provided that service is approved by the NHS.<sup>31</sup> However, many people (including professionals) are not aware of this option.

People told us that more needs to be done to improve the support available before and after a diagnosis, and throughout life. There is some support available, such as advice and guidance from [Family Action for](#) parents and carers of children waiting for a neurodevelopmental assessment, or who have recently been diagnosed with autism or ADHD. Some sessions of post diagnostic support are also now available for adults who have been diagnosed, and a resource pack is [available online](#). There is a Living Well with Autism course which was co-produced with people with lived experience of autism, available through the [Recovery College](#) run by Norfolk and Suffolk Foundation Trust.

However, people told us that there is not enough support while waiting for a diagnosis and limited support available post diagnosis. They told us that support needs to be improved before and after diagnosis, and that ongoing support, including therapy adapted to meet their needs, should be available. People also told us that there is a lack of clinical support for issues such as sensory needs and communication.

More also needs to be done to improve mental health support across Norfolk to prevent autistic people from reaching a crisis, and for those in a crisis. People talked about the need to improve mental health services, to ensure that they are appropriate for autistic people and that mental health support is not refused due to them being autistic. People told us they are not able to access mental health support when they need it. They also talked about the difficulties resulting from a misdiagnosis (when autism is not recognised), but also how autism may overlap or be overshadowed by other conditions. This can make it hard for autistic people to have their needs met, and for professionals to offer the right support.

The local suicide prevention strategy is currently being refreshed, and recognises that autistic people are a priority group. Our plans to achieve this priority need to reflect the local suicide prevention strategy. We will work with Public Health and other organisations to consider how the actions in our strategy plan can link to the local suicide prevention strategy and improve support for autistic people.

<sup>31</sup> [Patient choice at the point of referral - Norfolk & Waveney Integrated Care System \(ICS\)](#)  
([improvinglivesnw.org.uk](http://improvinglivesnw.org.uk))

Our plans also need to take into account the local [Eating Disorders Strategy](#), as research suggests that autistic people may be more likely to experience eating disorders.<sup>32</sup> We will identify where actions planned as a result of that strategy will help us to achieve the priorities within this strategy.

### What is important to people

“ ASD affects the whole experience of healthcare, and the long wait times and difficulty getting diagnosed is a significant barrier to accessing the correct healthcare and resources.  
Norfolk Resident

“ People are waiting too long for a diagnosis that can put people off a diagnosis when it is needed.  
Norfolk Resident

### Diagnosis

- Many people said that waiting times for an autism diagnosis should be reduced.
- People said that the tools used for diagnostic assessment should be appropriate for all groups, such as women and girls, and that it is important that staff keep up to date as the understanding of autism changes.
- People said that pre and post diagnostic information and support are important. This includes information and support around regulating emotions, understanding masking and sensory differences.
- People said that there needs to be more awareness that when autism has not been recognised, this can lead to misdiagnosis of other conditions. Misdiagnosis can lead to inappropriate medication.
- People said that the diagnostic pathways need to be improved for adults who may need assessments for more than one condition, such as autism and ADHD.
- People said that a private diagnosis was not accepted by their GP in some cases, and it should be.

<sup>32</sup>[Eating disorders \(autism.org.uk\)](https://www.autism.org.uk)

## Health services

- People said that autism annual health checks would be very helpful. These have been piloted in some parts of the country but are not yet available in Norfolk.
- People said that [My health passports](#) need to be more widely promoted and followed by health professionals.
- People said that there needs to be better access to specialist health services such as Speech and Language Therapy, sensory integration assessments and support for ARFID (Avoidant Restrictive Food Intake Disorder).
- People said the support offered by the Learning Disability and Autism Nurses in the acute hospitals needs to be better known about, and that it would be helpful if it was available out of hours.

## Mental health services

- People said that mental health support for autistic people needs to be more available. This includes therapy and counselling being adapted so that they are appropriate for autistic people.
- People said that better support is needed to stop autistic people going into crisis. People also said that more support should be available when autistic people are in crisis.
- People said that crisis telephone support should be available for autistic people and that there should be an option to speak to someone with expertise in autism.

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## 5

## Build the right support in the community

By 2029, we want autistic people to be able to live well in their communities. We want improvements in support to mean that fewer autistic people reach crisis point. When autistic people spend time in hospital, we want them to be able to return home or move to suitable accommodation with the right support as soon as they are ready.

### What we know nationally

The [Building the Right Support](#) national plan was updated in 2022, and states that all autistic people should be able to live full lives in their community, in their home, with access to the care that is right for them, when and where they need it.<sup>33</sup> Too many autistic people (particularly teenagers and young adults) are still being admitted into inpatient hospital settings, often because they struggle to access community support (including social care, mental health and housing support) before their needs escalate.<sup>34</sup>

In February 2024, NHS data shows that there were 2,045 autistic people and people with learning disabilities in mental health hospitals in England.<sup>35</sup> 67% of these people are autistic. There are 210 under 18 year olds in inpatient units who are autistic or have a learning disability, and 93% of them are autistic. There has been some progress in moving people with learning disabilities out of hospitals and into the community. However, the number of autistic people who do not have a learning disability detained in mental health hospitals has increased by 100% since 2015.<sup>36</sup>

### What we know in Norfolk

NHS data indicates that there were 35 people with learning disabilities and autistic people in inpatient settings in Norfolk and Waveney in February 2024.<sup>37</sup> As a proportion of the population, this is slightly below the average for England. This number included 15 autistic people, 5 autistic people who also had a learning disability and 15 people with learning disabilities.

<sup>33</sup>[Building the Right Support Action Plan - GOV.UK \(www.gov.uk\)](#)

<sup>34</sup>[The national strategy for autistic children, young people and adults: 2021 to 2026 - GOV.UK \(www.gov.uk\)](#)

<sup>35</sup>[Assuring Transformation NHS data](#)

<sup>36</sup>[Number of autistic people in mental health hospitals: latest data \(autism.org.uk\)](#)

<sup>37</sup>[NHS Assuring Transformation data: Learning disability services monthly statistics from Assuring Transformation dataset: Data tables - NHS England Digital](#)

The Norfolk and Waveney Integrated Care System requested a [Building the Right Support peer review](#) in 2022 to look at how services for autistic people and people with learning disabilities could be improved. This involved professionals and people with lived experience from other areas visiting Norfolk and Waveney and giving feedback about the support and services available. The peer review highlighted the need to address the inequalities in services that are experienced by autistic people. [Building The Right Support](#) covers both autistic people and people with learning disability both nationally and locally. Looking separately at the needs of autistic people could provide a clearer focus, to help address the recognised inequalities in services.

Some new services for autistic people have been established in Norfolk since 2019. These include a new short-term adult social care service for adults with emerging social care needs, which was set up in January 2024. [Titan travel training](#) has been extended to autistic adults known to Adult Social Services, and some assistive technology gadgets and apps can be provided for autistic adults living in their own homes.<sup>38</sup> And an award-winning care phone was rolled out by Adult Social Services during the pandemic, supporting people (including autistic people) to keep in touch with loved ones and professionals who supported them.<sup>39</sup> [Curators of Change](#) are working with Norfolk County Council to create a Real Care Deal for Norfolk, with the intention of providing a more ethical approach to how Adult Social Services works with people and providers.

Community support available to everyone has also improved, with autism social groups now being held in libraries across Norfolk.<sup>40</sup> These groups support autistic people to meet others, to help reduce loneliness and isolation. Information about the groups is available on the Norfolk Autism Partnership's '[What's On?](#)' webpage and in local libraries.

People have told us that much more needs to be done to improve the support available in the community. They told us that early intervention is important, to prevent people's needs from escalating. They talked about the need for ongoing support for autistic people, and improvements to social care services. And they told us about the importance of housing and independent living.

Carers of autistic people also find it hard to get the support they need. A survey of carers, carried out by Carers Voice Norfolk and Waveney during the development of the [All Age Carers Strategy](#), found that 62% of carers of autistic people had found it difficult to get the support they need. This rose to 77% for those carers who were also autistic themselves.

<sup>38</sup> [Assistive technology - Norfolk County Council](#)

<sup>39</sup> [Adult Social Care digital initiative scoops silver at prestigious national awards - Norfolk County Council](#)

<sup>40</sup> Data provided by Norfolk Autism Partnership Board

Our plans to achieve this priority need to reflect the [All Age Carers Strategy](#), and other local strategies which are relevant to support for autistic people in the community, such as the [Learning Disability Plan](#). We will identify where actions planned as a result of those strategies will help us to achieve the priorities within this strategy.

### What is important to people

Life at home, relationships – support for neurodiverse spectrum couples and help to have a healthy relationship and family life.  
Norfolk Resident

More support directed towards autistic adults. Not everyone will seek out the support.  
Norfolk Resident

### Early intervention

- People said that there should be more social groups for autistic people, to prevent loneliness and provide opportunities to meet others. This includes groups in smaller places as well as large towns and a mix of in person and online groups.
- People said there is a need for support to help autistic people understand themselves. This includes support with managing their own mental health and support for late diagnosed adults.
- People said that peer support would enable autistic people to support each other. A start-up pack could enable autistic people to set up new social and support groups.
- People said that parents, carers and families need more support.
- People said autistic people could benefit from support to identify and set up assistive technology (gadgets and apps that can help people to live independently).

### Support for autistic people

- Many people said that a drop-in service available to all autistic people is needed. This would mean people could get occasional support when they need it. Several ideas were suggested for this, such as using hubs in the community, or a bus that travels around.

- People said that guidance about positive relationships is needed. This includes making friends, how to have healthy relationships, and awareness of scams, financial exploitation, and domestic abuse.
- People said that support is needed to manage life changes and transitions. This includes moving home, getting a new job, becoming a parent and bereavement.
- People said that it would be helpful to have one consistent person to go to. And when services are working with people, it is helpful for them to check in regularly with the autistic person.

### Social care services

- People said that professionals should take a whole family approach. This includes considering siblings and their needs.
- People said that more respite options are needed to support family carers.
- People said that waiting times for allocation to a social care worker should be reduced.
- People said improvements to communication and the approach taken for an Adult Social Services assessment are needed.
- People said that more flexibility would help families to use Short Breaks funding at times that work for them, and that it can be hard to provide the evidence required to access support.

### Housing and independent living

- People said that autistic people need support to develop the skills for independent living. They said that people may appear to function really well in some areas, but still need support in others. This needs to start early, but also be available throughout the life span.
- People said that more information about independent living options is needed.

Davey Heidi  
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## 6

## Improve support within the criminal and youth justice system

By 2029, we want autistic people who come into contact with the criminal and youth justice system to get the support that they need. Through early intervention, we want fewer autistic people to become victims of crime or to be convicted of a crime. We also want those who have been convicted of a crime to get the additional support they may need to fully engage with their sentence and rehabilitation.

### What we know nationally

Autistic people are over-represented within the criminal justice system as victims, witnesses and defendants. However, they often have poor experiences when they come into contact with the criminal justice system.<sup>41</sup> This can be because of poor understanding of autism among professionals, and challenges with getting the reasonable adjustments they need to support them.<sup>42</sup> There is also evidence that autistic people who are in contact with the criminal justice system often struggle to get the health and social care services they may need.

Research in 2017 found that 9% of a sample of prison inmates were likely to be autistic<sup>43</sup> and it is recognised that neurodivergent young people are also over-represented in the youth justice system.<sup>44</sup>

There is evidence that autistic people are often not provided with reasonable adjustments in police stations or courts, or with an appropriate adult to support them (even when their diagnosis was known to police). When autistic people are involved in a trial, research has found that it is common for barristers, judges and magistrates to say or do something that suggests they do not have an adequate understanding of autism.<sup>45</sup>

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<sup>41</sup> [ACGPA inquiry](#)

<sup>42</sup> [Identification and support of autistic individuals within the UK Criminal Justice System: a practical approach based upon professional consensus with input from lived experience \(careknowledge.com\)](#)

<sup>43</sup> [Neurodevelopmental disorders in prison inmates](#)

<sup>44</sup> [Neurodiversity – a whole-child approach for youth justice \(justiceinspectors.gov.uk\)](#)

<sup>45</sup> [Autistic defendants are being failed by the criminal justice system | University of Cambridge](#)

## What we know in Norfolk

Local data confirms that the proportion of autistic people within the criminal justice system is higher than the general population, even though the data only includes those with a diagnosis. 3% of prisoners accessing prison healthcare in the East of England region have a diagnosis of autism.<sup>46</sup>

The three prisons in Norfolk all now have Neurodiversity Support Managers, who provide support for autistic prisoners. Autistic prisoners told us that this support is highly valued.

Norfolk Constabulary has brought in sensory boxes to support autistic people in police stations, and any autistic people in custody should see the [Liaison and Diversion Service](#) who help to identify appropriate support. This includes provision of [appropriate adults](#) to support autistic people through the process.

[Norfolk Youth Justice Service](#) (NYJS) was awarded the Youth Justice Special Educational Needs and Disability Quality Mark in February 2023, for partnerships securing better outcomes for children and young people with SEND in the youth justice system. NYJS in partnership with Norfolk Constabulary and Norfolk Children's Services operates a diversion scheme, which successfully works to divert children away from the formal criminal justice system. The NYJS health team is a multi-disciplinary team of health professionals providing support to children, families and professionals within the service.

People have told us that more needs to be done to improve support in the criminal and youth justice systems. They talked about the importance of early intervention and the need for support in police stations and courts, and in prison. They also told us about the importance of support for autistic people when they are released from prison.

## What is important to people

More awareness and support for reoffending programmes tailored for autistic people. Ensuring probation staff are trained to stop recall being the first option when someone with autism is struggling and can instead support them better.

Norfolk Resident

Some autistic people are coerced into criminal activity due to a variety of factors that is not a deliberate intention or awareness of hurting others, with lack of autism awareness from professionals. Norfolk Resident

<sup>46</sup> Data shared by NHS England (East of England)

## Early intervention

- People said that the right support early on could help to prevent a situation from getting much worse. This includes how the police approach an autistic person, to make sure they ask questions in the right way.
- People said that autistic young people and adults are vulnerable to exploitation and need support to prevent this.
- People said there is a need for support to understand good citizenship and appropriate behaviour.
- People said that those who may be autistic and are subject to Community Sentence Treatment Requirements (CSTRs) need more support, to prevent them from re-offending.

## Support in police stations and court

- People said there is a need for advocacy to support autistic people with communication and to help them understand what is happening. This includes the availability of [appropriate adults](#) to support autistic people in police stations.
- People said that more needs to be done to make reasonable adjustments for autistic people, particularly in courts.
- People said that autism friendly information about processes in court and police stations is needed.

## Support while in prison

- People said that autistic prisoners need more support, including reasonable adjustments to make the environment more appropriate.
- People said that more support is needed for autistic prisoners to develop work skills and get a job on release.
- People said that there should be autism friendly programmes for offenders.

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## Support on release from prison

- People said that autistic prisoners need support when they leave prison. Autistic prisoners sometimes miss out on probation support due to reaching the end of their sentence through being recalled.
- People said that licence conditions should be clear and unambiguous. They said that autism friendly information in approved premises could help autistic people to understand the rules and what they can and cannot do. This could also include approved premises which are specifically for autistic people.

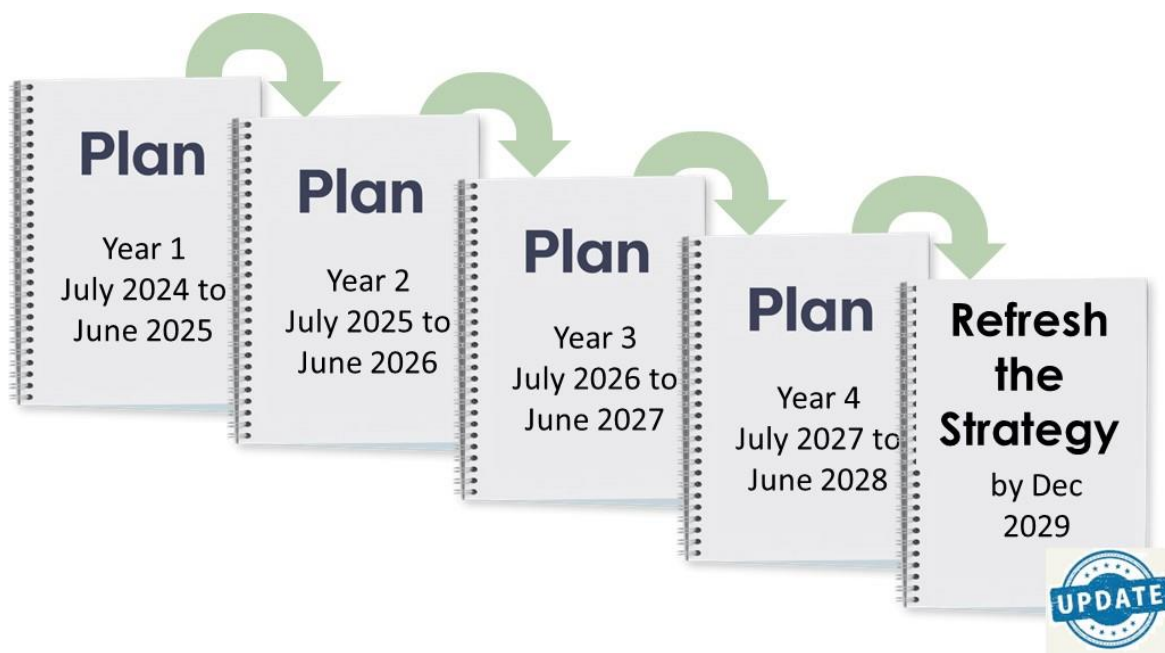
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## Making the vision a reality

This strategy should be read alongside the NAPB's strategy plan, which can be found on [their website](#). The year one plan will be developed with partner organisations from July 2024, and will be updated each year from 2025 to 2029.

The plan for each year will set out the key actions that partner organisations will take towards achieving the priorities of this strategy. The NAPB will put in place a working group which will include autistic people to oversee the development of the plan and to monitor it.

By January 2029, the NAPB will start work to refresh this strategy for 2030 onwards.



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## Glossary

**Co-production:** this is an equal relationship between people who use services and the people responsible for services. They work together, from the start to the end of a project.

**Education Health and Care Plan (EHCP):** a plan for a child or young person aged up to 25 who has complex special educational needs and disabilities. It sets out the support they need to achieve their best outcomes.

**Easy Read:** a way of making written information easier to understand by using simple language and illustrating the information with pictures.

**Healthwatch:** a statutory agency whose role is to monitor NHS services on behalf of the public and make its finding public.

**Independent advocacy:** independent advocates support people to speak up for themselves or give their views. They are independent because they do not work for the organisations that they are supporting people to talk to.

**Integrated Care System:** integrated care systems were set up by the Health and Care Act 2022. The [Norfolk and Waveney Integrated Care System](#) is a partnership of local health and social care organisations.

**Kitemark scheme:** an official scheme which awards a mark of quality and reliability to organisations which meet a required standard.

**National Institute for Health and Care Excellence (NICE):** this organisation provides evidence based recommendations for the health and social care sector, developed by independent committees.

**Norfolk Autism Partnership (NAP):** a partnership of autistic people, parents, carers, voluntary and statutory organisations working together to achieve an autism-friendly Norfolk. More information is available on the NAP's website: [Home - Norfolk Autism Partnership](#).

**Norfolk Autism Partnership Board (NAPB):** the Board which manages the Norfolk Autism Partnership. Members of the Board include autistic people, parents/carers and representatives of voluntary and statutory organisations in Norfolk. The Board meets every two months.

**Preparing for Adult Life (PfAL) team:** this team is responsible for ensuring young people make a smooth transition into Adult Social Services. They work with young people who are likely to need support from Adult Social Services when they turn 18.

Waveney Heidi  
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**Reasonable adjustments:** the Equality Act (2010) requires employers, businesses and service providers to make reasonable adjustments so that their services are accessible to everyone. For example, by being flexible about appointment times, or providing a quiet place to wait.

**Special Educational Needs and Disabilities (SEND):** usually used in the context of children and young people up to the age of 25 years.

**Specialist Resource Base (SRB):** these provide children and young people with the extra support they need within a mainstream school. [Autism SRBs](#) are specifically for autistic children and young people.

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Agenda item: 09

<b>Subject:</b>	<b>Norfolk Learning Disability and Autism Review: Tricordant Final Report</b>
<b>Presented by:</b>	<b>Joanna Yellon Director of LD&amp;A NHS Norfolk and Waveney Integrated Care Board</b>
<b>Prepared by:</b>	<b>Tricordant</b>
<b>Submitted to:</b>	<b>ICB Board</b>
<b>Date:</b>	<b>22 May 20204</b>

**Purpose of paper:**

In the summer of 2022 Norfolk CC and Norfolk & Waveney ICB commissioned a Review from Tricordant exploring how the outcomes for people with learning disabilities and/or autism (LD&A) in Norfolk, could be improved through the planning, the commissioning and provision of LD&A services.

**Executive Summary:**

**Context**

The core remit of the Review has been to recommend how the planning, the commissioning and governance of services in the Norfolk system should be developed to improve outcomes for those adults (people aged 18 and over) who have complex needs arising from LD&A.

**Summary of Stage 1 Findings**

Stage 1 summarised the current arrangements for LD&A commissioning and governance across NCC and the ICB which have incrementally and unintentionally developed over the last decade. This included LD&A not seen as a priority and no overall funding agreement.

**Summary of Stage 2 Findings**

For Stage 2 a different way of working was agreed to ensure better engagement and join up of the work of officers from the County Council and ICB and co-production with our experts by experience. A summary of the findings included Commissioning in Norfolk is fragmented, the system spends a large proportion on a small number of people, outcomes are poor, and a System strategic reset is needed in governance.

**individual workstreams**

There were 8 individual workstreams within which each area was evaluated, and the findings informed the final recommendations.

Davy Head  
 16/05/2024  
 16/05/2024

## Options

It was deemed there are three main options available for the approach taken to implement improvement; 1. Do nothing, 2, Move to a single joint commissioning system 3. A Strategic Re-set as recommended in the paper.

## Key Recommendations

1. **Declare improvement of LD&A services a priority in the next JFP.**
2. Establish an **LD&A Executive Board** to oversee LD&A across NCC and the ICB, including providers and partners with appropriate sub-groups.
3. Ensure **senior accountable ICB officer** for commissioning of specialist LD&A healthcare in ICB post restructure.
4. Agree **revised and improved commissioning structures** for LD and A in both NCC and ICB guided by Commissioning Development Plan.
5. ICB to take back accountability for **commissioning specialist healthcare services** (SHS) and lead collaborative service redesign guided by Building the Right Support National Service Model.
6. Ensure the **transfer of SHS to ICB is revenue neutral** through funding transfer agreement or reviewing LD&A elements of BCF.
7. Develop and implement **funding agreement** policies and procedures for agreeing joint service and individual care package costs including new approaches such as 'small supports scheme'.
8. Implement a programme of **business process improvement** including the creation of **shared strategic reports** underpinned by robust dataflows and processes.
9. Design and implement a **joint upstream LD&A quality** response for oversight and improvement across health and care Align and combine similar quality review processes.
10. Establish a **Strategic Workforce Planning and Delivery Steering Group**, with cross-system membership.

## Conclusion of Tricordant Report

It was felt the recommendations puts the System in a strong position to move to a much more robust and aligned commissioning position, which will also help create the conditions for better engagement of specialist healthcare providers and indeed the wider care market.

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**Norfolk County Council** (NCC) produced an additional summary document for their Cabinet illustrating in more detail the population profile, how Social Services is taking this report forward, their principles of care and how this is to be coordinated alongside the Learning Disability plan for 2023 – 2028. The recommendations to Cabinet are summarised below:

**NCC Cabinet Recommendations**

- agree the actions for Adult Social Services in the Learning Disability Plan 2023-28
- agree the actions for Adult Social Services in response to the joint review of Learning Disability and Autism
- agree the approach to working with the ICB on the commissioning of Specialist Health Services
- delegate the authority for the financial arrangements relating to the transfer of Specialist Health Services to the ICB to the Interim Executive Director Adult Social Services.

**Recommendation to the Board:**

It is recommended the Board approves the Report recommendations.

<b>Key Risks</b>	
<b>Clinical and Quality:</b>	The implementation of the Recommendations would strengthen the system’s ability to deliver clinical and quality care.
<b>Finance and Performance:</b>	The report details the financial obligations for all organisations including the risk of transfer of funding for Specialist Services and services which have had poor historic funding.
<b>Impact Assessment (environmental and equalities):</b>	The implementation of the Recommendations would drive improvement in equity for the population
<b>Reputation:</b>	The implemented Recommendations would lead to greater transparency of commissioning across the System with greater scrutiny.
<b>Legal:</b>	The Report suggests there are legal obligations for Specialist Commissioning for the ICB.
<b>Information Governance:</b>	N/A
<b>Resource Required:</b>	Needs further development for longer term strategic implications.
<b>Reference document(s):</b>	Within Report
<b>NHS Constitution:</b>	N/A
<b>Conflicts of Interest:</b>	N/A

Davy Health  
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<b>Reference to relevant risk on the Board Assurance Framework</b>	N/A

**Governance**

<b>Process/Committee approval with date(s) (as appropriate)</b>	
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# Norfolk Learning Disability and Autism Review: Tricordant Final Report

November 2023

<b>Title</b>
<b>Norfolk Learning Disability and Autism Review: Final Report</b>
<b>System Lead Directors</b>
Tricia D’Orsi – Executive Director of Nursing ICB Debbie Bartlett, Interim DASC, NCC Jo Yellon, Director of LD&A Craig Chalmers, Director of Community Social Work, NCC
<b>Author</b>
Alastair Mitchell-Baker, Tricordant
<b>Purpose</b>
To provide a summary of Review findings and recommendations to the ICB and NCC.
<b>Recommendation:</b>
To acknowledge the findings of the Norfolk LD&A Review and support recommendations to facilitate a strategic reset of the system around a more aligned and joined up approach to LD&A system planning, commissioning and governance.

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## Appendices

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## 1. Introduction

In the summer of 2022, Norfolk CC and Norfolk & Waveney ICB commissioned a Review from Tricordant exploring how the outcomes for people with learning disabilities and/or autism (LD&A) in Norfolk, could be improved through the planning, commissioning and provision of LD&A services.

A summary report of the initial Discovery phase of the work was submitted to the ICB EMT and NCC Adult Social Care Directorate Leadership Team [DLT] in March 2023. Stage 2 was started in April 2023 to develop a shared approach to the issues identified in the discovery report. An interim report was submitted to NCC and the ICB in September.

This is the final report which provides a summary of Review findings and recommendations to the ICB and NCC. It is supported by a range of more detailed documents listed in Appendix 1.

## 2. Context

The core remit of the Review has been to recommend how the planning, commissioning and governance of services in the Norfolk system should be developed to improve outcomes for those adults (people aged 18 and over) who have complex needs arising from LD&A.

Key considerations include:

- National policy and guidance for both services for people with Learning Disability and Autistic people [helpfully summarised at <https://www.england.nhs.uk/long-read/learning-disability-joint-guiding-principles-2/>]
- Norfolk Adult Safeguarding Review around Cawston Park (2021).
- Norfolk Building the Right Support (BtRS) Peer Review (2022).
- Fragile and generally poor-quality care market around LD&A.
- Major workforce challenges.
- Severe operational and financial pressures on health and social care in Norfolk
- Continued overall high levels of health inequity with people with LD&A experiencing significantly worse outcomes.
- An historic debt issue between NCC and ICB, linked to major political concerns around resolution.

## 3. Summary of Stage 1 Findings

Stage 1 summarised the current arrangements for LD&A commissioning and governance across NCC and the ICB which have incrementally and unintentionally developed over the last decade. Key aspects are:

- Norfolk 'LD&A System' has strategies, but they are not driving all actions and understanding is variable across organisations.
- LD&A has received insufficient leadership attention.
- Staff are under pressure and not working in a joined-up way ...but want to be.
- There is a lack of an overall funding agreement and no overall shared view of performance and financial information.
- There is a lot of good work, but it does not appear to be brought together in a consistent and clearly understood way across health and care and overseen by clear governance processes driving system improvement.

Davey Heidi  
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- Day-to-day decision making around individual's care is reported as often dominated by financial considerations.
- NHS senior commissioning responsibility for LD&A has been unclear which has left NCC with some difficult commissioning challenges as they have tried to compensate. Recent ICB appointments have begun to address this issue.

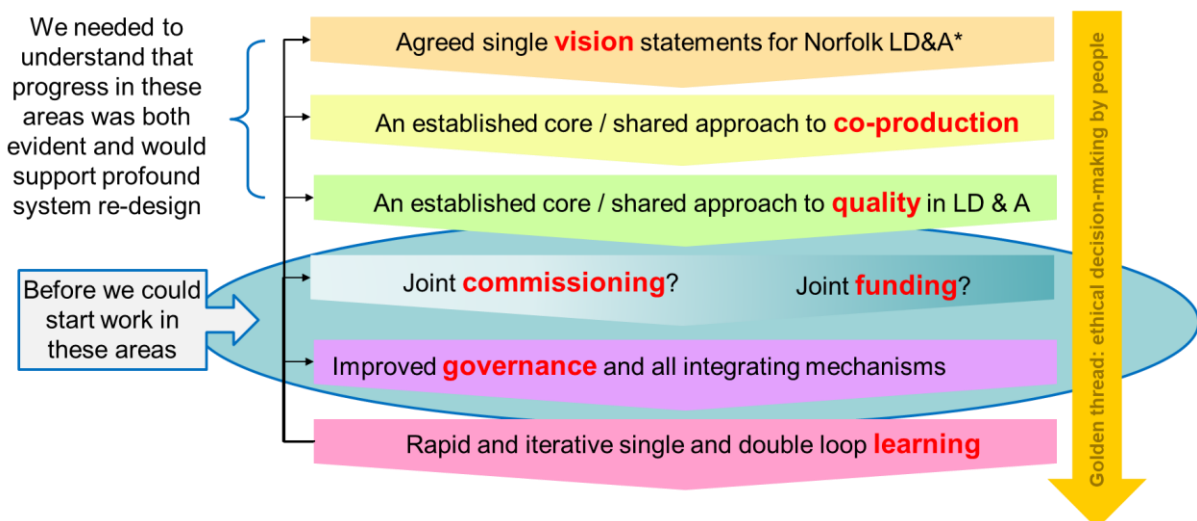
Such a problematic position is not unusual nor has arisen in one go: inefficiency happens by degree. Every decision and step taken over the last 12 years since the Learning Disabilities and Health Reform Grant of 2010 with the historic transfer of responsibility for funding and commissioning of services for adults with learning disabilities from the NHS to local authorities would have been made with good intent. However, in hindsight a problematic position has developed, with a set of unclear and complex arrangements for planning, commissioning and provision.

#### 4. Stage 2 Review Process

At the beginning of our Stage 2 work, we agreed a different way of working to ensure better engagement and join up of the work of officers from the County Council and ICB. We have been working with an integrated programme team (see appendix 2) meeting virtually on a fortnightly basis over the last few months using an agile project methodology. We would not underestimate the importance of how interactions have developed and improved since Phase 2 started. The team has learned how to discuss very difficult issues; and to survive the experience. This has been, and will continue to be, one of the project critical success factors.

This group of senior colleagues have helped to shape and steer our work through what has been at times a very challenging and difficult period, particularly as the issue of historic debt came to the fore. This had a very significant impact on frontline operational staff in both NCC and the ICB. We used the fortnightly programme team meetings to ensure we were up to speed with how things were developing in the system as well as helping colleagues to have open and constructive conversations.

The diagram below summarises the strands of work at a high level involved in stage 2.



Through the integrated programme team, the scope of our work has been refined through stage 2. Two significant additional workstreams have been added to the scope of our work:

- Business process review.
- Governance.

In addition, with the advice and support of the integrated programme teams we have planned and run 2 system workshops. We also ran a day long face to face workshop for the

integrated programme team itself in August. This workshop was highly productive. The behaviours were exemplary.

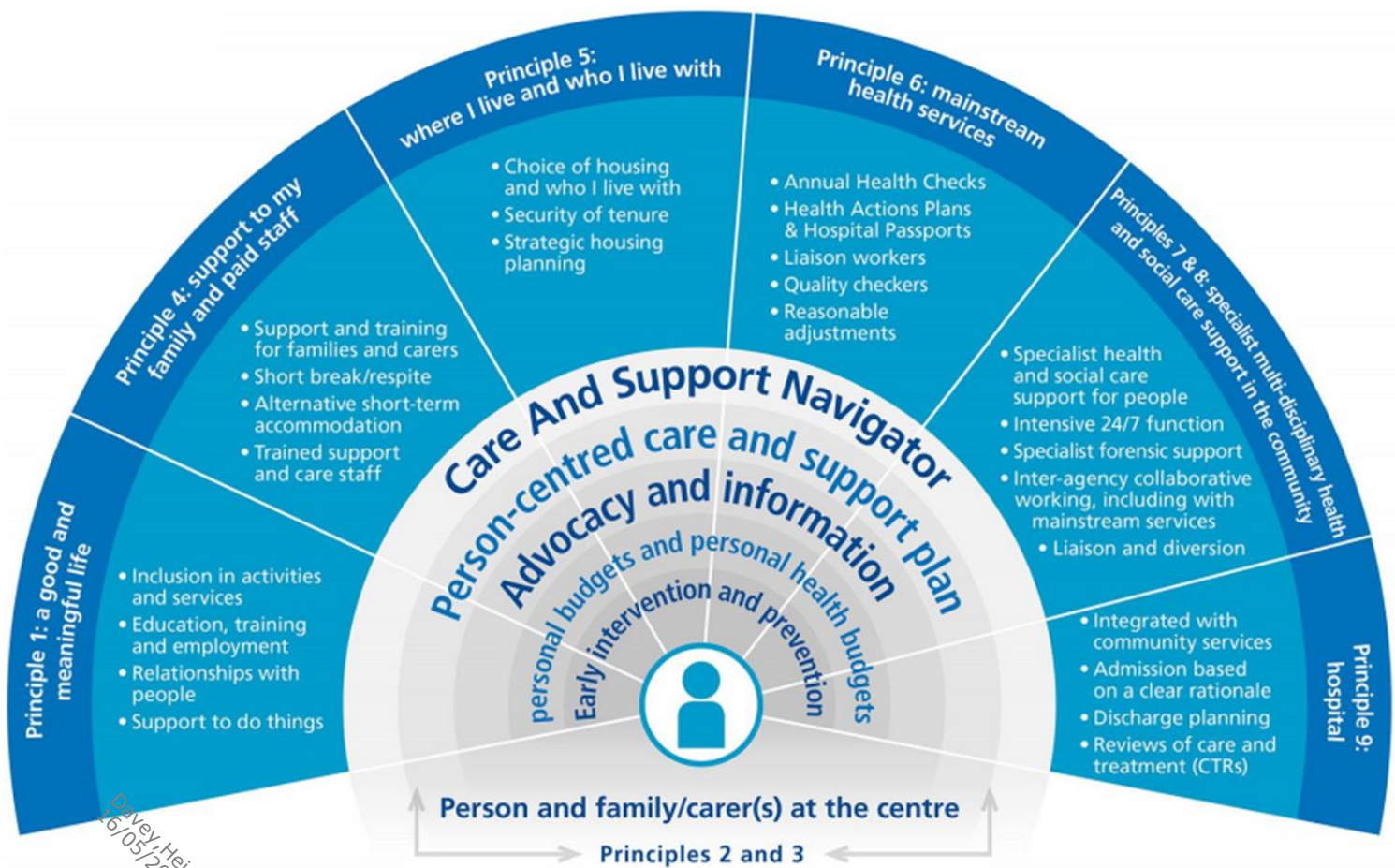
Throughout stage two of our work, we have continued to learn more about how the system is organised and works, and we have reflected on these emerging insights with the integrated programme team and adjusted our approach accordingly. We continue to be very grateful for the open and constructive approach of both ICB and NCC colleagues directly engaged with us.

## 5. Summary of key Stage 2 findings

### a) National good practice is clear.

People with LD&A are a small but vulnerable cohort of people with lifelong challenges who can – and deserve to – lead wonderful, ordinary lives with the rest of society welcoming them in and health and care supporting them where needed.

The National Service Model, developed with the support of people with lived experience, clinicians, providers and commissioners, sets out how services should support people with a learning disability and/or autism. With the right set of services in place in the community, the need for inpatient care will significantly reduce. The model is shown below. The Programme Team have mapped all commissioned and funded services from NCC and ICB for both LD and A services against the National Service Model.



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## b) Commissioning in Norfolk and Waveney is very fragmented.

The commissioning of specialist healthcare providers is fragmented e.g. ICB contracts with HPFT for Assessment and Treatment beds and part of the Intensive Support Team [using standard NHS contract], and NCC contracts with them separately [on council contract terms and conditions] for the LD Psychiatrist service for Norfolk. Both the ICB and NCC also commission services separately from NCHC which includes integrated community learning disability teams and other elements of the Intensive Support Team. This commissioning fragmentation makes collaboration across and with the 3 specialist healthcare providers more difficult as NSFT also provides MH services in Norfolk and LD&A services in Waveney. Section 6g outlines how we propose a broadly revenue neutral reset can be undertaken.

## c) The system spends significant resources on a small number of people.

The care and support of people with LD&A costs NCC and the ICB about £190M p.a. and that's just adults. This total spend is considerably more than the estimate reported to us in stage 1. See Appendix 3 for a breakdown.

Furthermore, the use of resources is concentrated on a few individuals. 80% of the cost is spent on 10% of the people with LD&A with high levels of need. We estimate that about 1000 -1500 people spread across cohorts in Transforming Care Partnership (TCP), Continuing Healthcare (CHC), inpatients, forensic, residential care and supported living, use 80% of the resources.

People with high levels of need will have an 'average' additional health and care spend of £100K per annum and hence a lifetime cost of around £5M. Getting it right first time in terms of meeting their needs is a critical opportunity across their life course. On average it is estimated that people with LD&A have an annual cost of circa £65K p.a on top of universal services.

We also know that the prevalence of learning disabilities in Norfolk is higher than England and the East of England.<sup>1</sup> This contributes to the predicted growing demand which has been analysed in the Demand and Capacity model produced as part of the project.

The fragmentation of commissioning makes it difficult to consider these people's needs and associated costs in a strategic joined up way at present. Their needs have often been compounded by the lack of appropriate skills in the workforce to ensure prevention and early intervention.

## d) Despite the resources invested outcomes are poor.

Despite the high levels of spend across the system, we know the overall quality of residential care provision in Norfolk is poor from CQC ratings. The most recent available Norfolk Joint Strategic Needs Assessment<sup>2</sup> reported drawing from national data, that 'People with Learning disabilities have poorer mental health, education and employment, they also have a lower life expectancy and a higher risk of early death compared to the general population, for example men with learning disabilities die on average 14 years younger than men in the general population and women 17 years younger.' The most recent Learning from Lives and Deaths – People with a Learning Disability and People with Autism (LeDeR) Report for

Davey Heidi  
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<https://fingertips.phe.org.uk/search/Learning%20Disability#page/3/gid/1/pat/6/par/E12000006/ati/302/are/E10000020/iid/200/age/1/sex/4/cid/4/tbm/1>

<sup>2</sup> <https://www.norfolkinsight.org.uk/jsna/adult-health-and-wellbeing/>

22/23<sup>3</sup> reports a higher disparity: ‘the latest data from the 2021 National LeDeR Report demonstrates the disparity in age of death for those with a learning disability. Compared with the general population, males with a learning disability die 22 years younger and females die 26 years younger.’

Overall, the system seems to be highly inefficient. It is holding very significant quality and financial risk, despite having committed senior and frontline managers and staff. For example, there is unclear, ambiguous and at times missing anticipated legal and governance documentation e.g. there is no Section 75 agreement nor recognised funding flows covering NCC commissioning of specialist healthcare on behalf of the ICB. This reinforces the need for a significant system ‘strategic reset’ to address the position which has incrementally and unintentionally developed over the last decade:

### e) A systemic strategic reset in governance and commissioning is needed.

We think it is important to restate that, whilst the current position is unsustainable, it has developed to its state of dysfunction by degree: both NCC and the CCGs/ICB have gone through several major structural changes (each intended to improve matters) with a loss of corporate memory and continuity.

Over time a problematic position has therefore developed, with a significant underinvestment of leadership attention in LD&A, and a set of unclear and complex arrangements for planning, commissioning, and provision. This is despite incredibly committed and talented staff and managers across the system. But as W Edwards Deming said, “A bad system will beat a good person every time.”

We recognise that ICB Executive Directors are keen to move at pace towards more joined up arrangements for the commissioning and delivery of LD&A. Our recommendations lay out a systemic and strategic reset to lay the foundations for this. There is also a need to rebuild trust with NCC Councillors, following the recent historic debt issue, before any further integration of commissioning responsibilities and funding can be considered.

## 6. Summary of individual workstreams

This section summarises the findings of the key workstreams in stage 2. More details are in the Storyboard Report.

### a) Co production

We found that the Norfolk system had significant strengths in co-production. There is energy, optimism and competence. There are good ideas. There is perhaps a tendency to ‘try new things’ rather than to make existing things work, but that is not unusual in systems that are keen to put things right. There is no doubt that people and organisations remain, after Cawston Park however, very wounded. This manifests, for example: as lack of trust; suspicion of planning for improvement; and defensive listening. We ourselves were disappointed by the way in which ideas – that had been carefully developed – could be dropped at short notice and without apparent reason. Although much of the Norfolk work in this area could be found in almost any other geography, there are two initiatives which we think deserve special leadership attention:

- Coalition for Change.
- The Ethical Framework (now to be called the Good Care Deal).

<sup>3</sup> <https://improvinglivesnw.org.uk/~documents/route%3A/download/854/>

## b) Quality and continuous improvement

We spent longer on understanding quality than we had expected to. People and organisations engaged willingly and openly. We found plans and initiatives that shared a common, and sound, approach both to quality, of itself, and quality improvement. Indeed, we had originally anticipated that a separate and short piece of work might be needed on system learning and improvement. We now think that work in Norfolk – combined with attention to national initiatives, such as NHS Impact and a joint response to the need for an Action Plan for BtRS – should address this issue. We formed the impression that our work may have been instrumental in bringing quality communities together and facilitating sharing and joint planning thus enhancing the joint quality work already being done.

We did find four areas where Norfolk might pay specific attention to quality, that may have a significant return on investment:

1. Establishing a joint approach to hearing the voice of everyone living with LD&A, including developing sound feedback systems, ideally in real time (in pursuit of a 'total population focus').
2. Establishing and sustaining a joint 'upstream' quality response based on prevention and early intervention.
3. Working out what data is needed to inform a whole population approach; what data is needed to lead and manage effectively; and how to make the most of less-than-perfect data to improve peoples lived experience and to ensure that people are safe while leading their best ordinary lives.
4. Improving the focus on skills and competencies needed within the LD&A social care workforce to improve people's experience and quality of life and to reduce poor outcomes'

## c) Workforce

Our key findings were:

- There is a very strong commitment and value set for the LD&A services across N&W from those interviewed, irrespective of which organisation they were employed. This provides a strong basis to deliver improvement and deliver change.
- The depth of knowledge around service provision and how things operate was strong though this usually was around individual's own organisations with more grey understanding about each other's services. Some formal approach to discussing geography wide workforce issues and planning strategies is one way of mitigating organisational barriers and brokering strong collaboration.
- The complexity of service commissioning was raised by most as a limiting barrier to stronger service integration due to the nature of how funding flowed, and the number of organisations involved. Furthermore, current LD&A workforce plans do not appear to be directly linked to service commissioning leaving individual organisations to piece together need.
- There are some areas of excellence that could be used to promote LD&A in Norfolk and Waveney as a good place to work including the investment and deployment of advanced practitioners across LD services in Norfolk and the Norfolk LD Psychiatry service which is one of only a few beacon sites for specialist medical LD training and academic medicine. These could be used to promote N&W as a place to learn and work in LD&A.
- Evidence shows that a strong medical workforce for a specialty provides the opportunity to promote the service and act as an anchor for attracting other professions into the area. This should be considered to grow, retain and stabilise the broader LD workforce.

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- Engagement with the education sector is patchy and inconsistent. The opportunity to establish a forum for LD&A workforce with all key FE and HEI institutions should be considered in order to plan and safeguard an ongoing workforce pipeline of care workers and specialist trained professionals.
- The area has a good reputation for encouraging people into apprentice roles at all levels and the use of the levy is usually oversubscribed.
- The ICB were presented a paper in March 23 “Norfolk and Waveney Learning Disability and Autism Workforce Transformation Report” which provides a helpful steer to the LD&A workforce across the geography but misses key data from Norfolk and Suffolk Foundation Trust (NSFT), the James Paget University Hospital and the Queen Elizabeth Hospital. This requires revision to include that data as part of a robust LD workforce planning exercise.
- The Norfolk County Council Social Care Workforce Strategy 22-25 prepares the way for the Social Care Reform agenda as it speaks to having the right mix and numbers of staff.

The ICS should provide an opportunity to plan a workforce for the whole geography tailored to the needs of LD&A service users. To that end one of key recommendations is that you establish a Workforce Planning and Delivery Steering Group, with membership from NCC, all NHS Trusts involved in LD and Autism, and a cross section of representative independent sector organisations including VCSE.

The group would oversee the following agendas:

- Learning about each other's services, the good points and the challenges, so everyone has a shared understanding of the position across the sector.
- Select all that is good about LD&A across the sector and build materials that can be used to promote the geography (and its services) to potential learners and employees.
- Undertake a robust workforce planning exercise, building on what has already been completed by Sophie Thomson in 2022. This would include a full demand and capacity plan to better map skills and workforce requirements by profession.
- Map out the existing HEI provider landscape and identify potential new players who would be able to serve the geography with the required workforce pipeline. This would require planning the clinical capacity requirement and how it might be achieved.
- Develop a sector-wide development programme for existing staff that not only ensured Oliver McGowan was implemented but looked to pool CPD opportunities across the geography to share burden and maximise Norfolk ROI.
- Assess the true cost required for the apprenticeship programme, in order that the levy is best utilised.

#### d) Strategy and Commissioning

Two key insights from the System workshops and Project Team have informed this work:

- Service users want radical changes in service provision as reflected in the LD&A and Autism Strategies developed by the Partnership Boards. This especially applies to housing with a shift required from a traditional residential care home model to people having their own front door usually through supported living.

The current unsuitable and fragmented pattern of provision, plus the mismatch between the scale of future demand and likely funding is such that the LD&A system will need to actively and wisely “commission its way out of” the current position.

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Meeting these challenges will require:

- Rigorous and careful strategic commissioning aligned across the Council and ICB, actively engaging experts by experience and providers, guided by the BtRS service model, delivering the agreed LD and Autism Strategies, and,
- Active person-centred operational commissioning (and contract management) of individual packages of care, including CHC and IPPs for people with LD&A, joined up across the council and NHS, which can flex to meet people's health and care needs and avoids costly escalation of care.

These are distinct functions, which need to have clear and distinct accountabilities. Commissioning, quality, coproduction and funding need to be aligned, with clear and explicit funding agreements between the council and ICB, overseen by appropriate governance. Joint commissioning should be retained where this already exists and works well. The opportunity is there, over time, to work towards having a single accountable lead executive officer for Norfolk LD and A.

Our recommended principles and approach are summarised in the storyboard and the detailed commissioning development plan.

### e) Governance

One of the key stage 1 findings was that governance structures were disjointed and tended to focus on the operational aspects of commissioning and service delivery. Whilst there has been improvement of existing mechanisms over the last few months, our strong recommendation is for a significant reset of collaborative system governance to ensure both strategic space and operational rigour. Appendix 4 shows the recommended new structure which should replace and subsume most of the existing ICS governance in this area. Key aspects are highlighted below.

A new LD&A Executive Group to have Strategic and Operational Oversight of Adult LD&A, working with LD Partnership Board and Autism Partnership Board to:

- Set strategic direction for the Norfolk LD&A system.
- Review and drive implementation of agreed local strategies and National Policy & Legislation for LD&A e.g. National Strategy for Autistic Children, Young People, and Adults; Building the Right Support LD&A Service Model; Building the Right Support Action Plan.
- Embed Ethical framework in LD&A governance and practice.
- Coordinate effective use of ICB and NCC resources to support LD&A Commissioning e.g. Finance; Procurement; Transformation; Population Health/Public Health; Mental Health Programme; CYP; Housing; Employment; Criminal Justice; Education.
- Ensure partnership governance is developed e.g. s75 clarity on any delegation; pooled budgets; s117 for LD&A; joint funded policies and procedures; clarity on scheme of delegation for operational commissioners LD&A.
- Improve the co-ordination and collaboration between the anchor institutions in the Norfolk health and care system and with other programmes through representation at the LD&A Executive Group and throughout the sub-committees. This includes links to N&W Children and Young People's services, including a focus on transition.

Draft Terms of Reference for the LD&A Executive have been developed. These include Providers as partners in governance to shape service transformation and consider new care model for LD&A in line with national policies and legislation (including implications of likely changes to Mental Health Act).

We propose appointment of a System LD&A Programme Director to drive implementation of the overall LD&A Strategic and Operational Commissioning Development Plan. It is important for the new LD&A Executive Group to sit within both the governance structure for the ICB and for the Norfolk County Council.

An early decision is needed around how Waveney is considered by the LD&A Executive Group given NCC's remit only covers Norfolk. There are joint governance arrangements with Suffolk CC and SNEE ICB previously agreed for Waveney, but there is always a danger the needs of Waveney residents are neglected as the service model and provision there is completely different to Norfolk. The decision should be informed by the Transforming Care Partnership geographical definition for ease.

Consideration is also needed around relationship with place across N&W through the Health and Wellbeing Partnerships and/or Place boards, to both receive feedback on needs and drive service development.

The proposed LD&A Executive Group would enact the oversight and assurance responsibilities of the ICB and NCC for the LD&A Programme across the system and hence requires Director leadership and participation. Reporting and accountability of the LD&A Executive Group should follow the relevant governance in the ICB, (suggested to the new Commissioning Committee), and Norfolk County Council.

The LD&A Executive Group will have both strategic and operational commissioning oversight and assurance supported through 5 proposed sub-groups which will have delegated responsibilities across the system. All sub-groups will operate as collaborative arrangements between ICB; NCC; and providers. Appendix 4 shows the illustrative workstreams of the proposed sub-groups. These would ensure that there is space for strategic work and ensure operational rigour in the system, across:

- Joint Strategy
- Joint Delivery Group
- Best Use of Resources
- Workforce
- Quality & Safety

## f) Finance

The care and support of adults with LD&A costs NCC and the ICB about £190M p.a. as shown in Appendix 3. This excludes the majority of CYP services, the use of general health services by people with LD&A and most significantly autistic people's use of adult mental health services which is estimated at £60M. In addition, Suffolk CC spend circa £18M p.a. on social care costs of people with LD& A in Waveney.

This total spend is focussed on a small number of people with 80% of the cost estimated to be spent on 10% of the people with LD&A with high end needs [about 1000 -1500 people spread across cohorts in TCP, CHC, inpatients, forensic, residential care and supported living]. People with high levels of need will have an 'average' additional health and care spend of £100K p.a. This is typically nearer £150K p.a. for people being discharged from inpatient settings after a long stay [see Red Quadrant Report]. This results in lifetime costs of many million, so getting it right first time in terms of meeting people's needs is a critical opportunity across their life course.

The current fragmentation of commissioning makes it difficult to look at people's needs and associated costs in a strategic joined up way at present. There is a significant opportunity we

believe to take a strategic systemic view across the Norfolk LD&A system and drive improvement through strategic commissioning. Finance has a key role enabling this through:

- Formal agreements on funding contributions and amounts, and mechanics of joint funding. Failure to agree clear arrangements increase the overall system financial risk and places significant unnecessary burden on frontline staff. This in turn gets in the way of them proactively managing placements and associated contracts thereby reducing the scope for improving quality and reducing cost. Other systems have agreed a range of clear agreements [examples are available] with corresponding financial arrangements<sup>4</sup>,
- Ensuring robust timely financial and activity reporting at the system level. Given the national growth in this area of health and care there is potential for a major financial risk especially around CHC and IPP for people with LD&A.
- Supporting strategic and operational commissioning including transfer of funding around SHS and redesign of local services.

### g) Specialist healthcare services

The commissioning of specialist healthcare providers across Norfolk and Waveney is unhelpfully fragmented. The core elements of what is required for holistic and integrated LD&A service model as per BtRS, is currently split. Elements include:

- ICB contract with HPFT for Assessment and Treatment beds and part of the Intensive Support Team [using standard NHS contract],
- NCC contract with HPFT separately [on council contract terms and conditions] for the LD Psychiatrist service for Norfolk based on a service specification last updated in 2014.
- NCC contract with NCHC for integrated community learning disability teams and some other services
- ICB contract with NCHC for other elements of the Intensive Support Team.
- ICB contract with NSFT for LD&A services in Waveney (and of course, Suffolk CC commission social care for LD&A)
- ICB contract for Adult Mental health Services in North and Waveney which includes significant services for Autistic people and meeting the mental health needs of people with LD&A with reasonable adjustments.
- Inpatient and community forensic services are provided separately by HPFT through the EoE Specialist MH provider Collaborative.
- NCC and ICB commission jointly the Autism Diagnosis service from NCHC.

This commissioning fragmentation makes collaboration across and with the 3 specialist healthcare providers more difficult. It impacts quality oversight and workforce development.

NICE guidance suggests that a single overarching joint LD&A commissioner would be appropriate. In the case of Norfolk, however, Tricordant and the joint Programme Team, believe that, at least in the first instance, the fragmented commissioning and a lack of clear governance back to the ICB are the principal issues for SHC, rather than any perfect refinement of the systemic approach.

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<https://moderngov.staffordshire.gov.uk/documents/s160004/Agreement%20for%20Mental%20Health%20Act%20Section%20117%20Aftercare%20needs.pdf>

Furthermore, the current contracts for commissioning of SHC by NCC end in September 2024 and the Council has clearly identified they cannot continue to contract for these services. The services and costs are shown below.

<b>NCHC provision.</b>	Cost per annum
ASN Norfolk Autism Diagnostic Service. (ASD)	£481,000 (since April 2023 £384,000 funded by ICB)
Community Learning Disability Service. (CLD, Norfolk only)	£4,454,800
<b>HPFT provision</b>	
Adult LD Psychiatry Service (Norfolk only)	£853,900.
<b>NCHC provision (Health and Social Care Service currently)</b>	
Mill Lodge – Residential Respite Unit (mainly utilised by CHC)	£839,000. (approx. £350,000 income generation from CHC)

There is no overarching governance or funding agreement in place between NCC and the ICB for what are clearly healthcare services and thus NCC are arguably ‘ultra vires’. There is therefore a burning platform for change.

We believe that a phased conservative approach to improvement should be adopted which can be built on as governance arrangements, clear financial agreements, robust ways of working and trust with members is rebuilt. Establishing clear governance oversight by both the ICB and NCC is required but to move to a single joint LD&A commissioner and team at the same time would represent too high a level of risk in a first phase of change.

From discussion with Programme Team, we propose therefore a staged, largely revenue neutral process.

1. NCC and ICB agree approach and discuss and agree with providers involved (NCHC, HPFT and NSFT). We anticipate the ASD, CLDS and Psychiatry services transfer with Mill Lodge subject to a joint review.
2. NCC and ICB agree arrangements for handling transfer of financial responsibility back to the ICB to ensure it is revenue neutral as far as possible. This could be through a separate agreement or as part of a review and refinement of the LD&A elements of the BCF. We understand these are currently not specific and do not include SHS. We understand there are some small cost pressures relating to inflation associated with each service.
3. NCC novate contracts to ICB as soon as possible. Contracts transfer to NHS Terms and conditions consistent with the other NHS contracts each Trust has with the ICB. Services remain formally on the current service specifications.
4. ICB formally inform providers [using the new PSR if appropriate] that given the timescales they will not be undertaking a formal procurement process immediately.
5. ICB Commissioning and Nursing Directors, supported by the Joint Commissioners for LD&A and Autism, lead a collaborative process to prepare with NCC, service users and providers a revised overall integrated service specification in line with BtRS and contemporary good practice. This needs to be supported by updated needs analysis and financial planning.
6. ICB should use this opportunity to explore with neighbouring ICSs, the scope for planning Inpatient service provision (currently provided by HPFT) on a wider footprint than just N&W as with the reduction in overall demand for inpatient care but increasingly specialist nature of needs, individual ICSs are increasingly too small a footprint for planning inpatient provision. There are not yet the commissioning, governance or required provider relationships in place to progress this. This was a key recommendation of the East of England LD&A BtRS Review by Tricordant in 2022.

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7. ICB and NCC work with providers to explore the potential for a collaborative/alliance bid as appropriate. Significant valuable work was previously produced by local providers as part of the aborted MCP process. Thus, this process needs to be handled sensitively but has some real foundations to build on.

#### h) LD&A Business Processes

Tricordant was requested by the County Council and ICB to review the business processes in respect of payments for LD&A. The scope of this work was quickly amended to cover all health and care work jointly funded by NCC and N&W ICB.

Tricordant convened Strategic and Operational Groups of NCC and ICB colleagues to understand and map current processes since no end-to-end process maps currently exist; and then identify required improvements. It also soon became clear that no formal financial agreements exist between NCC and ICB with everything done at risk leading to the recent historic debt situation.

The work has been severely hampered through the difficulty of convening meetings with all the necessary people in attendance. Enough was done in the early stages, however, to understand that there are significant flaws in the ways of working especially around any changes in packages of care with, as a minimum, communication and administration breakdowns. More serious areas of breakdown may be uncovered as the work continues. It is now understood that an internal NCC-led project team had already been looking at this issue and there has been confusion over the leadership of the work. A decision has been made by NCC to continue this work internally. Tricordant have been invited to the workshops as an external observer. We presume this negates the need for any further Tricordant facilitation or leadership of this work which we respect but make the point that this work is of such material significance that an external perspective will be valuable.

Based on our experience in this area with other clients and what we know of the N&W position we make the following observations as areas for recommended action.

- The urgent need for formal agreement on funding contributions and amounts, and mechanics of joint funding as outline in prior sections.
- A clear link between the process flow and financial & activity reporting. Given the national growth in activity in this area of health and care there is potential for a major financial risk.
- Clear lines of accountability both managerially and clinically, supported by accurate and appropriate data, to manage the levels of activity and financial exposure.

## 7. Options

There are three main options available:

- Do nothing. Continue with the current arrangements as far as possible.
- Immediate move to a single joint commissioning system for health and care for people with LD and A.
- Strategic system reset as recommended in this paper.

A high-level assessment is shown below of these 3 options.

Options	Pros / opportunities	Cons / Risks
<b>Do Nothing:</b>	<ul style="list-style-type: none"> <li>• Maintain current operationally focussed governance arrangements (which are reported to have improved over the last 6 months)</li> </ul>	<ul style="list-style-type: none"> <li>• Continued poor outcomes for people with LD&amp;A</li> <li>• Significant and growing financial risk for NCC &amp; ICB exacerbated by</li> </ul>

		<p>fragmented service provision and growth in LD&amp;A demand.</p> <ul style="list-style-type: none"> <li>• Specialist health provision for the LD population in Norfolk is too fragmented resulting in confusion about roles and responsibilities.</li> <li>• Norfolk County Council does not have an overarching Section 75 between NCC and the ICB for commissioning of Specialist Health Services for LD&amp;A which means NCC is operating 'Ultra Vires' and current arrangements end next year.</li> <li>• Insufficient shared quality oversight</li> <li>• Lack of strategic governance oversight and coordination</li> <li>• Insufficient capacity and focus on strategic commissioning.</li> <li>• Missed opportunities to address workforce challenges in a joined-up way</li> </ul>
<b>Single commissioner:</b>	<ul style="list-style-type: none"> <li>• In line with NICE recommendations</li> <li>• Able to pull together all aspects of BtRS model as strategic commissioner</li> </ul>	<ul style="list-style-type: none"> <li>• Requires strategic governance to be in place.</li> <li>• Very major change required in structures, roles and resources across NCC/ICB with significant risks at time of already significant organisational uncertainty.</li> <li>• As LD&amp;A is main Adult social care cost the Council will want to retain control and hence ICB will need to delegate complex set of accountabilities and contracts</li> <li>• Lack of political trust and appetite for such arrangements following recent historic debt issue</li> <li>• Will take a long time to negotiate and agree required partnership documentation and changes required are short-term</li> </ul>
<b>System reset</b>	<ul style="list-style-type: none"> <li>• Improve outcomes and manage costs pressures in face of growing demand through resetting and elevating governance focus on strategic change and collaboration.</li> <li>• Can build on complementary capabilities and resources of both organisations.</li> <li>• Rebuild trust across organisations.</li> <li>• Sets foundations for future move to more integrated commissioning where adds value.</li> <li>• Develop new holistic joined model for specialist healthcare services</li> </ul>	<ul style="list-style-type: none"> <li>• Significant change requiring leadership attention and change management.</li> <li>• New LD&amp;A executive requires Executive Director time and involvement.</li> </ul>

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	collaboratively with providers led by ICB	
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The recommended changes have a small additional direct cost from the costs of implementation [such proposed joint programme director on a part time basis for 6 months] and senior leadership time for the LD&A Executive.

- There are also ongoing costs, which are unavoidable under any option, associated with
- the redesign of the SHS in line with the BtRS model,
  - addressing current service cost pressures,
  - addressing the autism diagnostic service backlog (potentially partly funded by future SDF).
  - addressing general lack of autism services (potentially partly funded by future SDF)
  - demographic driven demand in LD&A

However, we believe these changes will help manage costs pressures by:

- Reducing the need for expensive hospital admissions and escalation of care packages through redesigning the local service model to meet good practice. However, it should be noted that whilst this is intuitively correct and national policy, the recent financial analysis for the BtRS national action plan was inconclusive in supplying financial evidence about the relative costs of community and inpatient care.
- Stabilise the growing demand from people with LD&A for CHC through improved design and integration of services.
- Enhanced ability to plan for and manage the projected demographic demand growth in LD&A.
- Reducing the overall governance burden and duplication across the system

A full financial analysis is not possible at this stage; however, the financial and quality risks of no change are significant.

## 8. Key recommendations.

Please find below our major recommendations which have been discussed with the integrated Programme Team. These recommendations are underpinned by a set of design principles iterated several times within the project team. These guide both key recommendations and the detailed work set out in the storyboard and commissioning development plan.

No.	Recommendation	Proposed Accountability	Time Frame	Rationale
1	<b>Declare improvement of LD&amp;A services a priority in the next JFP</b>	ICB Executive Management Team	Feb 2024	<ul style="list-style-type: none"> <li>Surely the facts speak for themselves.</li> <li>LD&amp;A services include all services for adults with LD&amp;A including CHC</li> </ul>
2	Establish an <b>LD&amp;A Executive Board</b> to oversee LD&A across NCC and the ICB, including providers and partners with appropriate sub-groups.	NCC DASC and ICB EDN	Jan 24	<ul style="list-style-type: none"> <li>Provide collective strategic leadership to drive and enable the system reset needed, including overseeing actions identified in this report.</li> <li>Embed better engagement with Experts by Experience and providers throughout governance and commissioning.</li> </ul>

				<ul style="list-style-type: none"> <li>• Reduce duplication, oversee management of collective resources and manage system risks.</li> <li>• Reduce overall governance burden.</li> <li>• Recognise separation of LD and Autism strategies and commissioning and ensure delivery of both.</li> </ul>
3	Ensure <b>senior accountable ICB officer</b> for commissioning of specialist LD&A healthcare in ICB post restructure	ICB EDN and Dep CEO	Dec 23	<ul style="list-style-type: none"> <li>• Provide clarity of accountability and direction</li> </ul>
4	Agree <b>revised and improved commissioning structures</b> for LD and A in both NCC and ICB guided by Commissioning Development Plan	NCC DASC and ICB EDN	From Dec 23	<ul style="list-style-type: none"> <li>• Reflect distinct strategic and operational commissioning responsibilities across the system.</li> <li>• Ensure NCC and ICB structures are aligned and effective.</li> <li>• Whilst recognising cost pressures in both organisations, there are significant opportunities with sufficient commissioning capacity and capability to see much better outcomes and use of resources</li> </ul>
5	ICB to take back accountability for <b>commissioning specialist healthcare services (SHS)</b> and lead collaborative service redesign guided by Building the Right Support National Service Model	ICB Accountable Commissioner [as per 2]	March 24	<ul style="list-style-type: none"> <li>• NCC no longer able to continue commissioning on behalf of ICB from Sept 24</li> <li>• ICB able to redesign and align SHS approach with NCC, experts by experience and key providers</li> </ul>
6	Ensure the <b>transfer of SHS to ICB is revenue neutral</b> through funding transfer agreement or reviewing LD&A elements of BCF	LD&A executive- via proposed Use of Resources subgroup	March 2024	<ul style="list-style-type: none"> <li>• Current LD&amp;A elements of BCF are unclear and outside remit of existing joint committee.</li> <li>• Enables management of transfer of funding responsibility for SHS from NCC back to the ICB so overall it is as near resource neutral as possible for both authorities</li> </ul>
7	Develop and implement <b>funding agreement</b> policies and procedures for agreeing joint service and individual care package costs including new approaches such as 'small supports scheme'	NCC and ICB Finance Directors. (LD&A Executive)	March 24	<ul style="list-style-type: none"> <li>• An <u>essential</u> enabler for aligned working and preparing the ground for further joint and any delegated commissioning.</li> <li>• Reduces system risk.</li> <li>• Avoid repeat of inter-authority debt issue.</li> <li>• Embrace good practice from other authorities (available)</li> </ul>
8	Implement a programme of <b>business process improvement</b> including the creation of <b>shared strategic reports</b>	LD&A Executive	Early 2024	<ul style="list-style-type: none"> <li>• Assure current business improvement work is delivered and embedded.</li> <li>• Ensure strategic oversight of LD&amp;A at systems level</li> </ul>

	underpinned by robust dataflows and processes.			
9	Design and implement a <b>joint upstream LD&amp;A quality</b> response for oversight and improvement across health and care Align and combine similar quality review processes.	LD&A Executive – proposed subgroup	March 2024	<ul style="list-style-type: none"> <li>• Opportunity to use strong existing ICB infrastructure to support NCC commissioners with a more proactive and dedicated approach to LD&amp;A</li> <li>• Informed by user voice and whole population data.</li> </ul>
10	Establish a <b>Strategic Workforce Planning and Delivery Steering Group</b> , with cross-system membership	LD&A Executive – proposed subgroup	Jan 2024	<ul style="list-style-type: none"> <li>• Enable system level workforce planning and delivery.</li> <li>• Coordinate work with HEIs</li> <li>• Develop Norfolk LD&amp;A workforce capacity and capability</li> </ul>

## 9. Critical success factors

These are key areas where we believe as a review team you need to pay close attention to ensure successful and sustainable implementation of the recommendations. They focus on how you work together.

- I. 'Ensure that all service delivery and improvement is effectively co-produced with those who have lived and / or professional experience. That would always be the case. In Norfolk's case it means taking specific leadership action to:
  - Support the Coalition for Change in its role to understand and improve co-production capacity in the county and coordinating the application of that capacity in every facet of LD&A delivery; and
  - Ensure that The Real Care Deal (formerly The Ethical Framework) continues to inform every development in LD&A and continues to be built on a clear understanding of the needs and wants of people, communicated personally by those people.'
- II. All providers (including the care market) are clearly and appropriately involved in both governance and commissioning process.
- III. The commissioning structures ensure clear accountabilities, and the environment empowers and motivates staff, making the most of individual competence and ambition. Team working across NCC and ICB is facilitated by the co-location of staff working within a joined-up governance framework.
- IV. There is joint oversight of any source of improvement / transformation funding that comes into the system.
- V. Explicitly agree and document policies and procedures around funding and working together to clarify accountabilities and risk, to enable and foster collaborative working.
- VI. Continued focus on building relationships and trust between senior leaders and managers across the ICB and NCC including encouragement and space for informal meetings and co-work outside of formal meetings to foster radical compassionate candour.
- VII. Regularly take stock of system maturity and progress using feedback from experts by experience, partners and appropriate external review processes.

## 10. Risks and mitigations

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The main risks and proposed mitigations for the recommended way forward are summarised below.

Risk	Likelihood	Impact	Score	Mitigation
Fail to agree approach across ICB/ NCC	L	H	Medium	All recommendations have been worked up with integrated Programme Team. DASC and CNO continue to meet regularly as report is refined and taken through governance processes. Briefing of key members and non-executives.
Managing scale of change required in governance and commissioning given pressures of normal business & limited capacity	M	H	High	Appoint joint LD&A Programme Director to stand up the new arrangements and coach commissioning teams in new ways of working. Remove duplication and promote aligned and coordinated working. Co-locate teams.
Engagement of key stakeholders in co-production partners and providers	M	M	Medium	Continue to inform and engage stakeholders. Joint communication from DASC & CNO to explain new arrangements. Meet with key providers. Repeat system workshops
Lack of clear agreement and plan for specialist healthcare services	M	H	High	Develop a shared plan [aided by joint LD&A PD if appointed] identifying clear accountabilities across NCC /ICB taking account of capacity
Failure to agree clear funding policies	M	H	High	LD&A Executive to oversee development of clear agreements covering all NCC/ICB joint and delegated commissioning. [aided by joint LD&A PD if appointed]
LD&A neglected in face of national priority focus on UEC performance and finance	H	M	High	Establish LD&A Executive to ensure strategic focus to improve outcomes, reduce inequalities, and mitigate significant financial and quality risks. Declare LD&A reset an explicit priority in next ICB JFP.
Failure to develop robust shared financial and contracting processes to support operational commissioning	M	M	Medium	New governance arrangements ensure continued focus on BPR work and developing transparent processes with clear reporting arrangements.

## 11. Implementation

We recognise that these recommendations are not trivial. They represent a proposed reset of the governance at a system level to better enable and support strategic commissioning and planning of services, and frontline operational commissioning, management, and delivery of care.

We would therefore recommend that careful attention is paid to the implementation process including consideration of the following:

- Establish a small senior steering group of 2 Executive from each Authority to provide overall governance and guidance for the change over the next six months.

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- Appoint a joint LD&A Programme Director to manage the programme of change, supporting and coaching key staff in NCC and ICB to facilitate new ways of working.<sup>5</sup>
- Establish / continue the Joint Programme Team of key NCC and ICB staff involved in LD&A to facilitate local ownership and alignment.
- Develop clear action plans for each of the recommendations with clear accountabilities and timescales. These can build on much of the excellent work already being done within the system and good practice from other systems but ensure it is aligned within an overall strategic direction and has executive support through the LD&A Executive.
- Review any existing governance or working groups in LD&A and ensure they are either subsumed within or aligned with the new system.

## 12. Conclusion

We are confident that the recommendations here will put you in a strong position to move to a much more robust and aligned commissioning position, which will also help create the conditions for better engagement of specialist healthcare providers and indeed the wider care market. Our research has found that very few systems actually have completely joined up health and care commissioning in this area.

Our recommendations will allow you to move towards established good practice at a reasonable pace, with sustained executive attention across the ICB and NCC helping the system to collaborate better, join up provision, reduce risk, make better use of existing resources and crucially improve outcomes.

Our principal critical success factor for this work is a committed senior leadership team across Norfolk, taking timely and good decisions; and showing clearly that LD&A matters. We are therefore very grateful for the chance to present this candid summary of our work to you, for your guidance and direction.

In summary, in our Stage 1 discovery work we used the Galbraith Star Model to provide feedback for the Norfolk system – see Section 3 above. It may be useful if we use the same model to outline the prospects for improvement in commissioning and provision of services for people with needs deriving from LD&A in Norfolk, if the recommendations of this report are implemented swiftly and assiduously:

<b>Galbraith Dimension</b>	<b>Our initial headline comment</b>	<b>The prospects of our work</b>
Strategy	System has strategies but they are not driving all actions. Understanding is variable across organisations.	<ul style="list-style-type: none"> <li>• Proposed joint subgroup will focus on working with the independent Partnership Boards, providers and partners to drive joint development of strategy, and strategy implementation<sup>6</sup> across the system.</li> <li>• Leadership placed in central and pivotal role in these tasks.</li> </ul>
Structure	NHS senior commissioning responsibility is unclear	<ul style="list-style-type: none"> <li>• Recommended governance structure should support a robust business focus on:               <ul style="list-style-type: none"> <li>○ Strategy (through engagement with the independent Partnership Boards).</li> </ul> </li> </ul>

<sup>5</sup> We can provide a recommended job description and work programme for this role and associated support.

<sup>6</sup> See the principal role of assiduous implementation of strategy in 'What Really Works: The 4+2 Formula for Sustained Business Success' (HBR July 2003 by Nitin Nohria, William Joyce, and Bruce Roberson).

	and NCC left with tricky challenge*	<ul style="list-style-type: none"> <li>○ While maintaining crucial independence in people-led strategy-making.</li> <li>○ Consistent and clear oversight, (essential to Local Govt scrutiny).</li> <li>● A simple organisational structure will provide clear accountability and responsibility.</li> </ul>
Processes	Overall Governance appears unconnected and day to day decision making reported as dominated by finance.	<ul style="list-style-type: none"> <li>● A comprehensive governance reset will ensure that key functions align with (and support) LD&amp;A.</li> <li>● Implementation of value-led, waste-free finance and business processes including a programme of continuous business improvement.</li> </ul>
Reward and incentives	Lack of an overall shared performance and finance information hindering system improvement	<ul style="list-style-type: none"> <li>● Development and agreement of key lawful funding agreements.</li> <li>● Development of shared performance and finance reporting.</li> </ul>
People and leadership	Great people but insufficient leadership attention	<ul style="list-style-type: none"> <li>● Consistent and clear executive leadership oversight will support managers and frontline staff in LD&amp;A.</li> <li>● Motivation in a system where staff experience less stress and conflict; and can see most work is devoted to meeting the needs of people.</li> <li>● A specific and systemic perspective on workforce matters (supported by the workforce subgroup) will 'fill the vacuum' and provide dynamic advice to support local action on workforce matters.</li> </ul>
Culture and identity	People are under pressure and not working in a joined-up way ...but want to be!	<ul style="list-style-type: none"> <li>● Collective, dynamic (and present) system leadership will develop, exemplify, sustain and reward productive behaviours.</li> <li>● Designed and enhanced cross-sector connection will support 'join-up' and will promote collective resilience.</li> </ul>

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## Appendix 1: Supporting documents.

- Norfolk & Waveney LD&A Review PID, September 2022
- Summary report of the initial Discovery phase of the work, submitted to the ICB EMT and NCC Adult Social Care Directorate Leadership Team [DLT], March 2023.
- Stage 2 Interim update report, September 2023.
- Norfolk LD&A Demand and Capacity model (developed by Andy Whiting and handed over by Tricordant July 2023]
- Norfolk & Waveney LD&A Workforce Review (led by Patrick Mitchell)
- Stage 2 Storyboard incorporating workstream reports, Nov 2023
- Commissioning Development Plan, Nov 2023 (Kathryn Hudson)
- Draft TOR for LD&A Executive.
- Implementation support including Joint LD&A Programme Director.

## Appendix 2: Review Team members

### NCC

Lorna Bright  
Rachel gates  
Corinne Avery  
Craig Chalmers  
Rachel Gates  
Leon Ringer\*  
Tracy Walton (attended team workshop only)

### ICB

Joanna Yellon  
Tiffany Leefe  
Andy Hudson  
Paul Benton \*  
Bertone Santos-Socorro (attended team workshop only)

### Tricordant

Kathryn Hudson  
Keith Pople  
Andy Whiting  
Emma Engstrom  
Ros Alstead  
John Taylor\*  
Patrick Mitchell  
Alastair Mitchell-Baker

\* These colleagues were only able to attend a small number of PT meetings

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## Appendix 3: Collated N&W LD&A Costs

These are current best estimates and there is a complex relationship between NCC and ICB funding.

NCC commissioned		£m	ICB funded		£m
Residential care		£58.5	Continuing Health Care		£39.8
Supported living		£43.0	Individual Patient Pathways		£11.1
Day services & direct payments		£12.2	HPFT Astley Court		£3.2
Transport		£5.0	HPFT community Forensic		£0.6
Social work		£4.5	HPFT EATS		£0.5
Home support		£8.0	ASD & ADHD		£1.7
Other		£8.5	Other		£2.7
<b>Sub-total NCC social care</b>		<b>£139.7</b>	CYP		£2.1
			Waveney		£1.2
Community LD teams		£4.5	BCF		£15.4
LD psychiatry		£0.9			
ASN Norfolk Autism Diagnostic Service		£0.1			
Mill Lodge – Residential Respite Unit		£0.8			
<b>Sub-total NCC health care</b>		<b>£6.2</b>			
<b>Total Norfolk County Council</b>		<b>£145.9</b>	<b>Total ICB</b>		<b>£78.2</b>
<b>Of which ICB funded</b>		<b>-£33.4</b>			

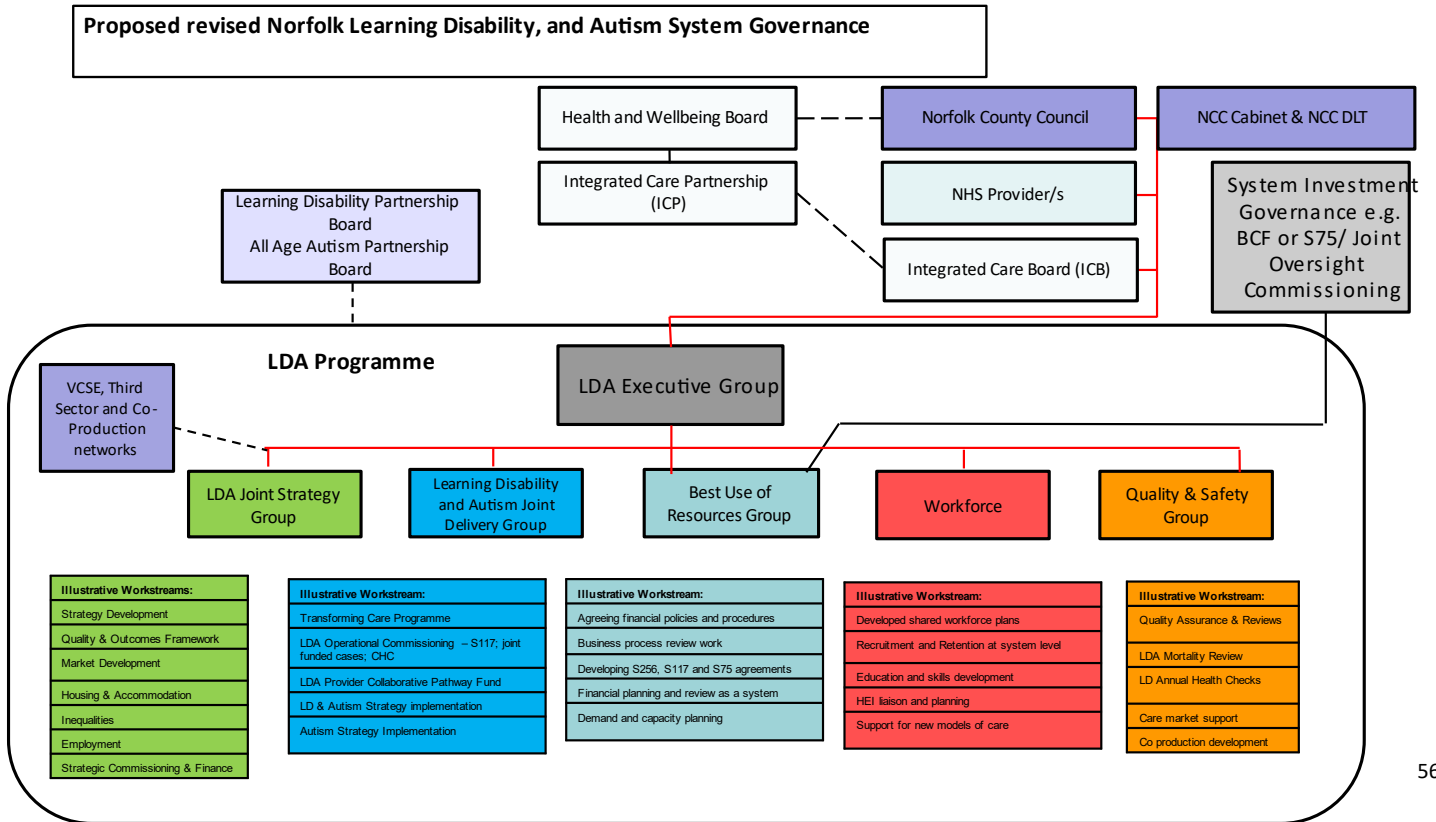
<b>GRAND TOTAL SYSTEM SPEND</b>	<b>£190.7</b>
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### Notes exclusions

Share of MH spends	£60.0
Other health spend for people with LD&A	Value unknown
Suffolk CC spend	£19.2

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## Appendix 4: Proposed System Governance for LDA



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Agenda item: 10

<b>Subject:</b>	<b>Primary care access recovery plan and improving the issues across the primary-secondary care interface</b>
<b>Presented by:</b>	<b>Mark Burgis, Executive Director of Patients and Communities Sadie Parker, Director of Primary Care</b>
<b>Prepared by:</b>	<b>Sadie Parker, Director of Primary Care Amanda Sear, Senior Manager, Primary Care</b>
<b>Submitted to:</b>	<b>Norfolk and Waveney ICB Board</b>
<b>Date:</b>	<b>22 May 2024</b>

## 1. Introduction

The purpose of this paper is to provide an update on progress of the system capacity and access recovery plan in response to [the Delivery Plan for Recovering Access to Primary Care](#); and, as part of this, the work on-going to support improvements across the primary-secondary care interface.

An overview of Pharmacy First, launched on 31<sup>st</sup> January 2024 is also included. Pharmacy First is a national scheme designed to make pharmacies the first port of call for many patients who need healthcare advice and potentially treatment for several common health conditions without needing a GP appointment and is a key pillar of plans for recovering access to primary care.

## 2. Background

This paper seeks to set out progress made since the paper presented to the Board in November 2023.

### Primary care access recovery plan

The expected outcomes for 2023/24 included:

1. We will continue to develop our interface programme of work and review all opportunities within the ‘General practice and secondary care: Working better together’ report.
2. We aspire to increase the number of sign-ups to the NHS App, and we will support practices to deliver promotional events for their patients.
3. We aim to support 34 practices to update their telephony systems to a cloud-based system to help them to better manage their call demand, so patients get a better experience of contacting the practice.

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4. We want to support as many practices as possible to transition to the modern general practice access model by the end of 2024/25 maximising the use of the transition funding provided to ICBs.
5. We seek to develop a culture of improvement and want to work with practices and PCNs to harness the power of technology and the tools available to support this.

Please see the following progress updates on each of the expected outcomes for 2023/24 listed above.

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

The ICS’ Clinical Interface Group, chaired by the ICB Executive Medical Director has continued to meet, with positive engagement from system partners. The group has a wider remit than that set out in the Delivery Plan guidance, recognising that when the interface between primary and secondary care works well, the patient experience is far more positive.

Recruitment is underway to recruit to a dedicated interface post within the ICB primary care team to support the co-ordination of our work across the system. The role will work with clinicians and managers across ICS partners to develop, implement and monitor processes which support good, organised care and enables clinicians to deliver the changes needed in a way they recognise and value.

- In 2023, 53/105 practices reported at least one issue. 625 issues were reported in total.
- In 2024 as of 24<sup>th</sup> April 37/105 practices have reported at least one issue. 269 issues have been reported to date.
- In 2023, the numbers of issues reported by individual practices ranged from 1 to 109.
- In 2024, as of 24<sup>th</sup> April, the numbers of issues reported to date by individual practices ranged from 1 to 51.
- 9/105 practices have reported over 20 issues in 2023.
- 52/105 practices have never reported an issue.

Key themes to date include:

- Ensuring appropriate health professionals working in the community, can request laboratory tests via the WebICE system (for example for wound swabs, urine cultures, nutrition monitoring bloods) and similarly to receive their own results directly, to reduce clinical risk and prevent duplication of work in practices.

*The Queen Elizabeth Hospital has implemented this system. The Norfolk and Norwich and James Paget Hospitals have formed a working group to progress this work and development of a roll-out plan is underway.*

- Ensuring appropriate health professionals working in the community, can

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request other diagnostic tests via the WebICE system after appropriate training in line with Ionising Radiation (Medical Exposure) Regulations (for example first contact physiotherapists being able to request plain X-rays) and similarly to receive their own results directly, again reducing time, errors and additional work for practices.

*The Queen Elizabeth Hospital has implemented this system. The Norfolk and Norwich and James Paget Hospitals are committed to implementing this for those working in the community. The LMC has been particularly helpful in the development of this approach.*

- Enabling private consultants to refer patients directly into Trusts, rather than requesting the GP makes that onward referral to hospitals.

*The Trusts review their Access Policies annually and this is expected to be included in the next update. While agreed in principle by all Trusts, there are technical issues with enabling private consultants to refer electronically.*

- Trusts offering complete care e.g. making onward referrals as appropriate, sending urgent prescriptions directly to patients rather than asking them to seek these from primary care, arranging their own follow up phlebotomy, and checking and acting on results as well as other necessary follow up care instead of asking the patient's GP to act on or arrange these.

*All Trusts are committed to enabling their teams to undertake complete care. Trust self-assessments suggest this is not a systemic issue, but that one-off incidents continue to occur, and therefore this remains one of the key themes being reported through our reporting process. There are technical issues with Trust clinical systems which prevent electronic prescribing to a community pharmacy.*

- Trusts issuing fit notes for the full duration of absence as opposed to passing these requests back to GPs.

*This is now one of the lowest reported themes from practices, with several months having seen no reported issues. This is well understood in Trust specialties, however one-off incidents continue to occur. There are technical issues associated with the Trust clinical systems, which prevent electronic fit notes in being issued.*

- Improving communication, such as timely discharge letters which appropriately and clearly signal any actions or important information for general practice

*This has been one of the lowest reported themes from practices, with several months having seen no reports. This is well understood in Trust specialties.*

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*During February and March there appears to have been an increase in communication issues highlighted, including missed and delays with information reaching general practice. 17 issues were logged in February overall - and 6 as of 13 March. Work to understand and resolve issues flagged is ongoing.*

- Developing and implementing a process for reviewing and agreeing new pathways of care, to ensure there are no unintended consequences on general practice.

*This process is now well-established, and time is spent understanding any concerns the LMC has and how they can be addressed before pathways and referral forms are finalised. Where we cannot agree to a particular requested change, the rationale is provided to the LMC.*

All providers have undertaken the contractually required self-assessed gap analysis and developed an action plan for improving the effectiveness of their interface working arrangements, in line with the NHS standard contract annual requirements. This process is overseen by the ICB's contracting and procurement team. Recognising contractual issues are likely to be significantly under-reported, the ICB has also been using data collected from the reporting process to support the Trusts with their action planning.

The *General practice and secondary care: Working better together* report outlines potential quick win actions for systems to implement to improve the working across the primary-secondary care interface. Good progress continues to be made with implementing the suggested actions (see Appendix A).

A new mandatory Self-Assessment Tool was introduced by the national team and had its first deadline at the end of April 2024. An update was given at the April Provider meeting, demonstrating a positive response from the acutes. They all provided a clear and thorough assessment responding to the 4 priority headings: Onward Referrals, Discharge, Call/Recall and Clear Points of Contact. Future actions were identified and acknowledged, with a collaborative supportive format agreed. This will be repeated six monthly so that NHS England can monitor progress nationally, and the following update will be in October 2024.

## **Challenges**

Progress continues to be made in the high priority areas for improving the working across the primary-secondary care interface, however a challenging winter and the impact of strikes affected the capacity of NHS provider organisations to respond as quickly as they might have liked.

Progress with implementing some of the key initiatives, such as ICE requesting and enabling private referrals, has been slow. Nationally, it is reported that interface issues make up approximately 20% of practice workload with an already over-stretched workforce, and while our local practices anecdotally report the same, we do not have the local data to evidence this. Under-reporting of issues from general practice is likely to be masking capacity issues.

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Reporting patterns and referral behaviours, however, may change in light of the British Medical Association's General Practitioners Committee England being in dispute with NHS England in relation to the 2024/25 General Medical Services contract for general practice. The BMA has written to ICBs asking them to include a new risk on their Board Assurance Framework. This has been included in our general practice resilience risk reporting. We will be monitoring any potential impact associated with the dispute across the primary – secondary care interface, and other areas closely as the situation develops.

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

Many NHS App promotion events have been held since last July, dozens of NHS App Ambassadors have been signed up, and an NHS App toolkit developed for practices to use. Half a million Norfolk & Waveney residents are registered for the NHS App, which is just over 51% of the population with a range of practice sign up from 41% to 69%. Over the last 3 months, new sign ups to the NHS app in Norfolk & Waveney have been 49,000, 49,500 and 51,000 patients consecutively, which demonstrates that the numbers are growing regularly. We can also see that there are 600,000 log ins to the NHS App monthly, with 75,000 repeat prescriptions are ordered and over 300,000 patient record views.

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

The Digital Team had implemented a pilot programme of cloud-based telephony (CBT) support before the national scheme was introduced. This included 38 practices with an operational date of the end of October 2024. Through the national scheme, a further 50 practices have been funded for Cloud Based Telephony systems over two phases. Of these, 36 practices are live with their new systems and 14 are in flight, with all installations due to be completed by the end of October 2024. The remaining 17 practices have CBT in other forms or with providers not on the national framework. This is for a variety of reasons, including contracts terms already agreed. The Digital Team continues to support these practices to ensure that their systems are compatible with national reporting requirements.

As well as valuable information on incoming calls to support management of demand and capacity, the new systems have call back functionality which means patients do not have to stay on the line paying for the call, the practice will ring back when the patient reaches the front of the queue.

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

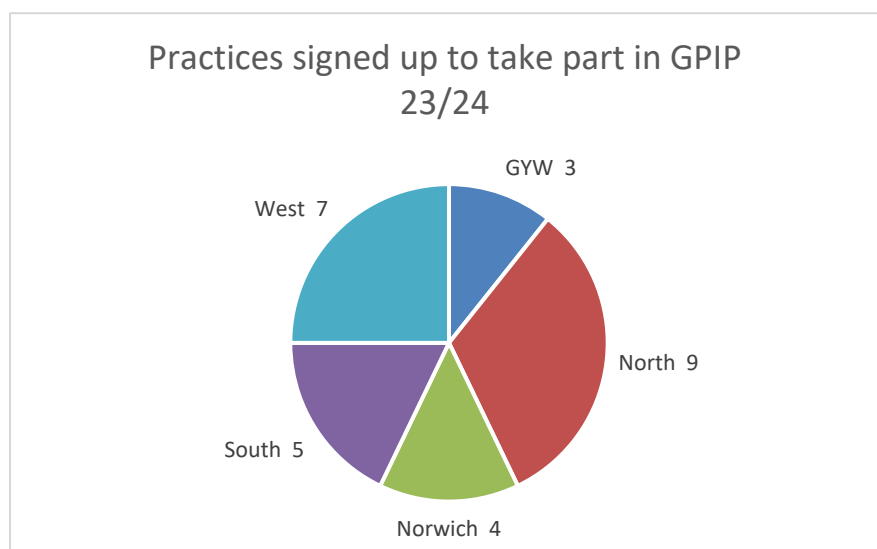
The GP Improvement Programme and Care Navigation Training assists practices in moving towards the General Practice Access Model.

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Throughout 2023/24 all practices have been working as part of their primary care network under PCN Capacity and Access Improvement Plans (CAIP), to move towards greater alignment with the Modern General Practice Access Model. Each of the PCNs have been working towards achieving the milestones they submitted in their CAIP at the start of 2023/24. The Primary Care Commissioning team have been coordinating the process of receiving the PCN plans, reviewing them, providing feedback and guidance and supporting PCN Leads with delivery. Through this process the team were able to identify practices which needed additional support or could benefit from the various training offers.

The team are now in the process of reviewing the end of year reports for 2023/24 and releasing the final 30% of payment for local Capacity and Access Improvement from the Investment and Impact Fund. Based on progress to date, it is expected that all PCNs will receive the full final payment.

The GP Improvement Programme (GPIP) provides a suite of training & support offers, ranging from online resources to in-person facilitated workshops. Across the East of England, Norfolk & Waveney ICB have the highest number of practices accessing GPIP as an ICB. As part of this, 28 practices have signed up to the GP Intermediate or Intensive Support Programme (see below for a breakdown by Locality). The programmes provide a hands-on package of support delivered over either 13 weeks (Intermediate) or 26 weeks (Intensive).

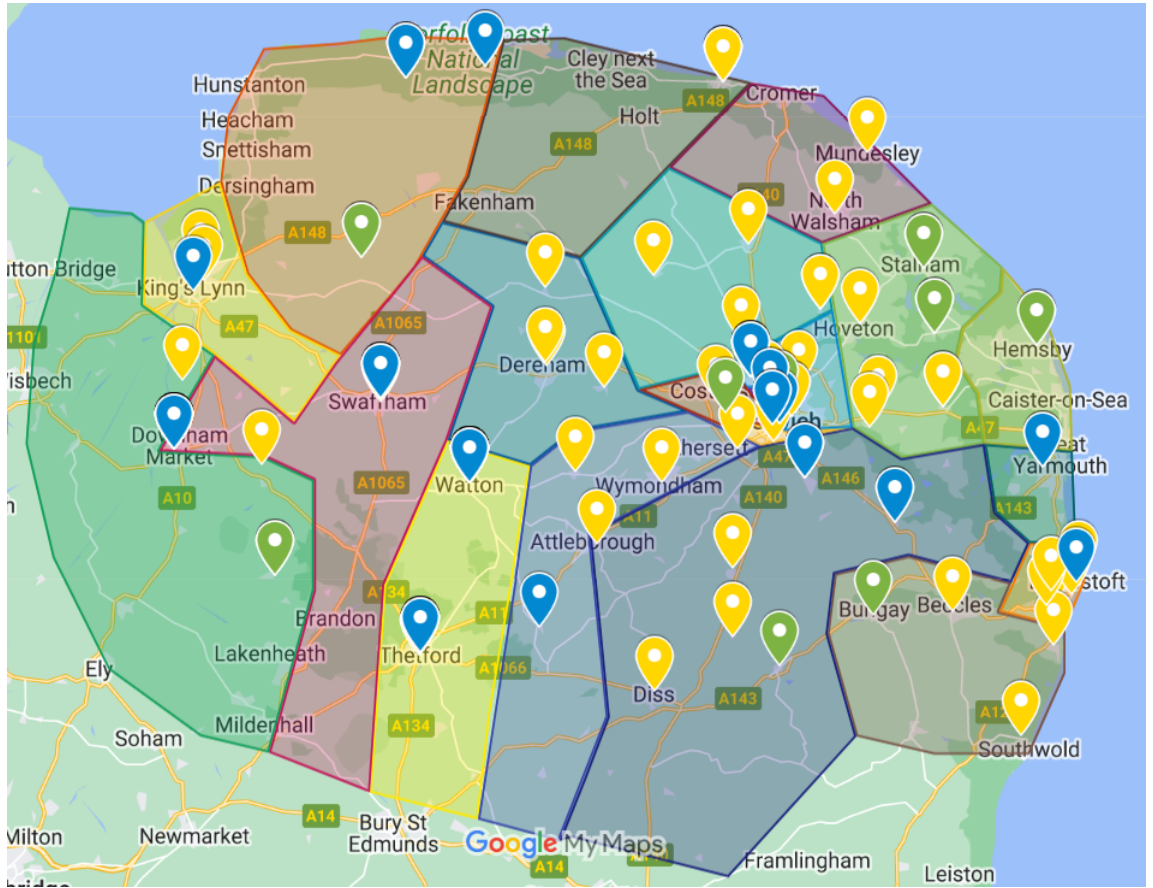


N&W ICB Practices Signed up to GPIP by Locality (2023/24)

Care Navigation training to February 2024: uptake across Norfolk and Waveney shown below:

- 68 practices have sent staff on a course (64.76% uptake from practices in N&W)
- Every PCN has sent at least one learner on a course.
- In total 123 learners attended a Care Navigation course over the past year (March 2023 - February 2024).
- Highest attendance was on the National Foundation Level courses (63 learners), followed by the local course (48 learners) and Advanced Level (12 learners).

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Key:  
 Green – Advance National Programme  
 Blue – Local Programme (via Training Hub)  
 Yellow – National Programme

**Transition Cover Funding**

Norfolk & Waveney ICB were allocated £860,000 in Transition Cover Funding for 2023/24 and were able to draw down 99% of this funding for practice support. £305,089 was released in response to 38 practice requests in February 2024. A further £547,158 was paid to 66 more practices by the end of March 2024.

Practices receiving the Transition Cover Funding have been asked to provide the following by the end June 2024:

- Completed Support Level Framework or Self-Assessment Form.
- Evidence to demonstrate their use of funding.

The Support Level Framework and Self-Assessment forms provide insight into where practice believe they are and where they are heading to across three key areas:

- Understanding demand and available capacity
- Patient experience
- Managing non-patient facing workload

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

Whilst the national Digital Pathways Framework launch has been delayed, this has not stopped progress in the use of digital tools and technology. Practices are supported through provision of an intranet site, giving access to resources and information about clinical system optimisation, best practice in messaging, the online consultation systems available and how to switch. Practices also have direct access to the Clinical Systems and Digital First Primary Care Support team for any queries they may have.

Practices have been provided with modern messaging tools, enabling direct messaging to patients via a floating toolbar, which also allows links to forms allowing patients to provide information directly.

Practices have access to a social media managed service that runs campaigns on their behalf, such as promotion of the NHS App and Pharmacy First schemes.

Two area wide forums are in place, DIGIT is a forum for anyone with an interest in IT and digital tools in primary care, and a separate, smaller forum is aimed at the PCN Digital Transformation Leads, giving them more detailed information on initiatives that can support primary care.

A small number of practices have adopted RPA – robotic process automation – of patient registrations and are saving around 15 minutes per registration. The ICB Digital Team has developed an automation for processing repeat prescriptions and this is also being made available to practices.

We are working on initiatives with Care Homes such as proxy access for online medication ordering and remote observations, to take tasks away from General Practice, and are rolling out the Shared Care Record to give clinicians in other settings access to information that they need without having to call the GP Practice.

New modern infrastructure is being implemented in all GP Practice premises which will bring fast fibre connectivity and wi-fi throughout the building, enabling the use of apps and giving patients the ability to use the internet to access services and information. Visiting clinicians from other services such as Mental Health, will be able to connect seamlessly using GovRoam.

## **Pharmacy First**

### **Progress**

In May 2023 when the delivery plan for recovering access to primary care was launched an ambition was set to build on the clinical services provided within our community pharmacies to help support their integration within the NHS and to

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make them the first port of call for many minor illnesses

This saw significant investment in:

- The launch of a new national Pharmacy First service enabling pharmacies to treat seven common conditions without the need in most cases for referral to a GP.
  - otitis media
  - sore throat
  - sinusitis
  - shingles
  - infected insect bites
  - impetigo
  - uncomplicated urinary tract infections in women
- Expansion of the already existing hypertension service which has already delivered over 930,000 blood pressure checks in just over a year. This has the potential to prevent over 1,350 cardiovascular events such as heart attacks and strokes. Savings of around £13 million would be seen from the reductions in these events across primary, secondary, and social care.
- Development of the oral contraception service to allow Community Pharmacist to not only continue treatment for patients but also to initiate treatment.

In all 3 cases it means that more people have the possibility of being seen outside of a GP setting for their triage and treatment, albeit Pharmacy First is a voluntary service for community pharmacy.

We currently have 168 community pharmacies out of 171 across Norfolk and Waveney signed up to provide the Pharmacy First service. All pharmacies signed up to the Pharmacy First service also have the capacity to support minor ailment referrals.

- To date we have had no patient concerns raised directly to the ICB regarding the service which points to a successful launch.
- Data shows that we have had activity on our ICB website landing page, which includes a *frequently asked questions* section.
- General practice engagement with the service overall has been good, but the ongoing impact of workforce challenges on pharmacy service provision in some area has caused some expected nervousness in making electronic referrals in preference to signposting.

### **Challenges**

- **Digital Integration** - The service, when introduced nationally at the end of January 2024, launched with unexpected, **limited** IT functionality. NHS England continues to work on this element of digital interface, and we

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understand the rollout of this will be phased imminently across the four pharmacy IT platforms mandated as part of the service.

- **Absence of activity data** – ICB level data remains unavailable 3 months post launch. We are assured this data will be available in due course.
- **Lack of formal referrals** – most activity is currently driven through signposting or walk-ins. Increasing the use of electronic referral system by General Practice, particularly for pharmacies located in more rural locations, will be key to making the scheme viable for pharmacies in the longer term.
- **Lack of training** – training linked to the national launch was limited, particularly with general practice and NHS111 providers - a local engagement plan has been developed designed to fill some of the gaps. Clinical training was provided locally by the ICB for 120 pharmacists with a focus on upskilling knowledge for ENT (ears, nose and throat) and the use of otoscopes. Clinical mentoring is also being reviewed as part of our review of development and training needs.

**Key next steps:**

- Develop a toolkit/support package for our local practices to support with frequently asked questions.
- Work continues improving the functionality for referrals between General Practice and Pharmacy, this is critical to the future of the service. Although the current format is fully functional there is limited desire to use it due to it not being user friendly. If following research, a more user-friendly option is not available then a robust support package will need to be developed to ensure the uplift of electronic referrals using current functionality.
- Develop a training package and review the need for training sessions for our general practice teams on electronic referrals (current solution) to support the need for this approach going forward.
- Continue to monitor the risks of the service using the intelligence we receive within the ICB to ensure that patient safety is not impacted, and that support is provided in the areas where it is required. This will be done in conjunction with the ICB Pharmacy quality team.
- Deliver a post launch CPD (Continuing Professional Development) event for pharmacy contractors and general practice colleagues involved in the service to gain feedback and insights into opportunities for support post launch. The event is due to be completed in May 2024 and the invite to all relevant stakeholders has already gone out for parties to register their interest.
- Explore the need for a clinical mentorship programme to help support pharmacists within this new clinical field. This will also help to build and maintain current local relationships and to support our integration agenda.
- Develop a Pharmacy First communication plan and release patient directed communication to highlight the service locally, to encourage patients to think Pharmacy First. The timing of this will be key to ensure the public's confidence in the service remains high following positive experiences Our first directed

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communication was over the Easter period and focused on the Infected Insect Bite Clinical Pathway due to its seasonal occurrence at this time.

Once the Pharmacy First service has embedded, focus will switch to the hypertension and contraception services with the encouragement for sign up from our community pharmacies with initial numbers being low compared to that of the Pharmacy First service.

The Primary Care Workforce Team (PCWT) at Norfolk and Waveney ICB works alongside colleagues from community pharmacy to support the uptake of the Pre-Registration Trainee Pharmacy Technician Programme. The PCWT supports employers in accessing their government levy, regional funding allocation and supports candidates with their application to the course. With potential changes in supervision in pharmacy there will be more emphasis on technicians taking greater accountability for the operational running of the dispensary whilst the Pharmacist focusses on patient care and services. The role of a GPHC Registered Pharmacy Technician is essential to the future of the pharmacy workforce and the long-term aspirations of the workforce/recovery/access plan.

## Conclusion

Whilst progress continues against implementing the ambitions outlined within the Delivery plan for recovering access to primary care, the resilience of general practice remains a significant issue and, without addressing this, delivery against some of the ambitions in our system capacity and access improvement plan will be limited.

New posts were introduced under the ICB organisational change programme designed to bring a greater focus across all system partners on the overall resilience of general practice and to improve the effectiveness of outputs from the System Interface Group. As the ICB transitions into the new operating model a positive impact is expected. The dispute, however, between the British Medical Association's General Practitioners Committee and NHS England has the potential to disrupt many of the workstreams sitting under the recovering access programme. The ICB will continue to monitor the national and local situation closely and work with providers to mitigate this wherever possible.

## Recommendation

The ICB Board is asked to note the following:

- The progress, and challenges, against the ambitions of the *Delivery Plan for Recovering Access to Primary Care and General Practice and Secondary Care: Working better Together*.
- The focus on year two of the delivery plan against key targets will continue to follow the key themes of:
  - Empowering patients
  - Implementing modern general practice access

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- Building capacity
- Cutting bureaucracy

Further detail on delivery actions for 2024/25 can be found in Appendix C, with locally led workstreams for embedding Pharmacy First, improving interface, building our primary care workforce and supporting effective Primary Care Network plans for improving access under the PCN DES Contract. A further update will be brought to Board, in line with the national guidance requirements, later in the year.

Underpinning all workstreams will be an approach aimed at improving the resilience of primary care and addressing health inequalities.

<b>Key Risks</b>	
<b>Clinical and Quality:</b>	Quality and capacity in primary care can be impacted due to inefficient working arrangements across the primary-secondary care interface, causing resilience and workforce issues.
<b>Finance and Performance:</b>	Capacity of care can be impacted due to inefficient working arrangements across the primary- secondary care interface. Potential industrial action by general practice could impact on the performance of other healthcare partners.  Failure to progress against the interface requirements of the plan will affect the ICB's and ICS assurance process.
<b>Impact Assessment (environmental and equalities):</b>	Reduced capacity could constrain the ability to target health inequalities.
<b>Reputation:</b>	Non-delivery of the ambitions outlined within the plan poses a significant system reputational risk due to the high profile of the plan nationally.  Lack of perceived progress against primary secondary interface poses a reputational risk with practices.
<b>Legal:</b>	None identified
<b>Information Governance:</b>	System IG group established in response of challenges working across providers highlighted in previous report.
<b>Resource Required:</b>	Primary Care Workforce Transformation, Contracting and Procurement, Medical Directorate, Mental Health Directorate and Digital and Primary Care resource must be retained to support the delivery of this plan.  Dedicated capacity within the ICB and secondary care providers is required to ensure timely progress with improving issues across the primary- secondary care interface. There is an ICB capacity risk relating to the

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	organisational change process and associated vacancy management processes.
<b>Reference document(s):</b>	<a href="#">Delivery Plan for Recovering Access to Primary Care General practice and secondary care: Working better together</a>  Delivery Plan for Recovering Access – Update published December 2023 <a href="https://www.england.nhs.uk/long-read/primary-care-access-recovery-plan-delivery-update/">https://www.england.nhs.uk/long-read/primary-care-access-recovery-plan-delivery-update/</a>  Delivery Plan for Recovering Access – Update and Actions published April 2024  <a href="https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care-update-and-actions-for-2024-25/">https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care-update-and-actions-for-2024-25/</a>
<b>NHS Constitution:</b>	<a href="#">NHS Standard Contract</a>
<b>Conflicts of Interest:</b>	GP and Trust partner members may be conflicted.
<b>Reference to relevant risk on the Board Assurance Framework</b>	Risk to resilience of primary care, on BAF and monitored through PCCC. Score of 16.

## Governance

<b>Process/Committee approval with date(s) (as appropriate)</b>	N/A
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## Appendix A

Progress against potential quick win actions for systems set out in *General practice and secondary care: Working better together* report

Recommended action	Progress
<p>GPs giving trainee doctors regular 'show and tell' sessions on how to fill out discharge summaries in the most informative and accessible way.</p>	<p><b>On-going</b></p> <p>Providers have suggested they include information about the interface requirements within their junior doctor inductions and teaching sessions. This is currently in progress.</p>
<p>Provide clinicians with read-only access to health record systems across the interface.</p>	<p><b>On-going</b></p> <p>The Norfolk and Waveney Shared Care Record is being rolled out across the system, supporting this action.</p>
<p>Employ a Primary Care Liaison Officer to help in the resolution of queries between secondary care and general practice</p>	<p><b>On-going</b></p> <p>This has been highlighted to our providers for consideration. The Norfolk and Norwich Hospital has recruited a GP to be their Associate Medical Director supporting Primary Care Liaison. Other providers are developing local interface forums to resolution of queries between secondary care and general practice. ICB is recruiting to dedicated interface manager role.</p>
<p>Provide patients with a written update on where they are on the waiting list, asking if they still require or want treatment</p>	<p><b>On-going</b></p> <p>This recommendation has been shared with our providers. Providers already contact patients, either by phone or letter, when they have been waiting for extended periods to confirm they wish to remain on the waiting list. The ICB regularly provide practices with updates on waiting times per specialty and provider so that this information can be shared with patients at the time of referral.</p>

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<p>Standardise outpatient clinical letters where possible (placing particular emphasis on concise GP recommendations)</p>	<p><b>On-going</b></p> <p>There is work ongoing currently led by the ICB to review the content of clinic letters, including the requirement for clinic letters to be addressed directly to patients rather than referrers. This action is being considered alongside this work.</p>
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## Appendix B

<b>A. Empower patients</b>			
1	Enable patients in over 90% of practices to see their records and practice messages, book appointments and order repeat prescriptions using the NHS App by March 2024.	<b>Partially complete</b>	Half a million Norfolk & Waveney residents are registered for the NHS App. 75,000 repeat prescriptions are ordered via the NHS App by Norfolk & Waveney residents each month via the App and there are 308,000 record views.
2	Ensure integrated care boards (ICBs) expand self-referral pathways by September 2023, as set out in the <a href="#">2023/24 Operational Planning Guidance</a> .	<b>On track</b>	Self-referral pathways are in place across the services in the community and acute settings. At the end of March 2024 self-referrals made up 16% of all referrals for 23/24. For the community provided services it was 29% and for the acute based services it was 5%.
3	Expand pharmacy oral contraception (OC) and blood pressure (BP) services this year, to increase access and convenience for millions of patients, subject to consultation.	<b>Ongoing</b>	Launched December 2023, see paper for further detail for plans to monitor and expand.
4	Launch Pharmacy First so by the end of 2023 community pharmacies can supply prescription medicines for seven common conditions.	<b>Ongoing</b>	Launched January 2024, see paper for further detail on next steps and challenges.
5	Greater flexibility to release pharmacists' time for patient-facing services.	<b>On track</b>	Public consultations delivered and legislative changes, in preparation, the Primary Care Workforce Team are working alongside colleagues from community pharmacy to support the uptake of the Pre-Registration Trainee

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			Pharmacy Technician Programme
<b>B. Implement Modern General Practice Access</b>			
6	Support all practices on analogue lines to move to digital telephony, including call back functionality, if they sign-up by July 2023.	<b>Implementation nearing completion</b>	88 practices signed up and due to transition under two national phases and system pilot programme, 36 practices now live with the rest due to be completed by the end of October 2024. 17 remaining practices have their own CBT solution
7	Provide all practices with the digital tools and care navigation training for modern general practice access.	<b>Complete</b>	All practices have had access to funding to support procurement of digital tools. Further details of care navigation uptake can be found in the paper.
8	Deliver training and transformation support to all practices from May 2023 through National General Practice Improvement Programme.	<b>Complete</b>	All practices offered opportunity for support, further detail of take up can be found in the paper.
<b>C. Build capacity</b>			
9	Make available an extra £385 million in 2023/24 to deliver 26,000 more direct patient care staff employed and 50 million more appointments by March 2024 (versus 2019).	<b>Complete</b>	We have delivered both and exceeded staff roles within Direct Patient Care roles compared to 2019.  DPC FTE across Norfolk and Waveney – total 1,118.39 FTE PCN Joiners rates 71% for DPC DPC ARRS increase by 39% since March 2019

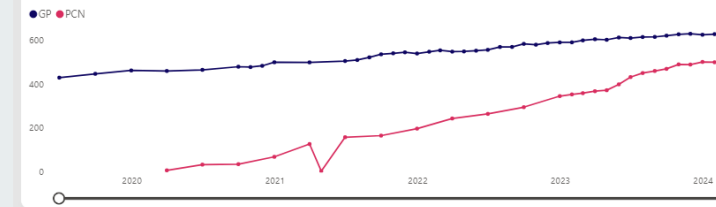
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### Primary Care - GP & PCN Workforce

Breakdown of both PCN and GP staff in post (FTE) as at the latest month submission, and over time.



N&W GP & PCN FTE Over Time



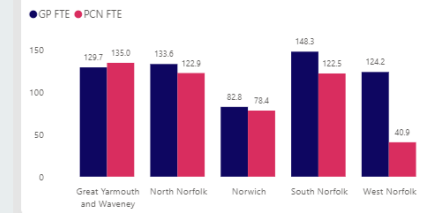
**618.67**  
Latest GP FTE

**499.72**  
Latest PCN FTE

Filters applied:

Staff Group: DPC  
Place: Multiple selections

Latest Month N&W GP & PCN FTE



Staff Group	Latest GP FTE	Latest PCN FTE	PCN Leaver Rate	PCN Joiner Rate
DPC	618.67	499.72	25.2%	71.0%
Advanced Occupational Therapist Practitioner	0.00			
Advanced Paramedic Practitioner	15.85	1.79	0.0%	200.0%
Advanced Pharmacist Practitioner	9.49	6.52	92.2%	260.8%
Advanced Physiotherapist Practitioner	0.20	0.43	0.0%	200.0%
Advanced Podiatrist Practitioner	0.00			
Apprentice	0.00			
Apprentice - Health Care	0.00			
Apprentice - Other	4.53			
Apprentice - Pharmacist	1.00			
<b>Total</b>	<b>618.67</b>	<b>499.72</b>	<b>25.2%</b>	<b>71.0%</b>

10

Further expand GP specialty training

Ongoing

86% of N&W are now an approved training practice by NHSE  
 35% increase of Tier 3 Educators across the system during 23/24, this is an additional 35 Tier 3 GP's  
 5 PCN's piloting the PCN Learning Organisation Model  
 95% success rate of an 18-month GP Fellowships from CCT qualification within primary care. 19 new GP Fellowships within 23/24 and expected 21 new GP Fellowships within 24/24.

11

Change local authority planning guidance to raise the priority of primary care estates.

On track

Work underway with Department for Levelling Up, Housing and Communities.

The National Planning Policy Framework (NPPF) requires local planning authorities to ensure that health and wellbeing, and the health infrastructure are considered at all levels of planning and decision making

- In addition to the work being led nationally between DHSC and DLUHC, to raise the priority of healthcare infrastructure in planning guidance, locally the ICB are working closely with our local authority and planning colleagues.

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			<ul style="list-style-type: none"> <li>- The ICB Estates team employs a Planning Liaison and Policy Lead who is responsible for influencing planning guidance, local plans, and responding to consultations. They ensure the impacts on healthcare and its estates infrastructure is highlighted throughout the planning and decision making processes and that mitigation is considered and prioritised.</li> <li>- A Planning in Health Protocol forms the basis for engagement between local planning authorities, the Norfolk and Waveney ICS, Health Providers and Public Health. The ICB estates team provides a single point of contact with planners to engage with the ICB and healthcare providers.</li> <li>- Discussions are taking place between the ICB and local authority colleagues to remove barriers preventing health accessing Community Infrastructure Levy (CIL) in Greater Norwich (Norwich, South Norfolk and Broadland) and King's Lynn &amp; West Norfolk.</li> <li>- Our collaborative working with council and local planning authority colleagues has brought many positives. There are many instances where we have been successful in obtaining CIL and/or S106 capital contributions to help us expand our infrastructure. There are also several ongoing infrastructure initiatives the ICB, and local councils are working on together to provide new capacity in multi-tenanted sites/buildings, providing a range of services and facilities.</li> </ul>
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**D. Cut bureaucracy**

	Reduce time spent liaising with hospitals by improving the interface with primary care, especially the four areas highlighted by the Academy of Medical Royal Colleges report, in a public board update in Autumn.	<b>Ongoing</b>	Detailed update can be found in the paper.
13	Streamline the Investment and Impact Fund (IIF) from 36 to five	<b>Complete</b>	This has been completed and approach will continue in 2024/25. In 2024/25 the number of IIF indicators will be reduced further from 5 to

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	indicators – re-target £246 million – and protect 25% of Quality and Outcomes (QOF) clinical indicators.		2 (retaining the indicators on learning disability health checks and FIT/ testing), and the funding from the other 3 indicators (flu and access) will be redirected into the CAP.
14	Reduce unnecessary bureaucracy and administrative burdens placed upon General Practice to free up time for patients through the bureaucracy busting concordat.	<b>On track</b>	DHSC work ongoing with other government departments.

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Appendix C

NHS National Delivery Actions for 2024/25

<b>A. Empower Patients</b>		
1	Increase use of NHS App and other digital channels to enable more patients to access to their prospective medical records (including test results) and manage their repeat prescriptions.	<p>Increase NHS App record views from 9.9m to 15m per month by March 2025.</p> <p>Increase NHS App repeat prescription numbers from 2.7m to 3.5m per month by March 2025.</p>
2	Continue to expand Self-Referrals to appropriate services.	Increase number of self-referrals across appropriate pathways by a further 15,000 per month by March 2025.

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3	Expand uptake of Pharmacy First services.	<p>Increase PF pathways consultations per month by at least 320,000 by March 2025 Increase oral contraception prescriptions coming directly from a Community Pharmacy by at least 25,800 by March 2025.</p> <p>Increase Community Pharmacy Blood Pressure check appointments by at least 71,000 per month by March 2025 as part of our ambition to deliver a further 2.5 million blood pressure checks in community pharmacy.</p>
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**B. Implement Modern General Practice Access**

4	Complete implementation of better digital telephony.	Percentage of PCN practices meeting CAIP payment criteria (>90%).
5	Complete implementation of highly usable and accessible online journeys for patients.	Percentage of PCN practices meeting CAIP payment criteria (>90%).
6	Complete implementation of faster care navigation, assessment, and response.	Percentage of PCN practices meeting CAIP payment criteria (>90%).

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7	National transformation/improvement support for general practice and systems.	Programme milestones including sharing evidence, standards, best practice and support tools; which in turn enhance system-led targeted support to practices and PCNs.
<b>C. Build capacity</b>		
8	Continue with expansion and retention commitments in the Long Term Workforce Plan (LTWP).	As per the LTWP ( <a href="https://www.england.nhs.uk/long-read/nhs-long-term-workforce-plan-2/">https://www.england.nhs.uk/long-read/nhs-long-term-workforce-plan-2/</a> ).
<b>D. Cut bureaucracy</b>		
9	Make further progress on implementation of the four Primary Care Secondary Care Interface Arm recommendations.	Baseline in April 2024 using assessment tool and monitor ICB progress against implementation of AoMRC recommendations based on NHS Trust provider returns every 6/12.
10	Make online registration available in all practices.	More than 90% of practices using the on-line registration system by 31 December 2024.

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Improving lives **together**

Norfolk and Waveney Integrated Care System

# Integrated Care Board Finance Report

## February 2024

(Month 11, 2023-24)

ICB Board – Part One: 26th May 2024

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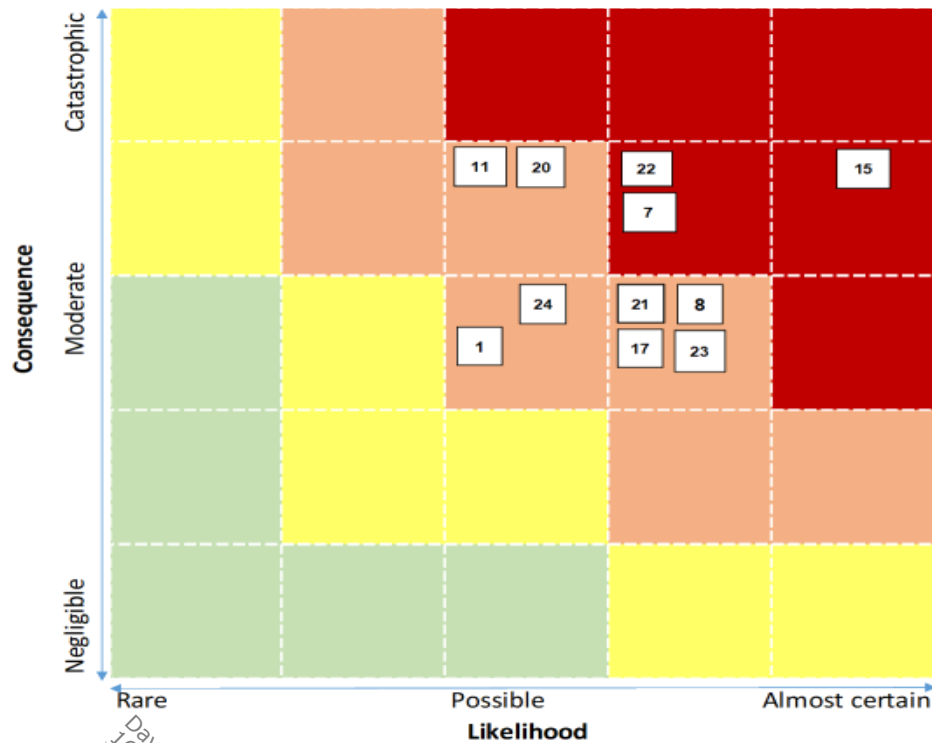
# 1. Executive Highlights

- This report represents the February 2024 year-to-date position of the ICB as part of the 2023/24 Financial Year.
- The ICB has reported a **Year-to-Date break-even position**, which is in line with the plan submission
- The **Forecast out-turn position is break-even**, in line with plan, but includes some offsetting variances, the major items being:
  - Full delivery of 17m of Pipeline Efficiencies. As part of the closing the gap exercise, £17.0 of pipeline efficiencies were identified of which £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.
  - £(19.4)m Continuing HealthCare (CHC) pressures as result of increases in High Costs Learning Disability packages and Fast Track packages
  - £(8.2)m Prescribing Pressure due to the Edoxaban Prescribing Rebate loss, national stock pressures, diabetes prescribing and increase in Oxygen Costs
  - £(14.9)m Pressure in Acute, including £10.7m anticipated system support required for QEH and additional independent capacity to reduce 78 week waiting list.
  - £16.5m under spend in Primary Care which includes a £17m anticipated underspend in dental contracts
  - £22.4m of combined smaller favourable benefits to include Prior Year, contract negotiations and other planning benefits.
- **The Underlying position at M11 is £(102.3)m deficit**, a deterioration of £(45.0)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 £(33.4)m due to Operational Pressures in CHC, Acute Independent Sector, Prescribing and Mental Health Packages. This is a small improvement of £(0.1)m against M10 underlying deficit of £(102.4)m.
- The **2023/24 Financial Plan included £75m of unmitigated risks** in-line with NHSEI guidance relating to efficiency delivery, investment slippage, service demand, inflationary pressures beyond funding, and corporate pay costs for the Re-Organisation.
- As at **M11 the £75m planning risk is reassessed for all aspects equating to £2.5m** net risk on a probability basis, which is excluded from the forecast. This risk has decreased from M10 (£7.3m). 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	Dec-23	Jan-24	Feb-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	12	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	12	12	12
Demand and Capacity	7	Continuing Health Care demand growth	9	16	16	16
	11	ERF: RTT backlog and Acute demand management	9	12	12	12
Efficiency	24	Patient Choice (Learning Disabilities & Autism)	9	9	9	9
	8	Efficiency, transformation development/delivery	8	12	12	12
			Extreme	3	3	3
			High	8	8	8
			Moderate	0	0	0
			Low	0	0	0
			Total Risks	11	11	11

As at M11 (February) 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 M10 (January).

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.

## 3. Statement of Financial Position (SOFP)

The Statement of Financial Position presents the aggregate closing position of the ICB as at 29th February 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 £44.6m balance is made up of aged debtors of £3.5m (including NCC £1.3m & NHSE £1.2m), net of a provision against this balance of £0.5m and prepayments and accrued income of £41.6m (including provider system support £17.8m & dental accrued income £15.6m). 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 £70m since year end, driven principally by ICB and system invoice accrual timing. The £159m balance is made up of trade creditors of £3m, Prescription Pricing Authority accruals of £18m, dental accruals of £4m, payroll costs including GP pensions of £3m, deferred income of £8m, prior year accruals of £16m and ICB and system invoice accruals of £107m. Provisions include legal, staffing and estates costs. There has been an in year part release against these provisions of £3m.

As part of the improvement in working capital with Norfolk County Council, outstanding non-PO transactions stand at £5.2m.

### 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 31/01/24	Position as at 29/02/24
<b>ASSETS EMPLOYED</b>			
<b>Non-Current assets</b>			
Right-of-use Assets	1,152	1,005	1,005
Accumulated Depreciation	(147)	(300)	(316)
<b>Total non-current assets</b>	<b>1,005</b>	<b>705</b>	<b>689</b>
<b>Current assets</b>			
Trade and Other Receivables	8,676	31,588	44,635
Cash and Cash Equivalents	1,649	2,801	683
<b>Total current assets</b>	<b>10,325</b>	<b>34,389</b>	<b>45,318</b>
<b>Current liabilities</b>			
Trade and Other Payables	(225,918)	(138,976)	(159,035)
Lease Liabilities	(219)	(192)	(192)
Provisions for liabilities and charges (including non-current)	(4,732)	(4,712)	(1,771)
<b>Total current liabilities</b>	<b>(230,869)</b>	<b>(143,880)</b>	<b>(160,998)</b>
<b>Long Term liabilities</b>			
Non-Current Payables	(686)	(686)	(686)
Non-Current Lease Liabilities	(775)	(511)	(472)
<b>Total non-current liabilities</b>	<b>(1,461)</b>	<b>(1,197)</b>	<b>(1,158)</b>
<b>Net assets employed</b>	<b>(221,000)</b>	<b>(109,983)</b>	<b>(116,149)</b>
<b>FINANCED BY TAXPAYERS EQUITY</b>			
General fund	(221,000)	(109,983)	(116,149)
<b>Total taxpayers equity</b>	<b>(221,000)</b>	<b>(109,983)</b>	<b>(116,149)</b>

## 4. ICS Financial Summary - Revenue

- The N&W ICS system financial performance is extracted from the PFR's submitted to NHSE.

Revenue surplus/(deficit) £m	Month 11 YTD			Forecast Outturn			FOT
Organisation	Plan	Actual	Variance	Plan	Actual	Variance	Confidence RAG
JPUH	(0.3)	0.0	0.3	0.0	0.0	0.0	Green
NNUH	(1.4)	(0.2)	1.2	0.0	(0.0)	(0.0)	Green
QEH	(1.0)	(9.2)	(8.2)	0.0	0.0	0.0	Green
NSFT	(1.2)	(1.2)	0.0	0.0	0.0	0.0	Green
NCH&C	0.1	0.1	0.1	0.0	(0.0)	(0.0)	Green
<b>Provider Subtotal</b>	<b>(3.9)</b>	<b>(10.6)</b>	<b>(6.6)</b>	<b>0.0</b>	<b>0.0</b>	<b>(0.0)</b>	
ICB	0.0	0.0	0.0	0.0	0.0	0.0	Green
<b>N&amp;W System Total</b>	<b>(3.9)</b>	<b>(10.6)</b>	<b>(6.6)</b>	<b>0.0</b>	<b>0.0</b>	<b>(0.0)</b>	

- The position M11 YTD is a £10.6m deficit, which is £6.6m adverse against plan.
- The adverse variance is mainly due to QEH who are £8.2m adverse to plan.
- Forecast outturn for the system is breakeven per the plan with all organisations confident (green RAG) for delivery.

# 5. ICS Financial Summary - Capital

- The N&W ICS system Capital Delegated Expenditure Limit (CDEL) position is from the IFR submitted to NHSE.

System CDEL £m	Forecast Outturn @ Mth 11										
	System 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		
<b>Excluding RAAC</b>											
JPH	7.0	0.0	7.0	6.9	(0.1)	0.1	0.6	0.5	7.1	7.4	0.3
NNUH	14.6	0.0	14.6	15.3	0.6	8.1	4.1	(4.0)	22.8	19.3	(3.4)
QEH	6.7	0.0	6.7	8.2	1.5	0.0	0.0	0.0	6.7	8.2	1.5
NSFT	12.6	0.0	12.6	9.6	(3.0)	2.4	1.6	(0.8)	15.0	11.2	(3.8)
NCH&C	4.8	0.0	4.8	4.5	(0.2)	0.0	0.5	0.5	4.8	5.0	0.3
<b>Subtotal excluding RAAC</b>	<b>45.7</b>	<b>0.0</b>	<b>45.7</b>	<b>44.5</b>	<b>(1.2)</b>	<b>10.6</b>	<b>6.8</b>	<b>(3.9)</b>	<b>56.4</b>	<b>51.3</b>	<b>(5.1)</b>
<b>RAAC</b>											
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
<b>Subtotal Including RAAC</b>	<b>78.5</b>	<b>9.3</b>	<b>87.9</b>	<b>86.6</b>	<b>(1.2)</b>	<b>10.6</b>	<b>6.8</b>	<b>(3.9)</b>	<b>98.5</b>	<b>93.4</b>	<b>(5.1)</b>
<b>Adjustments</b>											
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						(2.5)	0.0	2.5	(2.5)	0.0	2.5
<b>Total Adjustments</b>	<b>0.0</b>	<b>0.5</b>	<b>0.5</b>	<b>0.0</b>	<b>(0.5)</b>	<b>(2.5)</b>	<b>0.0</b>	<b>2.5</b>	<b>(2.0)</b>	<b>0.0</b>	<b>2.0</b>
<b>N&amp;W System Total CDEL</b>	<b>78.5</b>	<b>9.8</b>	<b>88.3</b>	<b>86.6</b>	<b>(1.7)</b>	<b>8.1</b>	<b>6.8</b>	<b>(1.4)</b>	<b>96.5</b>	<b>93.4</b>	<b>(3.1)</b>

M11 combined system CDEL performance is £3.1m below plan.

Strategic Capital Board approved c.£2m of additional expenditure in JPUH, QEH & NSFT to utilise the potential underspend.

In addition to system CDEL, RAAC & IFRS 16 funds, there is £123.8m of central programme funding, making the total capital resource for N&W ICS £220.3m.

Central Programmes £m	Forecast Outturn @ Mth 11										
	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		
<b>Total Central Programmes</b>			123.8	128.4	4.6	0.0	0.0	0.0	123.8	128.4	4.6
<b>N&amp;W Total Capital Programme</b>			<b>212.1</b>	<b>215.0</b>		<b>8.1</b>	<b>6.8</b>		<b>220.3</b>	<b>221.8</b>	

Currently the central programmes are showing an overspend but this is because the national IFR plans have not been updated with the latest scheme values.

# 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 <u>provider</u> 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 faceted 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.



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# 2024/25 System Wide Planning

ICB Board – 22 May 2024

Davey, Heidi  
16/05/2024 08:56:24

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16/05/2024 08:56:24

# 1. Executive Summary

- The N&W system financial plan was submitted to NHSE on the 2<sup>nd</sup> of May.
- The submitted system deficit was £36.0m. This included £5.5m of NNUH Technical PFI accounting changes, as mandated by national financial reporting policy.
- The system is leaving 23/24 with an underlying deficit of £228.4m. The 23/24 system break even position has been achieved by non-recurrent measures.
- An efficiency target of £176m (6.1%) is included in this plan. Of this £131.8m (75%) is recurrent and £134.3m (76%) is identified.
- The system reported £115.8m of net risk in addition to the £36m deficit.
- The system submitted a CDEL compliant capital plan, although risk exists around the impact and funding of IFRS 16
- NHS England expect the system's underlying deficit to be cleared by the end of 25/26.
- The Triple Lock will come into place in May 2024 due to the system deficit.

## 2. Underlying Position and 24/25 plan by organisation

- The Norfolk & Waveney System left 2023/24 with a £228.4m underlying deficit. The 23/24 system break even position has been achieved by non-recurrent measures.
- The next slide shows the drivers of this underlying deficit.
- The table top right shows the split of the underlying deficit alongside the submitted 2024/25 plan. The submitted £36m deficit includes £5.5m of NNUH Technical PFI accounting changes, as mandated by national financial reporting policy, without which the deficit would be £30.5m and NNUH would be reporting break even.
- The table bottom right shows the improvement in deficit between the 21<sup>st</sup> March draft plan submission and the 2<sup>nd</sup> May final submission. Overall the system position has improved by £58.8m.
- NCHC and NSFT were already at surplus break even on 21<sup>st</sup> March. Since then the ICB and NNUH (excluding the PFI adjustment) have reached break even while both JPUH and QEH have significantly improved their positions.

	23/24 Exit Underlying Surplus / (Deficit) £m	24/25 Plan Surplus / (Deficit) £m
JPUH	(36.7)	(17.9)
NNUH*	(49.9)	(5.5)
QEH	(24.5)	(14.1)
NSFT	(12.6)	0.0
NCHC	(2.4)	1.5
ICB	(102.3)	0.0
<b>N&amp;W Total</b>	<b>(228.4)</b>	<b>(36.0)</b>

	21st March Draft Surplus / (Deficit) £m	2nd May Final Plan Surplus / (Deficit) £m	Movement
JPUH	(31.2)	(17.9)	13.3
NNUH*	(32.5)	(5.5)	27.0
QEH	(26.8)	(14.1)	12.7
NSFT	0.0	0.0	0.0
NCHC	1.5	1.5	0.0
ICB	(9.9)	0.0	9.9
<b>N&amp;W Total</b>	<b>(98.9)</b>	<b>(36.0)</b>	62.9
<b>NNUH PFI</b>	<b>9.6</b>	<b>5.5</b>	<b>(4.1)</b>
<b>Total excl PFI</b>	<b>89.3</b>	<b>30.5</b>	<b>58.8</b>

### 3. Drivers of Underlying Deficit

- The drivers of the system's £228.4m 2023/24 exit underlying deficit are shown below.
- ICB Excess cost inflation from the outturn year is due to CHC and other package costs inflating by more than allocation since 2019/20. The CB has covered this non-recurrently to break even in each year.
- The next largest drivers are excess costs of service recovery (£40.7m) and recurrent costs funded non-recurrently in 2023/24 (£31.4m).

Drivers of Underlying Deficit £m	JPUH	NNUH	QEH	NSFT	NCHC	ICB	Total
UEC flow & discharge, causing overloading of capacity at all points in patient journey	(8.6)	0.0	(11.4)	0.0	0.0	0.0	(20.0)
Excess costs of elective, diagnostic and other service recovery	0.0	(31.3)	(9.4)	0.0	0.0	0.0	(40.7)
Excess cost inflation from the outturn year	(2.1)	(3.2)	(2.0)	(0.4)	0.0	(100.1)	(107.8)
Unsustainable investments in service developments and workforce growth	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Step challenge in the planning year financial framework including efficiency and convergence	(1.6)	(4.8)	(1.7)	0.0	(1.3)	(2.1)	(11.6)
Step challenge in productivity	0.0	0.0	0.0	(8.6)	0.0	0.0	(8.6)
Recurrent net deficit against non recurrent funding source	(24.4)	(5.9)	0.0	0.0	(1.1)	0.0	(31.4)
Other not included in above (explanation required)	(0.0)	(4.7)	0.0	(3.6)	0.0	0.0	(8.3)
<b>Total drivers of underlying deficit</b>	<b>(36.7)</b>	<b>(49.9)</b>	<b>(24.5)</b>	<b>(12.6)</b>	<b>(2.4)</b>	<b>(102.3)</b>	<b>(228.4)</b>

# 4. Efficiencies

- The table top right shows how the planned £176m system efficiency target is split by organisation. Each organisation is aiming to achieve at least 5% in 2024/25, a challenging target.
- Of this £131.8m (75%) is considered recurrent in the plan submission and £134.3m (76%) is identified.
- The table below shows the change in planned efficiency delivery between the 21<sup>st</sup> March draft and 2<sup>nd</sup> May final plan submissions. There has been an increase of £46.3m which has been the most significant contributor to the overall system deficit reduction of £58.8m between those dates.

£m	JPUH	NNUH	QEH	NSFT	NCHC	ICB	N&W Total
24/25 Plan Efficiencies £m	22.4	50.1	26.5	17.4	8.4	51.2	176.0
24/25 Plan Efficiencies %	7.1%	5.3%	8.1%	5.0%	5.3%	6.4%	
Recurrent	17.8	30.5	21.5	10.0	4.6	47.4	131.8
Non-recurrent	4.6	19.6	5.0	7.4	3.7	3.8	44.1
Recurrent %	80%	61%	81%	57%	55%	93%	75%
Identified	22.3	35.5	21.5	17.4	8.4	29.2	134.3
Unidentified	0.1	14.6	5.0	0.0	0.0	22.0	41.7
Identified %	99%	71%	81%	100%	100%	57%	76%

£m	21st March Efficiencies	2nd May Final Plan Efficiencies	Movement
JPUH	17.5	22.4	4.9
NNUH	27.2	50.1	22.9
QEH	17.1	26.5	9.4
NSFT	17.4	17.4	0.0
NCHC	8.4	8.4	0.0
ICB	42.1	51.2	9.1
N&W Total	129.7	176.0	46.3

## 5. Risks and Mitigations

- The table below shows the breakdown of the £115.8m system net risk reported in the 2<sup>nd</sup> May plan submission by organisation. There is £208m of identified risk offset by £92.2m of potential mitigations.
- The table below right shows the change in net risk position since the 21<sup>st</sup> March draft submission. Overall there is a £4.2m improvement although some organisations have seen their net risk position worsen.

£m	JPUH	NNUH	QEH	NSFT	NCHC	ICB	Total N&W
<b>Risks</b>							
Additional cost risk (capacity, pressures, winter, COVID)	(4.0)	(29.8)	(5.0)	(6.1)	0.0	(6.0)	(50.9)
Contract risk (excl. ERF)	0.0	0.0	0.0	0.0	0.0	(19.3)	(19.3)
Additional cost risk (inflation)	(1.2)	(3.0)	(2.0)	(1.0)	(0.4)	0.0	(7.6)
Efficiency risk	(5.2)	(27.6)	(15.0)	(6.0)	(6.0)	(17.9)	(77.7)
Income risk (excl. ERF)	(13.0)	(17.2)	(2.0)	(2.2)	0.0	(18.0)	(52.4)
<b>Total Risks</b>	<b>(23.4)</b>	<b>(77.6)</b>	<b>(24.0)</b>	<b>(15.3)</b>	<b>(6.4)</b>	<b>(61.2)</b>	<b>(208.0)</b>
<b>Mitigations</b>							
Additional cost control or income (excl. ERF)	13.0	26.8	0.0	0.0	0.0	0.0	39.8
Efficiency mitigation	5.2	6.0	0.0	0.0	0.0	0.0	11.2
Transformational / Pathway changes	4.0	0.0	0.0	0.0	0.0	0.0	4.0
Non-recurrent mitigation	1.2	5.0	5.0	0.5	0.0	12.0	23.7
Mitigations not yet identified	0.0	0.0	13.0	0.5	0.0	0.0	13.5
<b>Total Mitigations</b>	<b>23.4</b>	<b>37.8</b>	<b>18.0</b>	<b>1.0</b>	<b>0.0</b>	<b>12.0</b>	<b>92.2</b>
<b>Net Risk</b>	<b>0.0</b>	<b>(39.8)</b>	<b>(6.0)</b>	<b>(14.3)</b>	<b>(6.4)</b>	<b>(49.2)</b>	<b>(115.8)</b>

£m	21st March Draft Net Risk	2nd May Final Plan Net Risk	Movement
JPUH	0.0	0.0	0.0
NNUH	(23.5)	(39.8)	(16.3)
QEH	(14.3)	(6.0)	8.3
NSFT	(6.4)	(14.3)	(7.9)
NCHC	0.0	(6.4)	(6.4)
ICB	(75.8)	(49.2)	26.6
<b>N&amp;W Total</b>	<b>(120.0)</b>	<b>(115.8)</b>	<b>4.2</b>

## 6. Capital – System CDEL

### System CDEL

- The table below shows the breakdown of the total £80.7m system CDEL allocation, by category and organisation.

Org.	General / BAU CDEL £000s	BAU CDEL for DAC £000s	BAU CDEL for Hellesdon £000s	System CDEL Sub-Total	RAAC £000s	ICB - 2024/25 Capital Allocation £000s	Additional DAC Allocation £000s	2023/24 Rev Performance apportioned on General / BAU CDEL £000s	ICS Total CDEL Allocation (exc. IFRS 16) £000s
JPUH	5,258	2,300		7,558	7,203			508	15,269
NNUH	8,708	4,400		13,108			1,700	841	15,649
QEH	5,707	2,400		8,107	25,000			551	33,658
NSFT	5,302		3,760	9,062				512	9,574
NCHC	4,157			4,157				403	4,560
ICB				0		1,972			1,972
<b>Total</b>	<b>29,132</b>	<b>9,100</b>	<b>3,760</b>	<b>41,992</b>	<b>32,203</b>	<b>1,972</b>	<b>1,700</b>	<b>2,815</b>	<b>80,682</b>

- The N&W SCB (Strategic Capital Board) considered risk and prioritisations across all system partners and agreed to support the DAC & the Hellesdon development projects with £9.1m and £3.8m respectively from the £42m of general/BAU CDEL.
- In addition to the £42m of general BAU CDEL, specific system CDEL allocations were received for JPUH & QEH RAAC works of £32.2m, a specific £2m to the ICB for GP IT and Estate Infrastructure and an additional £1.7m was received from a national allocation for the DAC project.
- Finally, due to the 2023/24 system revenue breakeven performance, £2.8m of addition CDEL has been provided to the system and apportioned to organisations on the basis of the general/BAU CDEL allocation

## 6a. Capital – Central Funding

### Central Programme CDEL Funding

- The N&W system is also in receipt of additional CDEL resource funding from central programmes. Table below shows the breakdown of the total £128.3m by programme and organisation.

System Wide Central Programmes Funding	DAC & CDCs £000s	Elective Recovery £000s	UEC Capacity £000s	New Hospital Programmes £000s	Acute EPR £000s	MH EPR £000s	Other £000s	ICS Total £000s
JPUH	10,446	5,483		15,808	7,482		75	39,294
NNUH	26,700	27,467			18,456		1,400	74,023
QEH	3,500			3,200	7,421		75	14,196
NSFT			250			574		824
NCHC								0
<b>Total</b>	<b>40,646</b>	<b>32,950</b>	<b>250</b>	<b>19,008</b>	<b>33,359</b>	<b>0</b>	<b>1,550</b>	<b>128,337</b>

### IFRS 16 Impact Funding

- In addition to the System CDEL & Central Programme CDEL there is also a proposed allocation for the impact of IFRS 16.
- The notional allocation is £10.6m against an estimated system wide IFRS 16 impact of £19.8m, a £9.2m shortfall.
- Current guidance indicates that systems will be required to manage the IFRS 16 impact within this sum, any shortfall may have to be managed by utilising the BAU system CDEL, although this element of the capital plan is still subject to national consideration.



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# ICB Financial Plan Update

ICB Board – 22 May 2024

Davey, Heidi  
16/05/2024 08:56:24

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Davey, Heidi  
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## 2.1. 2<sup>nd</sup> May Plan Submission – Key metrics

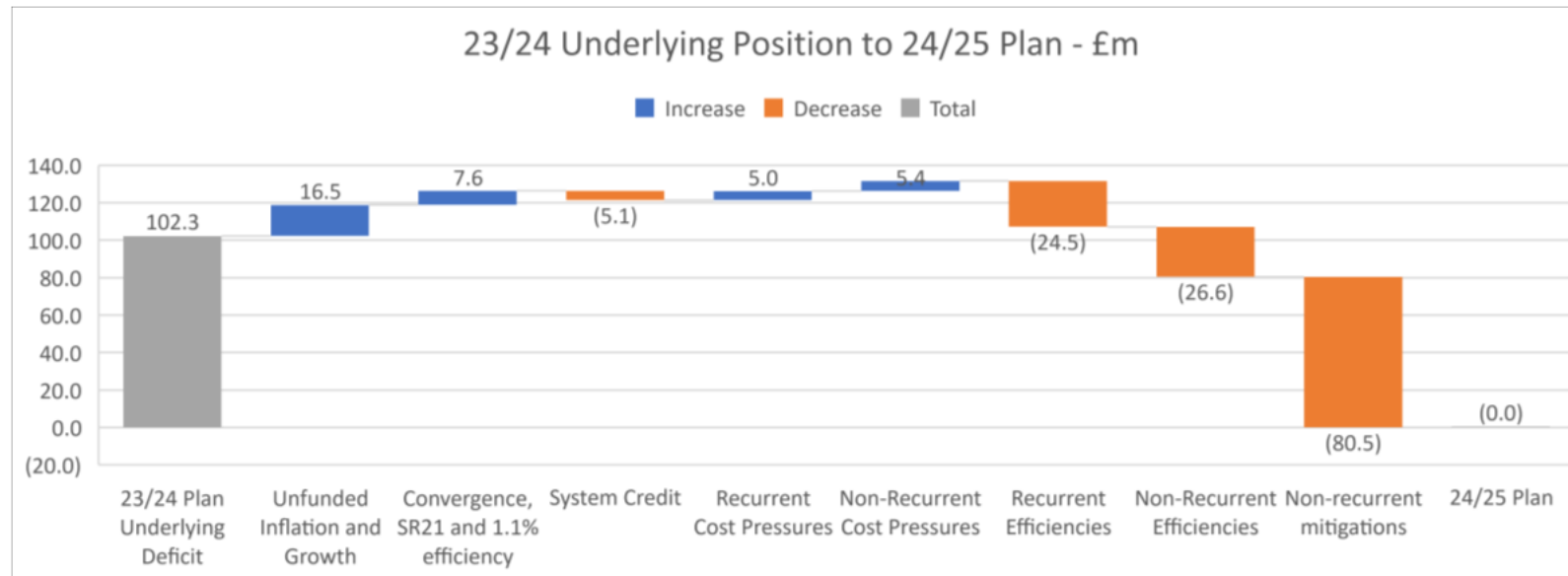
Key metrics from the ICB's 2<sup>nd</sup> May plan submission are as follows.

- 23/24 exit underlying deficit - £102.3m
- 24/25 position – break even
- 24/25 exit underlying deficit - £101.8m
- Efficiencies - £51.2m (6.4%), of which £28.3m (55%) is identified and £24.5m (47%) is considered recurrent
- Net risk - £49.2m
  
- Draft Planning Guidance was used to create the plan with updated CUF assumptions also applied.
  
- Two significant exceptions to guidance inflation assumptions are as follows;
  - Prescribing, where planned growth and inflation of 8% is far in excess of the 2.3% which formed part of the CUF calculation. This 8% assumption is based on trends and Medicines Management intelligence regarding 2024/25 prescribing prices and demand.
  - Prices of non-CHC packages of care (Intermediate Care, Neuro Rehab, Mental Health) tend to follow those in CHC so the ICB plan assumes the same level of inflation and growth (6.2%) as CHC for those packages.

Davey Heidi  
16/05/2024 08:16:24

## 2.2 Underlying Position to Planned Deficit

- The waterfall chart below shows the main movements from the ICB's exit 23/24 underlying deficit of £102.3m to its break even 24/25 plan.
- There is £16.5m of unfunded inflation, primarily within CHC and non-CHC packages of care, and the ICB is losing £7.6m of allocation due to convergence and the 1.1% efficiency requirement.
- The ICB is benefitting from the return of a £5.1m credit from system partners, and also has £10.4m of cost pressures including a £3m repayment to SNEE, repayment of this year's compulsory redundancy loan, and the requirement to further invest in Health Inequalities. The latter has been non-recurrently removed as a mitigation.
- The £80.5m of non-recurrent mitigations are described in more detail in section 2.3.



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## 2.3. 21st March Submission to 2<sup>nd</sup> May

- On 21<sup>st</sup> March the ICB submitted a draft plan with a deficit of £9.9m to NHSE. At the 2<sup>nd</sup> May submission this has been improved to a break even position, by increasing the organisation's efficiency target by £10m.
- Within the plan are £80.5m of mitigations, which along with additional efficiency assumptions brought the ICB's plan down from a first draft £94.1m deficit to break even, see the table on the right.
- Within these mitigations are £9m of additional system growth funding, £21.8m of investment slippage, £23.6m of assumed independent sector ERF income, £13.7m return of provider brokerage in 23/24 and £5.5m of reserve support from NHSE Specialist Commissioning.
- These mitigations are non-recurrent and will not improve the ICB's underlying deficit, which currently stands at £101.8m at the end of 2024/25. NHSE require the underlying deficit to be break even by the end of 2025/26.
- Many of these mitigations carry a level of risk and those have been included in the plan as net risks, see slide 2.5.

	£m
<b>Growth Funding</b>	
ICB Share of additional growth funding	9.0
<b>Slippage</b>	
ICB investment slippage	10.2
Capacity allocation slippage	10.6
SDF slippage	1.0
<b>Activity assumptions</b>	
ERF 23/24 - independent sector activity	17.6
ERF 24/25 - independent sector activity	6.0
<b>Finance methodology and system loans</b>	
Return of 23/24 provider brokerage	13.7
Regional SURGE (Spec Comm Reserve) Support	5.5
Regional 78 Week Funding	2.0
Financial Assumptions (CHC, Dental & Prescribing)	1.0
Estates Delapidation Provisions 2023/24	1.0
Discharge Funding Excess	1.0
Bad Debt Provision	1.2
Others	0.7
Total mitigating actions	80.5

## 2.4 Efficiencies

Recurrent Efficiencies Identified	Non Recurrent Efficiencies Identified	Unidentified Efficiencies	Total ICB Efficiency Programme
£000's	£000's	£000's	£000's
24,547	3,750	22,865	51,162
48%	7%	45%	

- The 2024/25 plan includes an efficiency target of £51.2m, this is an increase of £9m since the draft plan.
- £24.5m (48%) recurrent efficiencies and £3.8m (7%) non-recurrent efficiencies have been identified.
- £22.9m (45%) are to be identified.
- Plans to achieve 100% identified include;
- An ongoing scheme to review contracts and grants due to expire, plans to introduce an Allocation Gateway and a Recovery Template
- CHC and GP Prescribing efficiency groups meet fortnightly, both have standing items on the agenda for new efficiency ideas
- Fortnightly Performance Review Meeting (PRM) attended by EMT leads, Finance and PMO, one-off individual meetings with EMT leads, PMO and Finance to ensure all opportunities are being scoped.

Financial Year	Plan £000's	Actual/FOT £000's	Actual as % of plan
23/24	36,686	39,432	107%
22/23	18,674	19,229	103%
21/22	10,512	10,511	100%
20/21	6,420	1,000	16%
19/20	64,437	59,742	93%

- The ICB efficiency programme for 23/24 overachieved by 7%.
- The tables shows previous performance for 5 years.
- 19/20 was the last year of QIPP when schemes included savings with N&W providers.
- 20/21 did not deliver due to the Covid pandemic and redeployment of staff.
- Key members of staff that helped to deliver previous efficiency programmes are still involved in this process.

## 2.5 Risks and Mitigations

- The ICB submitted a net £49.2m risk position as part of the 2<sup>nd</sup> May plan.
- This is an improvement on the £74.9m net risk submitted on 21<sup>st</sup> March due to the introduction of £11.9m of potential mitigations and the reduction of some risks.
- The table on the right shows the breakdown of the £49.2m. The largest risks by value are as follows;
  - Non-delivery of efficiencies £17.9m. This is the risk of the ICB not achieving the £51.2m delivery target within the plan.
  - The risk that slipped Capacity Funding allocation will need to be spent £5.3m. This down from £9.7m in the draft submission.
  - Non-achievement of assumed ERF income in 23/24 and 24/25 £3m. This is down from £9m in the draft submission
  - Further unfunded inflation in CHC £10m.
- The largest mitigation is the potential for use of £9.9m unspent Dentistry money, although this is against current NHSE business rules.

Risks	£m
Non-delivery of efficiencies	(17.9)
Additional capacity funding (50%)	(5.3)
24/25 ERF	(3.0)
Pay costs for delayed compulsory redundancy roles	(3.0)
Prescribing - Wegovey/Ozempc	(3.0)
Prescribing High Cost Drugs (acute pressure)	(5.0)
Unfunded CHC demand and inflation	(10.0)
IPP/LDA (NCC Risk / Panel sharing application)	(6.0)
Specialised commissioning (inc EoE risk share)	(3.0)
NCC - legacy WC (23/24 items dispute)	(3.5)
ICES volume	(1.0)
Weight Management	(0.5)
<b>Total risks</b>	<b>(61.1)</b>
<b>Mitigations</b>	
Dentistry unmet need	9.9
BCF inflation	2.0
<b>Total mitigations</b>	<b>11.9</b>
<b>Net risk</b>	<b>(49.2)</b>

<b>Subject:</b>	<b>Board Assurance Framework</b>
<b>Presented by:</b>	<b>Karen Barker, Executive Director of Corporate Affairs and ICS Development</b>
<b>Prepared by:</b>	<b>Nikki Bartrum, Corporate Governance Senior Manager</b>
<b>Submitted to:</b>	<b>Integrated Care Board - Board Meeting – Part 1</b>
<b>Date:</b>	<b>22 May 2024</b>

**Purpose of paper:**

This paper presents the board with a copy of the updated Board Assurance Framework (BAF) to assist in the facilitation of discussions around risks associated impacting the ICB’s ability to deliver its strategic objectives.

**Executive Summary:**

Effective risk management is an essential part of the ICB's system of internal controls and supports the provision of a fair and well-illustrated Annual Governance Statement.

The BAF sets out the key risks that may impact on achievement of the ICB’s strategic objectives by mapping out the key controls that are in place to manage each risk and assurance that has been gained about the effectiveness of these controls. Each risk is owned by an Executive Director and an Operational Lead and scored against the grading matrix (see appendix 2).

The BAF categorises risks around 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 Board is presented with a copy of the BAF (Appendix 1) and the associated risk visual Appendix 2).

This paper comes to the Board following review by the Executive Management Team on 22 April 2024. The board are asked to note the following updates that have been made:

- **BAF05A: Barriers to full delivery of the Mental health transformation programme (Adults)** - the risk rating has increased from 12 to 16 (4x4)
- **BAF08: Elective Recovery** - the risk rating has decreased from 16 to 12 (3x4)

**Recommendation to Board:**

The Board are asked to receive and review the risks presented on the BAF.

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<b>Key Risks</b>	
<b>Clinical and Quality:</b>	None
<b>Finance and Performance:</b>	None
<b>Impact Assessment (environmental and equalities):</b>	None
<b>Reputation:</b>	It is important the Board is apprised of the key risks in the organisation currently.
<b>Legal:</b>	N/A
<b>Information Governance:</b>	N/A
<b>Resource Required:</b>	Corporate Affairs risk management resource
<b>Reference document(s):</b>	None
<b>NHS Constitution:</b>	N/A
<b>Conflicts of Interest:</b>	N/A
<b>Reference to relevant risk on the Board Assurance Framework</b>	See table.

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## 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

### Likelihood

		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
<b>Consequence</b>	1 Negligible	1	2	3	4	5
	2 Minor	2	4	6	8	10
	3 Moderate	3	6 BAF12a BAF12 BAF13	9	12	15
	4 Major	4	8 BAF22	12 BAF06 BAF08 BAF11 BAF14	16 BAF02 BAF03 BAF05a BAF05b BAF10 BAF15 BAF16 BAF19 BAF20 BAF21 BAF23	20 BAF09 BAF11a BAF18
	5 Catastrophic	5	10	15	20 BAF07	25

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

Version: 9      Date updated: 8 May 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												24/25
						1	2	3	4	5	6	7	8	9	10	11	12	
<a href="#">BAF02</a>	System Urgent & Emergency Care (UEC) Pressures	Mark Burgis	01/07/22	31/03/25	12	16	16	16	16	16	16	16	16	16	16	16	16	16
<a href="#">BAF03</a>	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	16	
<a href="#">BAF04</a>	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				
<a href="#">BAF05A</a>	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	16	
<a href="#">BAF05B</a>	Barriers to Full Delivery of the Mental Health Transformation Programme (CYP)	Tricia D’Orsi	01/07/22	31/03/24	8	16	16	16	16	16	16	16	16	16	16	16		
<a href="#">BAF06</a>	Health Inequalities and Population Management	Dr Frankie Swords Mark Burgis	01/07/22	31/03/25	4	12	12	12	12	12	12	12	12	12	12	12	12	12

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<a href="#">BAF07</a>	RAAC Planks	Steven Course	01/07/22	31/03/24	15	20	20	20	20	20	20	20	20	20	20	20		
<a href="#">BAF08</a>	Elective Recovery	Dr Frankie Swords	01/07/23	31/03/24	12	16	16	16	16	20	20	16	16	16	16	16	16	12
<a href="#">BAF09</a>	NHS Continuing Healthcare	Tricia D'Orsi	01/07/23	31/03/24	9	16	16	16	16	20	20	20	20	20	20	20		
<a href="#">BAF10</a>	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	16	
<a href="#">BAF11</a>	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		
<a href="#">BAF11A</a>	Underlying Deficit Position	Steven Course	01/07/22	31/03/24	12	20	20	20	20	20	20	20	20	20	20	20		
<a href="#">BAF19</a>	Right Care Now	Tricia D'Orsi	25/10/22	01/06/24	6	15	15	12	12	12	15	15	15	16	16	16	16	
<a href="#">BAF21</a>	Mortality Action Plan NSFT	Dr Frankie Swords	18/07/23	30/06/24	4				20	20	20	16	16	16	16	16	16	
<a href="#">BAF23</a>	System failure to meet access standards for cancer diagnosis and treatment	Dr Frankie Swords	22/11/23	31/03/24									16	16	16	16		

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## BAF02

<b>Risk Title</b>	<b>System / Urgent &amp; Emergency Care (UEC) Pressures</b>			
<b>Risk Description</b>	<p>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.</p> <p>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.</p>			
<b>Risk Owner</b>	<b>Responsible Committee</b>	<b>Operational Lead</b>	<b>Date Risk Identified</b>	<b>Target Delivery Date</b>
Mark Burgis	Patients and Communities Quality and Safety	Ross Collett	01/07/2022	31/03/2025

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
<ul style="list-style-type: none"> <li>• <b>Strategic Oversight:</b> 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.</li> <li>• <b>Business Continuity:</b> <ul style="list-style-type: none"> <li>○ 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.</li> <li>○ 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.</li> </ul> </li> </ul> <p><b>Specific controls to appropriately manage urgent and emergency care demand ensuring patient's needs are met:</b></p> <ul style="list-style-type: none"> <li>• <b>Hospital 'Admissions Avoidance':</b> A range of 'Admissions Avoidance' schemes are in place across N&amp;W to ensure that patients who have an 'urgent' care need are seen in a timely way in the right care setting, the core services are:           <ul style="list-style-type: none"> <li>○ <b>111 / GP led Clinical Advice Service (CAS):</b> 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.</li> <li>○ <b>Unscheduled Care Coordination Hub (SPOA):</b> The UCCH has been established since October 2023 as a</li> </ul> </li> </ul>	<p><b>Internal:</b> ICB Executive Management Team; Norfolk and Waveney UEC Programme Board; Three UEC Alliances aligned to each acute hospital system; System Control Centre (SCC)</p> <p><b>External:</b> ICS Executive Management Team (CEOs Group); Trust Boards; NHSE Regional Strategic Oversight</p>

single point of access for urgent care. The UCCH reviews the 999 and 111 stack coordinating the most appropriate response based on the patients' needs. The UCCH focusses on some of our most vulnerable and frail elderly patients to ensure only those that need a hospital admission or the service provided by an ED are conveyed. The UCCH also supports ambulance crews en-route and on scene with additional clinical support via the MDT and will release crews from scene within 30 minutes taking responsibility for patients who require alternative urgent care services such as Virtual Ward and UCR.

- **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.
- **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. This additional capacity has been maintained in to 24/25.
  - 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):**

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- 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 31<sup>st</sup> March 2023.
- 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 shown 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 31<sup>st</sup> 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 secondment has ended and the Discharge support from NOF4 is due to end in Q1 of 24/25 leaving a gap in system level capacity whilst UEC structure is reviewed post ICb restructure.
- 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 78% A&E 4-hour performance. Baseline average LoS is currently 8.1days for non-elective pathway.	A	31/03/25
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	31/03/25
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	31/03/25

**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	16
Change	↓	→	→	→	→	→	→	→	→	→	→	→

**Visual Risk Score Tracker – 2023/24**

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

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## BAF03

<b>Risk Title</b>	<b>Providers in CQC Special Measures (NSFT)</b>			
<b>Risk Description</b>	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.			
<b>Risk Owner</b>	<b>Responsible Committee</b>	<b>Operational Lead</b>	<b>Date Risk Identified</b>	<b>Target Delivery Date</b>
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 within the last quarter of 2024-25.
- 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.
- The Trust's Evidence Assurance Group (EAG) have received evidence of 13 completed Must Do actions of the original 30, at the time of writing; full completion is due by June 2024. A further 5 of 23 Should Do actions have also been completed with the remaining planned for April.

### 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.
- 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.
- Continued concerns and focus on the physical health monitoring of patients. The Trust has commenced an inpatient falls collaborative, involving their older people's wards.
- The key risk to delivery of NOF4 exit is around completion of staff training. The Trust remains in NOF4 with a recovery support programme in place with NHSE.

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	30/04/24
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	31/03/25
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	16	
Change	↓	→	→	↑	→	→	→	→	→	→	→	→	
Visual Risk Score Tracker – 2024/25													
Month	1	2	3	4	5	6	7	8	9	10	11	12	
Score													
Change													

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## BAF05A

<b>Risk Title</b>	<b>Barriers to full delivery of the Mental health transformation programme (Adults)</b>								
<b>Risk Description</b>	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								
<b>Risk Owner</b>	<b>Responsible Committee</b>		<b>Operational Lead</b>		<b>Date Risk Identified</b>		<b>Target Delivery Date</b>		
Jocelyn Pike	Quality & Safety		Emma Willey		01/07/2022		31/03/2025		
<b>Risk Scores</b>									
<b>Unmitigated</b>			<b>Mitigated</b>			<b>Tolerated (Target in 12 months)</b>			
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total	
4	4	16	3	4	16	2	4	8	
<b>Controls</b>					<b>Assurances on controls</b>				
<ul style="list-style-type: none"> <li>System wide governance framework in situ</li> <li>Finance &amp; Planning working group meet monthly to drive robust financial arrangements and deliver planned MHIS investment.</li> <li>Ongoing work with Population health management team to proactively contact and offer support/ physical health assessment and vaccination.</li> <li>Working in partnership with Norfolk and Suffolk Constabularies to implement a system wide collaborative approach to Right Care Right Person</li> </ul>					<p><b>Internal:</b> SMT, EMT, Board</p> <p><b>External:</b> N&amp;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,</p>				
<b>Gaps in controls or assurances</b>									
<ul style="list-style-type: none"> <li>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</li> <li>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.'</li> <li>Cultural, digital and operational collaboration to enable access and easily navigable mental health services, is at an early stage of development.</li> <li>Conflicting priorities across complex system transformation agenda</li> <li>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.</li> <li>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&amp;W population.</li> <li>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.</li> <li>The ICB restructure commenced July 2023 impacting on team capacity.</li> <li>Await delayed 24/25 planning guidance.</li> <li>Impact on some VCSE organisation ability to fully implement new services in context of requirement to pay the required increases to National Living Wage and National Minimum Wage.</li> </ul>									
<b>Updates on actions and progress</b>									
<b>Date opened</b>	<b>Action / update</b>						<b>BRAG</b>	<b>Target completion</b>	
29/04/22	Phase 1 of the N&W MH Transformation Programme Plan completed 31/03/24. The work transitions into Phase 2 with focus on integration of new services and pathway development. Continued co-production with partners and Experts by Experience and Clinical Reference Group is central to sustaining and embedding positive change.						G	31/03/25	

29/04/22	MH Workforce; Paper presented to Strategic Oversight board and action agreed to review workforce oversight and set up a MH workforce group. Progress delayed due to restructure, date for completion extended. Meeting booked with Workforce Lead 15/05/24 to progress this action.	A	31/10/24
29/04/22	National MH KPI achievement; developed Improvement Plans with support from NHSEI to work towards recovery of trajectories for the following: 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. 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 will continue across all areas including a further KPI in 24/25; Physical Health checks for people with severe mental illness, already identified as a challenging target where we submitted a reduced trajectory in recognition of primary care capacity and QOF challenges.	A	31/03/25
20/10/22	Community Transformation: Stocktake of Community Transformation underway to understand current position regarding recruitment, activity and spend against original transformation ambition and plans. Working with NSFT to strengthen and embed the model going into 24/25. Timeline extended to accommodate totality of work	G	31/06/24
29/08/23	Right Care, Right Person (RCRP); ICB Leads working in partnership with Norfolk and Suffolk Constabularies. RCRP roll out is currently paused while an independent review of the Norfolk Constabulary's approach to the incident in costessey on 19/01/24 is independently assessed by the College of Policing. It has therefore been agreed by all parties to pause, with the aim to ensure the roll out has been planned as effectively and safely as possible. As this is an independent review Norfolk Police have no control over the review timeline but have informed partners they are keen to implement RCRP as soon as they are permitted to by the College of Policing. Meanwhile all workstreams have been asked to review their plans and ensure they are fit for purpose for go live date when agreed.	G	TBC Previous target date 31/01/25 may change
22/03/24	Meeting with VCSE organisations impacted by requirement to pay increased Living and Minimal Wage increases to understand impact and proposed mitigations, including reduced services.	A	31/05/24

**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	16
Change	→	→	→	→	→	→	→	→	→	→	→	→

**Visual Risk Score Tracker – 2024/25**

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

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## BAF05B

<b>Risk Title</b>	<b>Barriers to full delivery of the Mental health transformation programme (CYP)</b>			
<b>Risk Description</b>	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			
<b>Risk Owner</b>	<b>Responsible Committee</b>	<b>Operational Lead</b>	<b>Date Risk Identified</b>	<b>Target Delivery Date</b>
Tricia D'Orsi	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
<ul style="list-style-type: none"> <li>Dedicated CYP strategic commissioning team now in place</li> <li>Effective System wide governance framework</li> <li>Collaboration with system partners to understand demand and capacity has begun and the shared resource is better understood.</li> <li>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.</li> <li>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.</li> <li>Financial slippage is being mitigated against protecting our ability to maintain MHIS investment.</li> <li>Implementation of system wide transformation programme</li> <li>Commitment from system partners to adopting Thrive approach – mental health needs being considered and addressed in wider health and social care settings.</li> <li>Additional partnership working with VCSE.</li> <li>All age Eating Disorder Strategy</li> <li>Established Children and Young Peoples System Collaboratives in Norfolk and Suffolk</li> <li>Working in partnership with Norfolk and Suffolk Constabularies to implement a system wide collaborative approach to Right Care Right Person</li> <li>Intensive day support unit now open for eating disorders and parent support offer in place.</li> <li>Professional Therapeutic Pathway in place</li> <li>Integrated Front Door phase one in place.</li> <li>Enhanced support offers for 18–25-year-olds in wellbeing hubs.</li> <li>Gender Identity Service in place</li> </ul>	<p><b>Internal:</b> SMT, EMT, Integrated Care Board, Finance Committee, Quality Committee,</p> <p><b>External:</b> 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</p>

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### 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 02/01/24 Workshop 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	→	→	→	→	→	→	→	→	→	→	→	

#### Visual Risk Score Tracker – 2024/25

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

## BAF06

<b>Risk Title</b>	<b>Health inequalities and Population Health Management</b>							
<b>Risk Description</b>	There is a risk that the ICB will not meet its statutory requirements to reduce HI or use PHM techniques to their full potential in line with the PHM strategy and HI strategic framework for action. If this happens, specific groups of people will experience poor outcomes which could have been prevented.							
<b>Risk Owner</b>	<b>Responsible Committee</b>		<b>Operational Lead</b>		<b>Date Risk Identified</b>		<b>Target Delivery Date</b>	
Mark Burgis / Dr Frankie Swords	Patients and Communities		Suzanne Meredith		01/07/2022		31/03/2025	
Risk Scores								
Unmitigated			Mitigated			Tolerated (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	1	4	4
Controls					Assurances on controls			
<ul style="list-style-type: none"> <li>The HI Strategic Framework for action and the PHM strategy have been developed. Implementation plans will be developed in 2024/25. Specialty advisors are leading on HI, PHM and the Core20Plus5 clinical areas.</li> <li>The NCC deputy DPH is leading the PHM team reporting to the ICB Medical Director working closely with the HI Clinical Lead and SRO.</li> <li>The Health Improvement Transformation Group (HITG) is established and focusses on Primary Prevention, reporting to the ICP. Key priorities: smoking, physical activity and Healthy weight.</li> <li>Community Voices gathering insights into HI and connecting with local communities.</li> <li>ICS groups set up for Inclusion health groups, vaccines inequalities, Core20plus5 programme group, NHS Anchors group, access and support programme group, reporting to HIOG</li> <li>Datahub Population Health dashboards in place to support reporting and health oversight.</li> <li>Health and wellbeing partnerships and place boards overseeing local work programmes. External factors that impact on "Plus groups" (such as the moving of hotels for asylum seekers which impacts on the services they receive) are raised by the HI team to be managed across the ICP.</li> </ul>					<p><b>Internal:</b> 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 (PHMOG) and PH and Inequalities Board with assurance reporting to Patients and Communities Committee.</p> <p>NHSE reporting of NHS Inequalities Improvement Frameworks and annual reporting against NHS statement on Information for health Inequalities. Elective Recovery Board receive monthly report on waiting lists per decile of deprivation index</p> <p><b>External:</b> Integrated Care Partnership Board</p>			
Gaps in controls or assurances								
<ul style="list-style-type: none"> <li>Embedding resources at Place level to co-ordinate the mechanisms needed to address HI and deliver PHM</li> <li>Further work required to develop the data hub and dashboards.</li> <li>NHSE HI funding not ring-fenced to support emerging work programmes and respond to system priorities.</li> <li>Agreed governance for Equality health impact assessments but uniform process not yet established.</li> </ul>								
Updates on actions and progress								
Date opened	Action / update					BRAG	Target completion	
05/04/24 <small>Davey Heidi 16/05/2024 08:56:24</small>	The PHM strategy has been published. The HI Framework for action has been endorsed by the Patient and Communities committee and will be published on 15 <sup>th</sup> May. Implementation plans are being developed for both. The new ICB structure includes a small HI team to lead these HI actions, co-ordinating and working with multi-partner agencies.					G	15/5/24 (to accommodate purdah restrictions)	

	A co-ordinating multi-partner health inequalities group is arranged for April that will prepare terms of reference and implementation plan to go to the ICP June meeting and other governance structures.	<b>G</b>	
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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	➔	➔	➔	➔	➔	➔	➔	➔	➔	➔	➔	➔
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score												
Change												

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BAF07

<b>BAF07</b>								
<b>Risk Title</b>		<b>RAAC Planks</b>						
<b>Risk Description</b>		<p>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.</p> <p>This could affect the safety of patients, visitors and staff.</p> <p>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.</p>						
<b>Risk Owner</b>		<b>Responsible Committee</b>		<b>Operational Lead</b>		<b>Date Risk Identified</b>		<b>Target Delivery Date</b>
Steven Course		Board/Finance Committee		Steven Course		01/07/2022		31/03/2024
<b>Risk Scores</b>								
<b>Unmitigated</b>			<b>Mitigated</b>			<b>Tolerated (Target in 12 months)</b>		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	5	25	4	5	20	3	5	15
<b>Controls</b>					<b>Assurances on controls</b>			
<ul style="list-style-type: none"> <li>Trusts have robust plans in place to manage a possible incident; however, these only cover immediate evacuation and not reprovision.</li> <li>Regional RAAC response plan is established.</li> <li>Regular surveys and assessments are being conducted to determine the severity of the issue and to identify and address signs of deterioration.</li> <li>Region-wide scoping piece commissioned to look at ongoing service transition and recovery.</li> <li>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.</li> <li>Legal position and recommendations provided by Browne Jacobson on ICB responsibilities should there be a catastrophic failure at either acute.</li> <li>Regular meeting established with NCHC and regional RAAC team to track progress on the community storage site RAAC removal.</li> </ul>					<p><b>Internal:</b> SMT, EMT, ICB Board</p> <p><b>External:</b> ICS Boards, Estates, NHSE/I, Individual trust boards</p> <p>RAAC related exercises have been undertaken to provide assurance of plans and procedures in responding to an evacuation of a RAAC impacted trust.</p> <ul style="list-style-type: none"> <li>Feb 22 - Exercise Farthing</li> <li>Jun 22 – Exercise Walker</li> <li>Nov 22 – Exercise Fox</li> </ul> <p>EPRR Core Standards incorporated a Deep Dive on health providers Evacuation and Shelter arrangements specifically due to the RAAC risk.</p> <p>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.</p>			
<b>Gaps in controls or assurances</b>								
<ul style="list-style-type: none"> <li>Lack of approval of region-wide scoping piece prevents full evaluation and plan of service transition and recovery</li> </ul>								

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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	→	→	→	→	→	→	→	→	→	→	→	

Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score												
Change												

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## BAF08

<b>Risk Title</b>	<b>Elective Recovery</b>			
<b>Risk Description</b>	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.			
<b>Risk Owner</b>	<b>Responsible Committee</b>	<b>Operational Lead</b>	<b>Date Risk Identified</b>	<b>Target Delivery Date</b>
Dr Frankie Swords	Quality & Safety	Sheila Glenn	01/12/2022	31/03/2025

### Risk Scores

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

#### 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 with non-recurrent funding allocated to assist with travel costs.
- Extending the use of insourcing and outsourcing opportunities to create capacity.
- New theatre capacity opened at NNUH in December 23. Additional orthopaedic capacity at NNUH and JPUH due summer/autumn 2024

#### Assurances on controls

Trusts are expected to ensure zero 52+ week waits by end of March 2025.

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.

## BAF09

<b>Risk Title</b>	<b>NHS Continuing Healthcare</b>							<b>Target completion</b>
<b>Risk Description</b>	<p>submitted zero 104-week HC for end of March 2024. The 8-week breaches reported for end of May with care at their own and/or their capacity or the appt. breaches 276 care NNUH.</p> <p>expecting to clear remaining 78-week breaches by end of April, by end of May and JPUH by end of June.</p> <p>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.</p> <p>213 breaches of the 65-week target (QEP x24, JPUH 5, NNUH x2213)</p> <p>continuing to use ICB staff to contact patients and make payments to transfer patients to alternative providers.</p> <p>This may lead to increased financial cost to secure a care package, could impact on hospital admissions and poor outcomes for people requiring NHS funded care in the elective orthopaedic theatre capacity will come onstream at the</p>			A	31/03/25			

<b>Risk Owner</b>	<b>Responsible Committee</b>	<b>Operational Lead</b>	<b>Date Risk Identified</b>	<b>Target Delivery Date</b>		
Tricia D'Orsi	2024, 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	023/24	3	9
<b>Visual Risk Score Tracker</b>								

### Controls

### Assurances on controls

<b>Score</b>	<b>16</b>	<b>16</b>	<b>16</b>	<b>16</b>	<b>16</b>	<b>16</b>	<b>16</b>	<b>16</b>	<b>16</b>
<b>Change</b>	→	→	→	→	→	→	→	→	→
<b>Visual Risk Score Tracker - Committee; Board</b>									
<b>Month</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>
<b>Score</b>	12							<b>8</b>	<b>9</b>
<b>Change</b>	↓								
<p>Commence work with finance team and Local Authorities (LAs) to work to stabilise the care market with Local Authority (LA) workforce teams to support care providers in additional training and support required.</p> <ul style="list-style-type: none"> <li>Regular financial updates to Finance Committee and Executive Management Team (EMT) to monitor impact of cost of care packages.</li> <li>Monthly operational finance meetings for Quality in Care (QiC) team.</li> <li>Monitoring of time taken to secure complex care packages and escalation process for CHC team if unable to source.</li> <li>Attendance at regional meetings to support feedback and sharing of good practice and innovation.</li> <li>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.</li> <li>Interim staff on secondment have been asked to extend the period of their secondment.</li> <li>Implementation of increased financial control.</li> <li>Increased staff establishment.</li> </ul>									

### Gaps in controls or assurances

<ul style="list-style-type: none"> <li>Ability to source and retain suitable workforce for either the NWICB CHC team or care provider market – ongoing.</li> <li>Lack of a whole system Care Workforce Strategy.</li> <li>Ability to stabilise the care market post Covid-19 and EU Exit.</li> <li>Capacity of CHC team to source or revise care packages.</li> </ul>
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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.	Complete	21/06/23
14/04/22	NSFT Discharge to Assess model to continue; currently funded through CHC. Case made to make this BAU, costing and evidence of effectiveness, shared with executive team.	Complete	21/06/23
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	→	→	→	→	↑	→	→	→	→	→	→	
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score												
Change												

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## BAF10

<b>Risk Title</b>	<b>EEAST Response Time and Patient Harms</b>			
<b>Risk Description</b>	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.			
<b>Risk Owner</b>	<b>Responsible Committee</b>	<b>Operational Lead</b>	<b>Date Risk Identified</b>	<b>Target Delivery Date</b>
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
<ul style="list-style-type: none"> <li>Daily sit-rep ensures ICB is sighted on real-time demand and resource.</li> <li>HALO role across all Acute sites to support Emergency Departments (ED).</li> <li>999 / 111 multi-disciplinary approach via CAS at IC24 to manage some ambulance calls and dispositions</li> <li>Pre-alert and rapid release processes in place with safety netting for patients waiting to be seen. Ambulance and ED revalidations embedded.</li> <li>Proactive public comms to promote appropriate use of NHS service options. This is reinforced across seasonal campaigns.</li> <li>UEC Tactical Group continues to review system-wide SIs and identify trends / themes.</li> <li>Interfacility transfers have improved with processes in place between organisations.</li> <li>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.</li> <li>System has agreed to a zero-tolerance position for ambulance handovers &gt;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.</li> </ul>	<p><b>Internal:</b> EMT, N&amp;Q Senior Team, ICB Clinical Lead for UEC and UEC Commissioning Team, ICB Quality and Safety Committee, ICB Board, Provider Governance Forum.</p> <p><b>External:</b> Regional Commissioning Consortium, NHSE Regional Team, OAG and CQC.</p>

### Gaps in controls or assurances

<ul style="list-style-type: none"> <li>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, during periods of increased pressure.</li> <li>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, including ‘corridor care, is an unintended consequence of 30min ambulance handover improvement.</li> <li>Significant challenge remains in social care re: capacity and workforce required to support packages of care in the community.</li> <li>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.</li> </ul>
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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	31/07/24
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.	Complete	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	16
Change	↓	→	→	→	→	→	↑	→	↓	→	→	→

Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score												
Change												

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## BAF11

<b>Risk Title</b>	<b>Achieve the 2023/24 financial plan</b>			
<b>Risk Description</b>	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			
<b>Risk Owner</b>	<b>Responsible Committee</b>	<b>Operational Lead</b>	<b>Date Risk Identified</b>	<b>Target Delivery Date</b>
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	↑	→	→	→	→	→	↓	→	→	→	→	

#### Visual Risk Score Tracker – 2024/25

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

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## BAF11A

<b>Risk Title</b>	<b>Underlying deficit position</b>			
<b>Risk Description</b>	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.			
<b>Risk Owner</b>	<b>Responsible Committee</b>	<b>Operational Lead</b>	<b>Date Risk Identified</b>	<b>Target Delivery Date</b>
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
<ul style="list-style-type: none"> <li>Analysis and understanding of underlying recurrent position, including drivers of the deficit on a monthly basis.</li> <li>ICS Medium Term Financial Model has been developed on consistent assumptions.</li> <li>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.</li> <li>Key lines of Inquiries (KLOEs) have been reviewed and provide assurances as to strong financial governance and best practice adoption.</li> </ul>	<p><b>Internal:</b> Board Reports and Minutes, Audit Committee reports and Internal Audit work plan, Finance Committee reports.</p> <p><b>External:</b> ICB assurance process, early flagging of risk with NHSEI and Protocol conditions.</p>

### 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	30/09/23
13/06/23	Identify mitigations to risk in plan to include unidentified efficiencies. Ensure new schemes deliver on a recurrent basis.	A	31/12/23
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	31/03/24

### 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	→	→	→	→	→	→	→	→	→	→	→	

### Visual Risk Score Tracker – 2024/25

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

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## BAF19

<b>Risk Title</b>	<b>Right Care NoW Programme</b>							
<b>Risk Description</b>	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.							
<b>Risk Owner</b>	<b>Responsible Committee</b>			<b>Operational Lead</b>		<b>Date Risk Identified</b>	<b>Target Delivery Date</b>	
Tricia D'Orsi	Quality and Patient Safety Committee			Danny Edmonds		25/10/22	01/06/24	
<b>Risk Scores</b>								
<b>Unmitigated</b>			<b>Mitigated</b>			<b>Tolerated (Target in 12 months)</b>		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	4	4	16	2	3	6
<b>Controls</b>					<b>Assurances on controls</b>			
<ul style="list-style-type: none"> <li>Daily review of all system discharge delays.</li> <li>Escalation process in place.</li> <li>Supplementary P1 capacity/reablement commissioned long-term by NCC.</li> <li>NCC trialling Social Work support to Community wards to reduce long length of stay (LLOS).</li> <li>Seasonal funding has set up 10 additional beds coming online to support discharge.</li> <li>Unmet care need list is being monitored through NCC.</li> <li>Single agreed system dashboard established and continuously developing to strengthen oversight.</li> <li>New Transfer of Care Form and processes approved for use across system.</li> <li>The system has committed to commissioning of the Optica system, implementation has been delayed, planned to commence by 24/04/24. This has the potential to reduce length of inpatient stay and streamline system data.</li> <li>7-day Discharge IDT is embedded in the Central and East localities.</li> <li>7-day Discharge Hub has been set up across all localities. Hub Managers participate in LLOS meetings at Acute sites.</li> </ul>					<p><b>Internal:</b> ICB Executive Management Team; UEC Board; Discharge Programme Board; ICB Quality and Safety Committee; Bi-weekly Discharge Touchpoint Meeting. Daily Integrated Discharge Team (IDT) Meetings; Strategic Operational Delivery Group; System Clinical Oversight Meeting.</p> <p><b>External:</b> Trust Boards, Trust Discharge Programmes e.g. HomeFirst, 3 x Acute System Operations, Resilience and Transformation Boards; NHSE oversight. Local Authorities.</p>			
<b>Gaps in controls or assurances</b>								
<ul style="list-style-type: none"> <li>Insufficient capacity within existing care market as local provision is not designed to meet current acuity and complex care requirements.</li> <li>Workforce pressures. Staff sickness and absence continue to impact on performance.</li> <li>Underutilisation of criteria led discharge.</li> <li>7-day working needs to embed fully across the whole Norfolk and Waveney footprint. This is improving but is still a risk.</li> <li>Breakdown and oversight of current ICB funding; what is recurrent and what is non-recurrent is unclear to Discharge Programme Board.</li> <li>Willow Unit modular build has been delayed. Recruitment is in progress. This will provide an additional 48 beds from 01/06/24.</li> </ul>								
<b>Updates on actions and progress</b>								
<b>Date opened</b>	<b>Action / update</b>					<b>BRAG</b>	<b>Target completion</b>	

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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 Willow Ward 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	24/04/24
01/11/23	A paper has been received by ICB EMT, to explore future funding streams to support discharge.	Complete	02/04/24
15/04/24	Birch Ward has opened week beginning 15/04/24, providing an initial eight new beds, going up to twenty by the end of the month. Action to fully establish this new capacity as an interim pending completion of the modular build.	G	30/04/24
15/04/24	Optica is due to go live by 24/04/24.	G	24/04/24

**Visual Risk Score Tracker – 2023/24**

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	16
Change	→	↓	→	→	→	↑	→	→	↑	→	→	→

**Visual Risk Score Tracker – 2024/25**

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

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## BAF21

<b>Risk Title</b>	<b>Mortality Action Plan NSFT</b>							
<b>Risk Description</b>	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.							
<b>Risk Owner</b>	<b>Responsible Committee</b>		<b>Operational Lead</b>		<b>Date Risk Identified</b>		<b>Target Delivery Date</b>	
Dr Frankie Swords	Quality and Safety Committee		Karen Watts		18/07/2023		30/06/2024	
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			
<p>NSFT have formulated an Action Plan and improvement programme focusing on learning from deaths, incorporating both Grant Thornton and Seagry recommendations, split in 3 areas:</p> <ol style="list-style-type: none"> <li>Collecting, analysing and reporting on deaths; involving the creation of a new electronic system for mortality information collection, analysis and reporting.</li> <li>Ensure learning through improvements to clinical practice; reviewing all Prevention of Future Deaths reports from 2013 to identify themes and ensure learning and improvement, including themes from the Forever Gone Report, Domestic Homicide Reviews and Serious Case Reviews.</li> <li>Work with service users, carers and bereaved families; detailed work with service users, families, carers and bereaved relatives who sit on our Learning from Deaths Action Plan Management Group</li> </ol> <ul style="list-style-type: none"> <li>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.</li> <li>The Trust has now adopted standardised classification of all deaths: natural and unnatural causes, expected and unexpected and has been using this reporting system for all deaths from 1.11.23.</li> <li>The trust is also systematically reviewing all historic deaths in the GT report to confidently categorise them in the same way and to ensure any learning is identified and acted on.</li> <li>Medical examiner scrutiny of all NSFT and community deaths is also being introduced April 2024.</li> </ul>					<p><b>Internal:</b> ICB EMT, Quality and Safety Committee, Board, System Quality Group, system Learning from Deaths Forum, ICB Serious Incident Oversight, LeDeR and Child Death Review.</p> <p><b>External:</b> Regional Quality Group, NHS England Oversight and Assurance of NSFT, NSFT Board, NSFT Medical Examiners, NSFT Quality Committee, NSFT Mortality Improvement Board, NSFT Co-production Groups, Norfolk HOSC and CQC.</p>			

Gaps in controls or assurances			
<ul style="list-style-type: none"> <li>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.</li> </ul>			
Updates on actions and progress			
Date opened	Action / update	BRAG	Target completion
11/01/24	First quarterly learning from death report to NSFT board, deep dive presented at ICS LFD forum	Complete	30/03/24
11/01/24	Interim Mortality Leads in place. Permanent Mortality Lead 8c appointed due to commence end of March 2024. X 2 Band 7 Clinical Investigation and Improvement Manager in post along with Band 6 Support Manager/Data Analysts and seconded Band 4.	Complete	30/03/24
11/01/24	Governance Structure for Mortality (Natural causes expected and unexpected deaths) set up	Complete	31/03/24
11/01/24	<b>Data recommendations</b> <ul style="list-style-type: none"> <li>Developed and implemented on the 6th November 2023 a new Mortality Data Pathway system on Sharepoint. NHS spine now automatically downloads each day as definitive source. Completed</li> <li>Sharepoint has a built-in audit of who has inputted data. Completed</li> <li>SOPs completed for Medical Records, Datix, Patient Safety, IT and Mortality teams.</li> </ul>	Complete	06/11/23  19/11/24
11/01/24	<b>Reporting Recommendations</b> <ul style="list-style-type: none"> <li>A review of different Mental Health Learning from Deaths Board papers undertaken to establish best practice. completed</li> <li>Learning from Deaths Board reporting template completed in line with national reporting requirements.</li> <li>Meeting with Public Health has occurred. Process agreed with Medical Examiners in N&amp;W. Trust part of ICB (N&amp;W) Learning from Deaths Committee. Links have been made with SNEE Quality Leads to discuss Medical Examiner and Learning from Deaths forums.</li> <li>Case Selection criteria for Structured Judgement Reviews completed and approved through the Learning from Deaths Committee and Quality Committee</li> </ul>	Complete	31/03/24
11/01/24	<b>Clinical Engagement</b> <ul style="list-style-type: none"> <li>Phase 1 Power BI dashboard developed and live from 1st November 23.</li> <li>Dashboard e available to Care Groups / Committees and will contain natural (expected and unexpected) as well as unexpected unnatural death data.</li> <li>Guidance is in place to assist staff in discharging patients from the electronic patient systems.</li> <li>Training has been completed for staff using the Sharepoint system with 'early support' in place from 6th November. Completed</li> </ul>	Complete	01/11/24  06/11/23
11/01/24	<b>Partnership Working</b> <ul style="list-style-type: none"> <li>Cause of death is now being achieved for approx. 84% as most GP practices and Acute hospitals are assisting with the information.</li> <li>Data sharing agreements in place with Acute Hospitals. In the process of exploring broader Information Sharing agreements for Mortality Reporting.</li> <li>Additional actions -Meeting has occurred with the Suffolk Registrar's Office following which a Data Sharing Application has been submitted. The Trust have been advised the process</li> </ul>	Complete	31/11/23

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	of approval could take 4-5 months. The same application will be made to Norfolk Registrar's Office. This will enable the Trust to directly gain the Cause of Death.		
11/01/24	<b>Governance</b> <ul style="list-style-type: none"> <li>Learning form Death's policy reviewed and ratified.</li> <li>A Programme Management Board (PMB) has been established chaired by the Chief Executive. The PMB meets monthly and has Terms of Reference. Completed</li> <li>The PMB is currently considering the patient-led data review process.</li> </ul>	Complete	31/08/23

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

Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score												
Change												

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## BAF023

<b>Risk Title</b>	<b>System failure to meet access standards for cancer diagnosis and treatment.</b>			
<b>Risk Description</b>	There is a risk that patients will come to harm due to the failure to meet access standards for cancer diagnosis and treatment.			
<b>Risk Owner</b>	<b>Responsible Committee</b>	<b>Operational Lead</b>	<b>Date Risk Identified</b>	<b>Target Delivery Date</b>
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	<p>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.</p> <p>NSS pathway and cancer Rapid Diagnostic Service funded via fixed term funding, awaiting prioritisation process for future commissioning</p>	<b>R</b>	<b>March 2024</b>									
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	→	→	→	
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score												
Change												

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**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	Date risk identified	Target delivery date	Score at target delivery	2023-2024 Monthly Risk Rating												24/25
						1	2	3	4	5	6	7	8	9	10	11	12	1
<a href="#">BAF12a</a>	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	6	
<a href="#">BAF12b</a>	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	6	
<a href="#">BAF13</a>	Personal data	Ian Riley	01/07/2022	31/03/2023	6	12	9	9	9	9	6	6	6	6	6	6	6	

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## BAF12a

<b>Risk Title</b>	<b>Impact on Business Continuity in the event of a large-scale Cyber Attack on N365 National Tenant</b>							
<b>Risk Description</b>	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.							
<b>Risk Owner</b>	<b>Responsible Committee</b>	<b>Operational Lead</b>	<b>Date Risk Identified</b>	<b>Target Delivery Date</b>				
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			
<ul style="list-style-type: none"> <li>NCHC are already signed up to receive CareCERT alerts. Remedial action is implemented where necessary.</li> <li>Windows 10, Threat Protection and MDE are in place for ICB and Primary Care devices.</li> <li>Secure boundary protection is in place.</li> <li>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.</li> <li>As of November 2022, NHS Mail is protected by Microsoft Safe Links &amp; Attachments</li> <li>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.</li> <li>Annual IT Health checks (Penetration tests) undertaken to identify weaknesses in ICT/Cyber controls.</li> <li>SDWAN (Software Defined Wide Area Network) implemented across the ICB.</li> <li>The ICB's ICT provider are an exemplar in terms of Cyber Security</li> <li>Leaver processes for NHS mail accounts are now standardised for the ICB so all leavers have their NHS Mail accounts disabled.</li> <li>MFA enabled for all ICB staff.</li> <li>MFA mandatory for non ICB Staff provided with an ICB NHS Mail address.</li> <li>NHSE have confirmed (August 2023) that they monitor and provide technical resource to support business continuity, data recovery and cyber breach remediation.</li> </ul>					<p><b>Internal:</b> Cyber Security Assurance Manager, Head of Digital, IG Working Group, NWICB N365 Technical Workstream Delivery Group</p> <p><b>External:</b> National Cyber Security Operations Centre, NHSE, NCHC, MTI Technology Limited (technical partner to NHSE)</p>			
Gaps in controls or assurances								
<ul style="list-style-type: none"> <li>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.</li> </ul>								
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 entitlements via NCHC					G	31/03/24	

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IT service where needed.	
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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	6
Change	→	→	→	→	→	→	→	↓	→	→	→	→

Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score												
Change												

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## BAF12b

<b>Risk Title</b>	<b>Impact on Business Continuity in the event of a Cyber Attack on the ICB</b>							
<b>Risk Description</b>	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							
<b>Risk Owner</b>	<b>Responsible Committee</b>	<b>Operational Lead</b>	<b>Date Risk Identified</b>	<b>Target Delivery Date</b>				
Ian Riley	Board	Anne Heath	01/03/2023	31/03/2023				
<b>Risk Scores</b>								
<b>Unmitigated</b>			<b>Mitigated</b>			<b>Tolerated (Target in 12 months)</b>		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	2	3	6	2	3	6
<b>Controls</b>					<b>Assurances on controls</b>			
<ul style="list-style-type: none"> <li>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)</li> <li>NCHC are already signed up to receive CareCERT alerts. Remedial action is implemented where necessary.</li> <li>Windows 10, Threat Protection and MDE are in place for ICB devices.</li> <li>Secure boundary protection is in place.</li> <li>Since November 2022, NHSMail is protected by Microsoft Safe Links &amp; Attachments</li> <li>InTune with mobile device management rolled out to staff using ICB issued and personal devices to access NHS Mail and MS Teams.</li> <li>MFA mandatory for non ICB Staff provided with an ICB NHS Mail address.</li> <li>Cyber security behaviour change support and awareness package with clear guidance developed to include:               <ul style="list-style-type: none"> <li>how to spot and report a phishing email</li> <li>how to get help if you have fallen for a phishing email.</li> <li>campaign to improve password security.</li> <li>campaign to raise awareness of giving your data away on social media.</li> <li>campaign to encourage self-enrolment for MFA.</li> </ul> </li> <li>MFA rolled out to all staff in ICB.</li> <li>provision of a channel dedicated to cyber awareness and information.</li> <li>NHSE have confirmed (August 2023) that they monitor and provide technical resource to support business continuity, data recovery and cyber breach remediation.</li> </ul>					<p><b>Internal:</b> Cyber Security Assurance Manager, Head of Digital, IG Working Group, NWICB Technical Workstream Delivery Group</p> <p><b>External:</b> National Cyber Security Operations Centre, NHS Digital, NCHC, MTI Technology Limited (technical partner to NHSE)</p>			
<b>Gaps in controls or assurances</b>								
<ul style="list-style-type: none"> <li>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.</li> </ul>								
<b>Updates on actions and progress</b>								

Date opened	Action / update	BRAG	Target completion
01/02/23	Phishing test was completed previously in 2022. Conduct Phishing Simulation to test user awareness of Phishing, providing specific Phishing Awareness training to those members of staff who click links and/or enter their credentials. The target date has been moved given the sensitivities of the staff consultation.	A	15/01/24
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	6
Change	→	→	→	→	→	→	→	↓	→	→	→	→

**Visual Risk Score Tracker – 2024/25**

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

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## BAF13

<b>Risk Title</b>	<b>Personal data</b>							
<b>Risk Description</b>	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, Particularly functions that were 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.							
<b>Risk Owner</b>	<b>Responsible Committee</b>		<b>Operational Lead</b>		<b>Date Risk Identified</b>		<b>Target Delivery Date</b>	
Ian Riley	Audit and Risk		Anne Heath		01/07/2022		31/03/2023	
<b>Risk Scores</b>								
<b>Unmitigated</b>			<b>Mitigated</b>			<b>Tolerated (Target in 12 months)</b>		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	5	20	2	3	6	1	3	3
<b>Controls</b>					<b>Assurances on controls</b>			
<ul style="list-style-type: none"> <li>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.</li> </ul>					<p><b>External:</b> ICS Establishment COP and EOE IG ICB Transition Group</p> <p><b>External:</b> IG Working Group and Population Health and Care Operational Delivery Group</p>			
<b>Gaps in controls or assurances</b>								
<ul style="list-style-type: none"> <li>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.</li> <li>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.</li> </ul>								
<b>Updates on actions and progress</b>								
<b>Date</b>	<b>Action</b>						<b>RAG</b>	<b>Target completion</b>
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	31/03/23
01/11/23	<p>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.</p> <p>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.</p>						G	01/09/24

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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	6
Change	→	↓	→	→	→	↓	→	→	→	→	→	→
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score												
Change												

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**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	Date risk identified	Target delivery date	Score at target delivery	2023-2024 Monthly Risk Rating												24/25
						1	2	3	4	5	6	7	8	9	10	11	12	
<a href="#">BAF14</a>	#WeCareTogether People Plan	Ema Ojiako	01/07/22	01/04/24	3	12	12	12	12	12	12	12	12	12	12			
<a href="#">BAF15</a>	Staff Burnout	Ema Ojiako	01/07/22	31/03/23	4	12	12	12	12	12	12	16	16	16	16			
<a href="#">BAF16</a>	The resilience of general practice	Mark Burgis	01/07/22	31/03/24	12	16	16	16	16	16	16	16	16	16	16	16	16	
<a href="#">BAF17</a>	Financial Wellbeing	Ema Ojiako	01/08/22	Ongoing	12	12	12	12	12	12	12	12	Closed in M09					
<a href="#">BAF18</a>	Resilience of NHS General Dental Services in Norfolk and Waveney	Mark Burgis	01/04/23	31/03/25	6	12	12	20	20	20	20	20	20	20	20	20		
<a href="#">BAF20</a>	Industrial action	Ema Ojiako	14/11/22	31/03/24	6	16	16	12	12	12	12	16	16	16	16	16		

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## BAF14

<b>Risk Title</b>	#WeCareTogether People Plan			
<b>Risk Description</b>	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.			
<b>Risk Owner</b>	<b>Responsible Committee</b>	<b>Operational Lead</b>	<b>Date Risk Identified</b>	<b>Target Delivery Date</b>
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
<p>#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</p> <p>People Board in place with an operating model of Networks, Groups, and Stakeholders contributing to and leading delivery of the strategy.</p> <p>Good linkages with both NHS and Social Care Providers.</p> <p>Alignment to local workforce strategies within NHS Provider organisations and the NCC Adult Social Care Workforce Strategy.</p> <p>N&amp;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&amp;W ICB Senior Team will review portfolios and ensure the right skills are in place to deliver against our agenda.</p>	<p><b>External:</b> Norfolk and Waveney people Board and associated stakeholder Networks and Groups including HRDs, DoNs, Education, OD and Culture &amp; Inclusion Leads</p> <p><b>Internal:</b> N&amp;W ICB Remuneration and Culture Committee</p>

### 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	<ul style="list-style-type: none"> <li>We now have 4 workstreams (system recruitment, reducing sickness, bank &amp; 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.</li> </ul>	A	31/3/23

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	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Newton Europe diagnostic work will support plans for a review of HR process and practice with strategic input from Director of People.</li> <li>• Director of People has commenced in post and is working with Director of Governance to realign portfolios.</li> </ul>		
30/03/22	Workforce Dashboard to monitor high level milestones and assess progress in place.	B	Complete
01/04/22	EDI lead commenced in role to support focus on WRES and Inclusion across the system.	B	Complete
19/08/22	ICS people plan #WeCareTogether will be refreshed (national mandate) – resource secured to lead this work which will ensure ICB staff are included	G	Ongoing
14/11/22	Refresh continues with c250 people engaged since August to review progress since 2020 and consider where updates are required for the #WCT People Plan. Refresh launch planned for early 2023 alongside updated #WCT platform which will develop over time to be a single point of access for people seeking support to join N&W ICS and to reach their potential working with us.	R	2024 - TBC
01/04/23	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.		
30/06/23	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.	G	Dec 2023
Sep 2023	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.		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	→	→	→	→	→	→	→	→	→	→	→	

**Visual Risk Score Tracker – 2024/25**

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

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## BAF15

<b>Risk Title</b>	<b>Staff burnout</b>							
<b>Risk Description</b>	<p>Burnout is measured by three elements.</p> <ul style="list-style-type: none"> <li>Exhaustion - an imbalance between work demands and individual resources.</li> <li>Individual strain - an emotional response of exhaustion and anxiety, which is heightened by not feeling effective.</li> <li>Defensive coping - changes in attitudes and behaviour, such as greater cynicism.</li> </ul> <p>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.</p> <p>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.</p> <p>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.</p>							
<b>Risk Owner</b>	<b>Responsible Committee</b>		<b>Operational Lead</b>		<b>Date Risk Identified</b>		<b>Target Delivery Date</b>	
Ema Ojiako	People and Culture		Jo Catlin		01/07/2022		31/03/23	
<b>Risk Scores</b>								
<b>Unmitigated</b>			<b>Mitigated</b>			<b>Tolerated (Target in 12 months)</b>		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	4	4	16	1	4	4
<b>Controls</b>					<b>Assurances on controls</b>			
<ul style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>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.</li> <li>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.</li> <li>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.</li> </ul>					<p><b>Internal:</b> SMT, EMT, ICB Board, Staff Involvement Group, Wellbeing Guardian</p> <p><b>External:</b> ICS Boards, NHSE/I</p>			

### 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
<b>Oct 21</b>	Established H&WB Champions and Steering Group, utilising NHS H&WB Diagnostic and resources to shape actions and approach. <ul style="list-style-type: none"> <li>• H&amp;WB summit held in September to commence ICS H&amp;WB strategy.</li> <li>• 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.</li> <li>• Presentation at Clinical Director and through Medical Director briefings highlighted H&amp;WB offers in place for Primary Care Workforce, this will also be captured in medical Director Blog in November for a wider audience.</li> <li>• 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.</li> </ul>	<b>G</b>	<b>31/01/23</b>
<b>May 22</b>	In response to NSS results, pilot new approach to wellbeing. conversations, incorporating available resources and support. Fully implement in July 2022.	<b>B</b>	<b>Complete</b>
<b>May 22</b>	Communications and engagement review has now completed with findings to be presented to EMT in August/September.	<b>B</b>	<b>Complete</b>
<b>May 22</b>	Refocused 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.	<b>A</b>	<b>April 24</b>

### 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	→	→	→	→	→	→	↑	→	→	→	→	

### Visual Risk Score Tracker – 2024/25

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

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## BAF16

<b>Risk Title</b>	<b>The resilience of general practice</b>							
<b>Risk Description</b>	<ul style="list-style-type: none"> <li>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).</li> <li>There is also evidence of increasing poor behaviour from patients towards practice staff, leading to retention and recruitment issues.</li> <li>There is an increasing risk of industrial action following the BMA referendum where the GP contract and associated uplift was rejected.</li> <li>The national GP contract price uplift does not cover the required increase in meeting the minimum wage.</li> <li>The LMC has written to practices to cease un-commissioned work associated with MGUS monitoring. Further communications are likely.</li> <li>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.</li> <li>This will have a wider impact as neighbouring practices and other health service partners take on additional workload which in turn affects their resilience.</li> <li>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.</li> </ul>							
<b>Risk Owner</b>	<b>Responsible Committee</b>	<b>Operational Lead</b>	<b>Date Risk Identified</b>	<b>Target Delivery Date</b>				
Mark Burgis	Primary Care	Sadie Parker	01/09/2020	31/03/2026				
<b>Risk Scores</b>								
<b>Unmitigated</b>			<b>Mitigated</b>			<b>Tolerated (Target in 12 months)</b>		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	4	4	16	3	4	12
<b>Controls</b>					<b>Assurances on controls</b>			
<ul style="list-style-type: none"> <li>Locality teams and strategic primary care teams structured around supporting the resilience of general practice—All practices have previously been supported to review business continuity plans.</li> <li>PCN ARRS (additional roles reimbursement scheme) funding has provided additional capacity but has not grown in this contract year.</li> <li>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.</li> <li>System interface group with representation from primary, community and secondary care system partners established.</li> <li>Standard contract requirements on interface – gap analysis and action plans, including monitoring being reviewed by contracts team. New national requirement for providers to self-assess using national toolkit 6-monthly</li> <li>Commencement of LMC General Practice Alert System sitreps</li> </ul>					<p><b>Internal:</b> Executive Management Team, workforce steering group, primary care strategic planning meetings, establishment of new general practice and community pharmacy delivery group, Primary Care Commissioning Committee, risk is on the Board Assurance Framework</p> <p><b>External:</b> NHS England via delegation agreement and assurance framework, Health Education England, Norfolk and Waveney Local Medical Committee, Health Overview and Scrutiny Committee meetings</p>			
<b>Gaps in controls or assurances</b>								
<ul style="list-style-type: none"> <li>Practice visit programme, CQC inspections focused on where there is a significant risk or concern.</li> <li>Significant number of 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.</li> <li>Continued reports of poor patient behaviour across practices, decrease in patient satisfaction with general</li> </ul>								

- 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 fully utilised by practices, leading to under-reporting of issues. Alternative approaches being considered with the LMC.
  - 50% overall response rate to LMC General Practice Alert System, meaning full picture is not available.
  - 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 and unavailability of primary care budgets due to the ICB's financial position impacting on our ability to support resilience and transformation in general practice.
  - Resilience policy in development, which will link into any bids for section 96 support.
  - Five-year Primary Care Strategy has expired, new strategic framework in development.
- Primary care dashboard/ delivery report remains in development, leading to a lack of integrated performance oversight.

Updates on actions and progress			
Date opened	Action / update	BRAG	Target completion
Jan 24	<ul style="list-style-type: none"> <li>• £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.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• The primary care and locality teams continue to work with individual practices at resilience risk to support them to stabilise.</li> </ul>	Complete	31/03/24
Feb 24	<ul style="list-style-type: none"> <li>• 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.</li> <li>• An additional £357k resilience funding has been made available to practices. As a result, practices have submitted request for extra</li> </ul>	Complete	31/03/24

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	<p>clinics including but not limited to enhancing support for learning disability annual health checks and asthma clinics.</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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&amp;W ICB are encouraging all practices to access this support.</li> <li>• 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.</li> <li>• N&amp;W ICB had 8 practices sign up to the final cohort of the GP Intermediate Support Programme run nationally – bringing our total practices who have engaged in the current phase of the GP improvement programme to 23 to date.</li> <li>• LD HC support to practices to improve the uptake and the quality of the annual LD HC continues with specific support with complex cases.</li> <li>• 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.</li> </ul>		
<p><b>April 24</b></p>	<ul style="list-style-type: none"> <li>• New interface monitoring tool released nationally, with expectation Trusts will review their baseline for submission in late April, and monitor progress six-monthly.</li> <li>• GP contract uplift has caused resilience concern among practices, with national BMA vote overwhelmingly in favour of rejecting the contract. Next steps are awaited but some form of industrial action is expected. In the meantime, the LMC has written to practices advising them to cease provided MGUS monitoring, due to it being un-commissioned.</li> <li>• Joint Forward Plan ambition for primary care updated. Work has commenced on developing our engagement approach to inform how we develop our vision and principles for primary care, and then our long-term strategic framework for general practice to underpin our approach to supporting development in future and to guide investment in primary care.</li> <li>• Locally commissioned services (x3) have been refreshed for 2024/25, however due to delays in confirmation of funding, this has delayed implementation in general practice and potentially affected patient services by leaving a service gap.</li> <li>• One further application for section 96 funding has been received from a practice.</li> </ul>	<p><b>A</b></p>	<p>30/04/24</p>

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	<ul style="list-style-type: none"> <li>Two branch surgery closure applications are being considered by the Committee.</li> </ul>		
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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	16
Change	→	→	→	→	→	→	→	→	→	→	→	→

Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16											
Change	→											

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## BAF18

<b>Risk Title</b>	<b>Resilience of NHS General Dental Services in Norfolk and Waveney</b>							
<b>Risk Description</b>	Primary Care Services became the responsibility of the Integrated Care Board from 1 <sup>st</sup> 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.							
<b>Risk Owner</b>	<b>Responsible Committee</b>		<b>Operational Lead</b>		<b>Date Risk Identified</b>		<b>Target Delivery Date</b>	
Mark Burgis	Primary Care		Sadie Parker		01/04/2023		31/03/2026	
<b>Risk Scores</b>								
<b>Unmitigated</b>			<b>Mitigated</b>			<b>Tolerated (Target in 12 months)</b>		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	5	4	20	4	3	12
<b>Controls</b>					<b>Assurances on controls</b>			
<ul style="list-style-type: none"> <li>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).</li> <li>Ring fenced dental budget for investment.</li> <li>Active engagement with dental contractors, LDC and Local Professional Network (and Managed Clinical Networks), regular dental newsletter in place.</li> <li>Dental Development Group established to engage with key stakeholders to agree short term plan by Sept 2023.</li> <li>Dental Services Delivery Group established reporting to PCCC.</li> <li>Dental Strategy and local workforce plan to be in place by May 2024.</li> <li>NHS England Long Term Workforce plan published June 2023.</li> <li>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.</li> <li>Clinical expertise provided by NHSE through the LPN, MCN and Senior Clinical Fellow roles during 2024/2025 for strategic development, transformation and commissioning purposes.</li> <li>Dental Data Review being updated to inform commissioning plans.</li> <li>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.</li> <li>Clinical Dental Advisor role to be recruited for ICB in 2024 to replace NHS England roles.</li> </ul>					<p><b>Internal:</b> EMT, Primary Care Commissioning Committee, Dental Services Delivery Group</p> <p><b>External:</b> NHS England, Norfolk and Waveney LDC, regional Local Professional Network and Managed Clinical Networks, Healthwatch Norfolk/Suffolk, NHS Business Services Authority</p>			
<b>Gaps in controls or assurances</b>								
<ul style="list-style-type: none"> <li>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.</li> </ul>								

- 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 in depth knowledge about the resilience and stability of all dental services across Norfolk and Waveney: primary, community and secondary care services.

**Updates on actions and progress**

Date opened	Action / Update	BRAG	Target completion
<b>Mar 24</b>	<p>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.</p> <p>NHS England Dental Recovery Plan 2024/2025 published 7 February 2024 (<a href="https://www.gov.uk/government/news/nhs-england-dental-recovery-plan-2024-2025">Faster, simpler and fairer: our plan to recover and reform NHS dentistry - GOV.UK (www.gov.uk)</a>) and the ICB is working to mobilise the individual elements of the Plan as details are released and adapt ICB plans accordingly:</p> <ul style="list-style-type: none"> <li>• 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</li> <li>• 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</li> <li>• Mobilisation of a mobile dental van to improve access and oral health prevention schemes.</li> <li>• Golden Hello to retain dentists working in NHS services for 3 years. This is addition to the ICB initiative.</li> </ul> <p>14 dentists have benefited from the ICB's workforce schemes to date.</p> <p>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.</p>	<b>Complete</b>	<b>30/04/2024</b>
<b>Apr 24</b>	<p>Actions to implement the Dental Recovery Plan, the UDA uplift and new patient premium, are complete. Discussions underway with NHS England region, Cambridgeshire &amp; Peterborough and Suffolk &amp; North-East Essex ICBs to mobilise a dental van across the 3 ICB areas.</p>	<b>Complete</b>	<b>30/06/2024</b>
<b>May 24</b>	<p>Both the Long-Term Dental Plan and the Dental Workforce Plan approved by Committee 7 May 2024 to help improve resilience and stability of NHS dental services.</p> <p>Risk to be raised with Dental Services Delivery Group about the risks associated with managing secondary care dental services contracts and lack of resources to monitor and support.</p> <p>ICB Clinical Advisor recruitment underway to support ICB with clinical advice and to work with East of England Regional Chief Dental Officers, Managed Clinical Networks and Clinical Fellows.</p> <p>Review of the Urgent Treatment service pilot is still underway and will report back to Dental Services Delivery Group in July 2024. Feedback</p>	<b>A</b>	<b>30/06/2024</b>

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	<p>from patient survey, providers, UEC, NHS 111 and IC24 will all inform the evaluation.</p> <p>Level 2 endodontics and periodontics pilot in East of England ceased 31 March 2024 increasing possibility of secondary care referrals or lack of access to these services for patients.</p>		
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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	20
Change	→	→	↑	→	→	→	→	→	→	→	→	→

Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	20	20										
Change	→	→										

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## BAF20

<b>Risk Title</b>	<b>Industrial Action (IA)</b>			
<b>Risk Description</b>	<p>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:</p> <ul style="list-style-type: none"> <li>NHS N&amp;W Integrated Care Board (ICB)</li> <li>Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUHFT)</li> <li>Norfolk and Suffolk NHS Foundation Trust (NSFT)</li> <li>Norfolk Community Health and Care (NCH&amp;C)</li> </ul> <p>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.</p>			
<b>Risk Owner</b>	<b>Responsible Committee</b>	<b>Operational Lead</b>	<b>Date Risk Identified</b>	<b>Target Delivery Date</b>
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
<b>5</b>	<b>4</b>	<b>20</b>	<b>4</b>	<b>4</b>	<b>16</b>	<b>3</b>	<b>3</b>	<b>9</b>

#### 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

#### Assurances on controls

**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

<p>incident to ensure a cycle of continuous improvement.</p> <ul style="list-style-type: none"> <li>• The Norfolk &amp; Waveney system is managing IA well, mitigating risks and working together to maintain workforce morale, wellbeing, and relationships with staff groups.</li> <li>• 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.</li> <li>• 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.</li> </ul>			
<b>Gaps in controls or assurances</b>			
<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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),</li> <li>• There is the potential for this to impact on health inequalities.</li> <li>• 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.</li> </ul>			
<b>Updates on actions and progress</b>			
Date Opened	Action / Update	BRAG	Target Completion
14/11/22	<p>ICB will support Trusts to be prepared by,</p> <ul style="list-style-type: none"> <li>• Consolidating completion of Trust's self-assessment templates for return in the event of IA.</li> <li>• Set up a N&amp;W Task and Finish Group for coordination with a rhythm of meetings.</li> </ul> <p>Strategic oversight by Directors of Nursing (DoNs) and HRD</p>	<b>G</b>	30/09/23
14/11/22	<p>ICB will share information on confirmed industrial action, including information on derogations across the system.</p> <ul style="list-style-type: none"> <li>• 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.</li> </ul>	<b>G</b>	30/09/23
14/11/22	<p>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.</p>	<b>G</b>	30/09/23
13/11/23	<p>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&amp;W System Control Centre and People/Workforce, working with system partners to mitigate risks.</p> <p>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.</p>	<b>G</b>	Ongoing

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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.	<b>G</b>	13/11/23
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**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	↑	→	↓	→	→	→	↑	→	→	→	→	

**Visual Risk Score Tracker – 2024/25**

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

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Agenda item:14

<b>Subject:</b>	<b>Quality and Safety Committee Report</b>
<b>Presented by:</b>	Aliona Derrett, Quality and Safety Committee Chair Tricia D’Orsi, Executive Director of Nursing
<b>Prepared by:</b>	Evelyn Kelly, Quality Governance & Delivery Manager
<b>Submitted to:</b>	Integrated Care Board Meeting
<b>Date:</b>	22 May 2024

**Purpose of Paper**

To provide the Board with an update on the work of the Quality and Safety Committee for the period of 26 March 2024 to 22 May 2024.

<b>Committee:</b>	<b>Quality and Safety</b>
<b>Committee Chair:</b>	Aliona Derrett
<b>Meetings since the previous update:</b>	04 April 2024, 14:00 – 17:00 <i>Please note that the May meeting of Committee was stood down.</i>
<b>Overall objectives of the committee:</b>	
<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	

<p><b>Main purpose of meeting:</b></p>	<p><b>04 April 2024: regular meeting of the Committee covering all standing items plus the following focus areas:</b></p> <ul style="list-style-type: none"> <li>• Quality Strategy Oversight and Dashboard</li> <li>• CYP Neurodevelopmental Service Provision</li> <li>• National Partnership Agreement Right Care, Right Person</li> <li>• Mortality Action Plan NSFT</li> <li>• The David Fuller Inquiry</li> <li>• Ambulance Response Times</li> <li>• Reasonable Adjustment Digital Flag</li> </ul>
<p><b>BAF and any significant risks relevant / aligned to this Committee:</b></p>	<p><b>Quality and Safety Committee BAF Risks:</b>  BAF03: Providers in CQC 'Inadequate' Special Measures  BAF05a: Mental Health Transformation Programme  BAF05b: CYP Mental Health Transformation Programme  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</p> <p><b>Proposed to Close to BAF and de-escalated to Team oversight:</b>  BAF06: Health Inequalities</p> <p><b>Quality and Safety Committee Significant Risks:</b>  SR04: Surge Capacity to Support Local Acute Trusts  SR05: Workforce Absence and Moral Injury  SR06: Public Trust and Reputational Damage  SR09: Elective Long Waits  SR10: Care Provider Capacity System-Wide Impact  SR13: Neuro-Developmental Service Provision  SR14: CYP Mental Health (Allocation of Case Managers)  SR16: CYP Mental Health Waiting Lists  SR19: CYP Podiatry Provision in Central Norfolk  SR20: CYP Speech and Language Therapy Provision  SR26: Deconditioning and Hospital Acquired Infections  SR43: Tuberculosis Service Capacity  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  SR52: Industrial Action Clinical Impact  SR54: CYP Responsible and Approved Clinicians in NSFT  SR55: CYP Staff Competences in NSFT  LC001: Community Epilepsy Commissioning</p> <p>A year-end review of Committee risks was undertaken, and all risks scored under 16 were de-escalated at Committee request, to be held by teams as part of their 'business as usual' oversight and improvement work.</p>

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	<p><b>Closed to Committee and de-escalated to Team oversight:</b>  NQ45 BPAS CQC Improvement Plan  NQ46 Learning from Patient Safety Events System Go-Live  SR51: Delegation of Specialised Commissioning Oversight  SR07: BCG Immunisation  SR15: CYP Mental Health (Crisis Team Capacity)  SR22: Digital Maternity Care Records  LMNS05 Smoking in Pregnancy  NQ47 Pharmacy Workforce  SR42: Discharge &amp; Short-Term Feeding Tubes  SR44: Wheelchair Service Waiting Times  LC002 Community Neurology Commissioning  LC003 Adult Speech &amp; Language Therapies Commissioning  SR11: Compliance with Deprivation of Liberty Standards  QIC-All-026: s117 Mental Health Act Personal Health Budgets  QICSGA29: Deprivation of Liberty Safeguards Backlog</p>
<p><b>Key items for assurance/noting:</b></p>	<p><b><u>04 April 2024</u></b></p> <p><b>Quality Strategy Oversight and Dashboard</b>  Committee received its first formal oversight report for the ICS Quality Strategy, including developing metrics for the updated and enhanced Quality Dashboard which will continue to be refined as part of the Integrated Performance Report refresh. Partner attendees were asked to ensure that the Quality Strategy and Implementation Plan has gone through their internal Boards and asked for feedback to be shared via Committee. The initial report on metrics and data collection was discussed and members fed back areas for further development. Committee discussed the role of the dashboard data in triangulating information across the system to help identify areas of focus for quality improvements.</p> <p><b>CYP Neurodevelopmental Service Provision</b>  Committee received a quarterly update on challenges and opportunities within children and young people’s neurodevelopmental services, which links to risk SR13. The ICB Director of Children, Young People and Maternity highlighted the development of the new CYP Provider Framework which will allow greater capacity to provide support for families on waiting lists. An update from the ICS CYP Collaborative emphasised the current focus on neurodevelopmental and mental health provision, as a response to data is showing a 350% increase in local referrals over the last two years, which is in line with what is happening nationally. National changes are expected around the support and services available to neurodiverse people.</p> <p>Committee were briefed on the challenges around transition and the need to develop pathways between CYP and adult services and to improve consistency of service so that young people have services to move into as they reach adulthood. This was illustrated by risks around the oversight of medication prescribing for Adults who have sought independent assessment, and backlog of children’s assessments for South Norfolk families accessing Suffolk pathways. The CYP Collaborative continues at pace and planning is being undertaken to develop the resources available to schools around neurodiversity.</p>

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### **National Partnership Agreement Right Care, Right Person**

Committee received a briefing on the implementation of Right Care Right Person (RCRP) [guidance](#) by Norfolk Constabulary. Committee heard that RCRP roll-out has paused within Norfolk pending independent review by the College of Policing, which will provide an examination of the planned implementation process as well as the wider engagement with system stakeholders, including health and social care. Committee discussed the impact of the Policing policy changes on mental health services, particularly with regards to access to safe spaces for people in crisis. The ICB Mental Health Team is engaged with this work and learning from Suffolk as an early adopter has been useful. Committee noted the importance of communication with primary care as and when the implementation of RCRP resumes in Norfolk. The ICB Executive Director of Nursing highlighted the importance of ongoing work around supporting people experiencing mental health crisis within our Emergency Departments and communities.

### **Norfolk and Suffolk Foundation Trust Mortality Action Plan**

The Trust Chief Nurse provided an update briefed Committee on the scope for their new data collection process which commenced in November 2023. The first report run from the new dataset covered the period from 01 November 2023 to 31 January 2024 and included 437 deaths, the majority of which (356) were deemed to be 'natural' including respiratory illness, heart disease and cancers and among the older population, neurological conditions including dementia and Parkinson's. Of the remaining deaths, 15 were deemed to be 'unnatural' deaths that potentially meet the Patient Safety Incident Response Framework in order to identify learning. The remaining deaths were pending cause and classification.

During April through to July 2024 the Trust will be reviewing and improving the ways they identify and share learning across the organisation. This work will be led by engagement with a range of Trust staff, as well as service users, carers, and bereaved families, alongside reviewing national best practice in this area. The ICB Executive Medical Director shared a piece of work that is being led by the ICB, around improving service user ethnicity reporting to support analysis of health inequalities.

### **The David Fuller Inquiry**

Committee were briefed on The David Fuller Inquiry which investigated the issues raised by the criminal conviction of David Fuller; how he was able to conduct inappropriate and unlawful actions in the mortuaries at Maidstone and Tunbridge Wells NHS Trust and why this went unnoticed. The first phase of the inquiry, on matters relating to Maidstone and Tunbridge Wells NHS Trust, concluded in November 2023 with the publication of the [Phase 1 Report](#). Phase 2 looks to a broader national picture, considering whether established procedures and practices in mortuary settings are sufficient to safeguard the security and dignity of the deceased. The ICB Director of Nursing and Quality provided an update on local mortuary security arrangements, reviewed as a response to learning from the Phase 1 Report. This includes the establishment of a joint Mortuary Group

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	<p>across the three Acute Hospitals. Committee was reassured by the level of scrutiny and the appropriateness of access within the three Acute Hospital mortuaries and requested a future update on progress with the full recommendations from the inquiry, across the system. An action was taken by the ICB Executive Medical Director to link with the local authorities to ensure that there was oversight of non-hospital settings, such as Funeral Homes.</p> <p><b>Ambulance Response Times</b>  Committee received an update on operational activity. Norfolk and Waveney was an outlier for Ambulance delays over 60 minutes at 22% in February 2024, against a regional average of 13%. However, the system does continue to see a positive downward trend in delays and improved performance for category 2 'serious condition' Ambulance response times. Committee were briefed on measures in place to help mitigate risk, including improving consistency of welfare checks when patients are waiting for an Ambulance and utilizing the Urgent Community Hub to triage patients and moving them to alternative services in the community if safe and appropriate to do so.</p> <p>Committee reflected on the spike in admissions over the Easter break and emphasised the importance of learning from adverse incidents. The ICB Director of Nursing and Quality noted that the national Patient Safety Incident Review Framework is shifting systems to new ways of working and the focus of the ICS Urgent and Emergency Care Harms Group is moving with it, along with the system Tactical Group which provides a forum to review incidents and delays and take forward learning collectively.</p> <p><b>Reasonable Adjustment Digital Flag</b>  The Reasonable Adjustment Digital Flag (RADF) is designed to highlight additional support that enables service users to access services equitably and shares this information across services so that people only have to 'tell' the health and social care system once. Implementing the RADF is an expectation of all NHS organisations, Social Care and VCFSE providers, with NHS England setting the target deadline of December 2025 for full implementation at a system-level. Committee received an update on individual Provider compliance with the RADF and discussed the complexities of linking up all providers in the digital space. The ICB EMT has committed to supporting the delivery of the RADF across the ICS, working across directorates to take this work forward.</p>
<b>Items for escalation to Board:</b>	Board to approve de-escalation of BAF06: Health Inequalities to Medical Directorate Team oversight.
<b>Items requiring approval:</b>	No items required Committee approval this month.
<b>Confirmation that the meeting was quorate:</b>	<b>Quoracy (as per Governance Handbook):</b> there will be a minimum of one Non-Executive Board Member, plus at least the Director of Nursing or Medical Director. The April 2024 meeting was quorate, as defined above.

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<b>Key Risks</b>	
<b>Clinical and Quality:</b>	This report highlights clinical quality and patient safety risks and mitigating actions.
<b>Finance and Performance:</b>	Finance and performance are intrinsically linked to quality, in relation to safe, effective, and sustainable commissioned services.
<b>Impact Assessment (environmental and equalities):</b>	N/A
<b>Reputation:</b>	See above.
<b>Legal:</b>	N/A
<b>Information Governance:</b>	N/A
<b>Resource Required:</b>	N/A
<b>Reference document(s):</b>	N/A
<b>NHS Constitution:</b>	The report supports the clinical quality and patient safety elements of the NHS Constitution.
<b>Conflicts of Interest:</b>	Committee member's interests are documented and managed according to ICB policy.

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Agenda item: 15

<b>Subject:</b>	<b>Finance Committee Report</b>
<b>Presented by:</b>	<b>Hein van den Wildenberg, Non-executive Member, Finance Committee Chair</b>
<b>Prepared by:</b>	<b>Emma Kriehn-Morris, Director of Commissioning Finance</b>
<b>Submitted to:</b>	<b>Integrated Care Board – Board Meeting</b>
<b>Date:</b>	<b>22 May 2024</b>

**Purpose of paper:**

To provide the Board with an update on the work of the Finance Committee up to including the 15<sup>th</sup> May 2024

<b>Committee:</b>	Finance Committee
<b>Committee Chair:</b>	Hein van den Wildenberg
<b>Meetings since the previous update</b>	Last update provided: 26.03.2024 Subsequent Meetings: 02.04.2024
<b>Overall objectives of the committee:</b>	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.
<b>Main purpose of meeting:</b>	To gain assurance on the financial position of the NHS entities in the ICS, and ICB respectively.
<b>BAF and any significant risks relevant / aligned to this Committee:</b>	BAF 11 – Achieve the 2023/24 financial plan  BAF 11A – Underlying deficit position
<b>Key items for assurance/noting:</b>	The main items discussed at the Finance Committee were as follows: <ul style="list-style-type: none"> <li>- Reconfirmation of financial delivery on plan for both ICB and the NHS entities in the ICS for the financial year 2023-24.</li> <li>- A deep-dive into the financial plan for 2024-25 as it stood at the time of the committee meeting (April 2<sup>nd</sup>). As Chair of the Finance Committee, I have had subsequent discussions with the Executive Director of</li> </ul>

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Finance on further developments, leading up to the submission to NHS England on May 3<sup>rd</sup>, 2024.

- A Spotlight on NSFT, the mental health trust, seen through a financial lens.

### **Financial Year 2023/24: (NHS entities in) ICS**

1. The Forecast OutTurn (FOT) for each of the NHS entities in the ICS was a break-even position for the financial year 2023/24. This points to an aggregate spend by NHS entities in the ICS of £2,463m for the financial year. This is subject to review by external audit.
2. However, the underlying deficit for the aggregate of NHS entities in the ICS is some £230m. This provides a particularly challenging backdrop for the plan for the 'new' financial year 2024/25: see further below.
3. The FOT for the aggregate system CDEL (Capital) expenditure by NHS entities in the ICS during 2023/24 was £ 93.4m, a £3.1m underspend against budget.

Please note that c.£128m has been spent during 2023/24 by NHS system partners on centrally funded capital programmes. The more material ones includes Hellesdon Ward (NSFT), Willow modular build (NCHC), Diagnostic Assessment Centre (acutes), Orthopaedic hub (JPUH).

### **2024/25: Plan submission for NHS entities in ICS**

The committee undertook a deeper review 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 limited 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 some £89 m, with further work being undertaken by all system partners to reduce this towards a balanced position.

The Executive Director of Finance has kept me, as Chair of the committee abreast of further developments. The ICB Board has similarly been updated on latest plan developments before submission took place. On May 3<sup>rd</sup>, all NHS entities in the ICS submitted a plan that in aggregate show a £ 36 m deficit (including a £5.5 m deficit due to an accounting change). The ICB has submitted a balanced plan for 2024/25.

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This plan submission carries a significant delivery risk. For example it includes an efficiency target of £ 176 m, £63m higher than achieved in the most recent year (2023/24).

There are a range of performance metrics that underpin this plan and while there are many lines of data within the Activity and Performance template, there are a number key metrics which are used as an indicator of system performance. The system and providers are mainly achieving the key targets, but there are two indicators that are likely to be the focus of regulators;

- **65+ week waits** – The plan is to '*eliminate waits over 65 weeks for elective care as soon as possible and by September 2024 at the latest*'. Two acute hospitals will meet this target by September, and the third one by December this year..
- **Bed occupancy** – The bed occupancy % is high across all three acute trusts. The aim is to achieve 92% this year..

Key workforce metrics:

- Total planned staff use (substantive + bank + agency) to reduce by 0.6% (ca. 150 wte=whole time equivalent) between March 2024 outturn position and end March 2025
- In this number, the total planned substantive growth is planned to grow by ca 600 wte, largely due to agreed capital growth.  
Bank staff usage is expected to reduce by 26% (ca. 520 wte) and agency use by 38% (ca 230 wte).
- Improvement in staff turnover and sickness absence.
- 

Despite good system working by ICS partners, **there remain several bigger financial realities:**

- The plan carries significant risk to delivery
- It is a deficit plan, so the system will be placed in a so-called triple-lock, where – in simple terms – investments outside plan parameters require sign-off by NHS outside the system.
- Thinking medium term, the underlying deficit remains significant: c. £200m for the NHS entities in the ICS, of which c.£100m for the ICB. The expectation from NHS England is that this underlying deficit is eliminated by 2026.

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- To help address the challenges, system leaders have established a Financial Recovery Board, chaired by CEO of NNUH and co-chaired by ICB Executive Director of Finance, to actively pursue levers to improved and sustained financial outcomes, whilst maintaining safety and quality.

**Spotlights**

The committee heard from the CFO of NSFT, who engaged us on NSFT through a financial lens. Some key take-aways

- The Trust submitted a break-even revenue plan for 2024/25 to NHSE.
- This includes:
  - an efficiency target of 5% (£17.4m target), split in the ratio of £10m Recurrent and £7.4m Non-Recurrent.
  - Investments of £ 3.2m related to the Trust’s recovery and quality improvement programme
  - Continued adherence to Mental health Investment Standard
  - Opening of new wards in Hellesdon.

**Items for escalation to Board:**

1. For the recent 23/24 financial year, each NHS entity (including the ICB) in the system is reporting a financial balance.
2. The *underlying* deficit for NHS entities in the system for 23/24 is some £ 230m (ICB’s share some £100 m).
3. The plan submission on May 3<sup>rd</sup> had following key financial parameters

<b>Financial Plan submission to NHS England (May 3<sup>rd</sup>, 2024)</b>	<b>Reported Plan Deficit</b>	<b>Underlying Plan Deficit</b>
<b>N&amp;W ICB</b>	Balanced Plan, with significant risk to delivery	c.£100m
<b>NHS entities in N&amp;W ICS, including ICB</b>	Deficit (c.£36 m*) with significant risk to delivery	c.£200m

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	<table border="1" data-bbox="520 203 1402 389"> <tr> <td data-bbox="520 203 815 389"></td> <td data-bbox="815 203 1123 389">* includes £5.5 deficit due to accounting change</td> <td data-bbox="1123 203 1402 389"></td> </tr> </table> <p>The associated key performance and workforce metrics have been captured in this document.</p> <ol style="list-style-type: none"> <li>4. The system is in triple-lock, creating additional scrutiny on investments outside plan parameters.</li> <li>5. A Financial Recovery Board has been established to actively pursue levers for sustained financial improvement, whilst maintaining quality and safety.</li> </ol>		* includes £5.5 deficit due to accounting change	
	* includes £5.5 deficit due to accounting change			
<b>Items requiring approval:</b>	None			
<b>Confirmation that the meeting was quorate:</b>	Confirmed that both meetings were quorate.			

<b>Key Risks</b>	
<b>Clinical and Quality:</b>	Not applicable
<b>Finance and Performance:</b>	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.
<b>Impact Assessment (environmental and equalities):</b>	Not applicable
<b>Reputation:</b>	Ensuring effective committees and order of business essential for maintaining the financial reputation of the NHS entities in the ICS, including the ICB
<b>Legal:</b>	Finance Committee is a committee of the ICB.
<b>Information Governance:</b>	Not applicable.
<b>Resource Required:</b>	None.
<b>Reference document(s):</b>	Not applicable.
<b>NHS Constitution:</b>	Not applicable.
<b>Conflicts of Interest:</b>	Not applicable.

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Agenda item: 16

<b>Subject:</b>	<b>Primary Care Commissioning Committee Report</b>
<b>Presented by:</b>	<b>Debbie Bartlett, Local Authority Member and Chair of PCCC</b>
<b>Prepared by:</b>	<b>Sadie Parker, Director of Primary Care</b>
<b>Submitted to:</b>	<b>Integrated Care Board – Board Meeting</b>
<b>Date:</b>	<b>22 May 2024</b>

**Purpose of paper:**

To provide the Board with an update on the work of the Primary Care Commissioning Committee for the May extraordinary committee meeting.

<b>Committee:</b>	Primary Care Commissioning Committee
<b>Committee Chair:</b>	Debbie Bartlett, Local Authority Member
<b>Meetings since the previous update on 26 March 2024</b>	7 May 2024 – extraordinary PCCC meeting.  (There was no meeting in April 2024. The meetings have been moved to quarterly going forward with the next meeting on 11 June)
<b>Overall objectives of the committee:</b>	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 <a href="#">here</a> .
<b>Main purpose of meeting:</b>	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.

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<p><b>BAF and any significant risks relevant / aligned to this Committee:</b></p>	<p><b>BAF16 – the resilience of general practice</b>  <b>Current mitigated score – 4x4=16</b></p> <ul style="list-style-type: none"> <li>• 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).</li> <li>• There is also evidence of increasing poor behaviour from patients towards practice staff, leading to retention and recruitment issues.</li> <li>• There is an increasing risk of industrial action following the BMA referendum where the GP contract and associated uplift was rejected.</li> <li>• The national GP contract price uplift does not cover the required increase in meeting the minimum wage.</li> <li>• The LMC has written to practices to cease uncommissioned work associated with MGUS monitoring. Further communications are likely.</li> <li>• 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.</li> <li>• This will have a wider impact as neighbouring practices and other health service partners take on additional workload which in turn affects their resilience.</li> <li>• 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.</li> </ul> <p><b>BAF18 – the resilience of NHS dental services in Norfolk and Waveney</b>  <b>Current mitigated score – 5x4=20</b></p> <p>Primary care services became the responsibility of the Integrated Care Board from 1<sup>st</sup> 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.</p>
<p><b>Key items for assurance/noting:</b></p>	<p><b>7 May 2024</b></p>

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	<ul style="list-style-type: none"> <li>This was an extraordinary committee meeting to hear urgent items, therefore there were no key items for noting.</li> </ul>
<p><b>Items for escalation to Board:</b></p>	<p>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 will be brought to the ICB Board in May.</p> <p>The British Medical Association (General Practitioners Committee) has written to all ICBs advising them to add the risk of industrial action in general practice to their risk registers. This has been incorporated into the overall general practice resilience risk in the Board Assurance Framework.</p> <p>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.</p> <p>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.</p>
<p><b>Items requiring approval:</b></p>	<p><b>7 May 2024</b></p> <p>There were two items on the agenda -</p> <ul style="list-style-type: none"> <li>Following an application from Holt Medical Practice in 2023, and the deferral of a decision at the February committee meeting to enable further public involvement work, a request to close the Blakeney branch surgery was heard. The recommendation to close the branch surgery, with a request to the practice to establish their proposed medicines collection service was approved. In considering the application, the committee reviewed data relating to the health profile of the local population, the Equality Impact Assessment (which had been reviewed following the further public involvement phase), and reviewed the report and the assurances provided against the NHS policy guidance manual and the ICB's general statutory duties. A significant amount of time on</li> </ul>

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	<p>the agenda was provided for public questions and comments before the committee reached their decision.</p> <ul style="list-style-type: none"> <li>The ICB's long term dental plan was approved, which builds on the short term plan currently in implementation. The plan detailed the work programme over the coming two years and set out intentions for three years after that. The aim was to continue to improve access by stabilising and strengthening dental services (including those provided in community and secondary care settings), with a focus on children and young people, reducing health inequalities, building a sustainable workforce and improving oral health prevention. The ICB's public and stakeholder engagement report was also published following a period of engagement earlier in the year, with over 2000 responses, overwhelmingly in support of our priority areas.</li> </ul>
<p><b>Confirmation that the meeting was quorate:</b></p>	<p>There are four voting members and three are required to be quorate. The meeting was quorate with the following attendance:</p> <p><b>7 May 2024</b></p> <p>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</p>

Key Risks	
<p><b>Clinical and Quality:</b></p>	<p>Care Quality Commission inspection reports are regularly reviewed. Quality responsibilities have been clarified in the revised Terms of Reference.</p>
<p><b>Finance and Performance:</b></p>	<p>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.</p>
<p><b>Impact Assessment (environmental and equalities):</b></p>	<p>All papers considered include consideration of the ICB's duty to reduce health inequalities.</p>

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<b>Reputation:</b>	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
<b>Legal:</b>	Terms of reference, primary medical services contracts, premises directions and policy guidance manual, ICB general duties.
<b>Information Governance:</b>	Any confidential or sensitive information is heard in private
<b>Resource Required:</b>	Primary care commissioning, quality, finance, primary care estates, primary care workforce, primary care digital, prescribing, locality and BI teams
<b>Reference document(s):</b>	Primary care services regulations, statement of financial entitlements, premises directions and policy guidance manual, delegation agreement with NHS England
<b>NHS Constitution:</b>	N/A
<b>Conflicts of Interest:</b>	Arrangements are in place to manage conflicts of interest

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Agenda item: 17

<b>Subject:</b>	<b>Commissioning &amp; Performance Committee Report</b>
<b>Presented by:</b>	<b>Hein van den Wildenberg</b>
<b>Prepared by:</b>	<b>Liz Joyce, Head of System Transformation</b>
<b>Submitted to:</b>	<b>Integrated Care Board – Board Meeting</b>
<b>Date:</b>	<b>22 May 2024</b>

**Purpose of paper:**

To provide the Board with an update on the work of the Commissioning and Performance Committee for the period 26<sup>th</sup> March to 22 May 2024. The Committee held its first meeting on 2<sup>nd</sup> May 2024.

<b>Committee:</b>	Commissioning and Performance
<b>Committee Chair:</b>	Dr Hilary Byrne, Deputy Chair Hein van den Wildenberg
<b>Meetings since the previous update on 26<sup>th</sup> March 2024</b>	Meeting held 2 <sup>nd</sup> May 2024 0900 – 1100 via MS Teams
<b>Overall objectives of the committee:</b>	<p>To make financial decisions / recommendations about business cases for commissioning and decommissioning, within the value of its delegated responsibilities as set out in the terms of reference. This forum is where decisions will be made about commissioning, other than for primary care which has its own committee.</p> <p>To consider and make decisions on clinical policies as recommended by the Clinical Policy Development Group.</p> <p>To consider and make decisions on recommendations from the medicines optimisation programme board.</p> <p>To oversee and gain assurance on the operational arrangements that support the commissioning of services.</p>

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	<p>Oversee the process of any further delegation of commissioning responsibilities from NHS to the ICB.</p> <p>Provide oversight to the Individual Funding Request panel.</p> <p>Conduct and lead the oversight of NHS system and commissioned provider performance, directing improvement resources and ensuring learning is implemented. This includes coordinating with regulators where formal improvement is required.</p> <p>Ensure that innovation, best practice, evidence and evaluation and the impact on health inequalities consistently informs our commissioning decisions.</p> <p>Approve the application of the Provider Selection Regime process for the procurement of any business cases that it approves under its delegation.</p>
<p><b>Main purpose of meeting:</b></p>	<p>The Committee exists to provide assurance and oversight and make decisions (within its delegations) on the commissioning and performance of services to ensure better outcomes for the population of Norfolk and Waveney. It will also consider the management of risk in all its work.</p>
<p><b>BAF and any significant risks relevant / aligned to this Committee:</b></p>	<p>There is not a specific risk register entry against this Committee. However, the following risks are inter-related to the remit of this new Committee, which will be making commissioning decisions and managing performance:</p> <p>BAF08 – Elective Recovery  BAF11A – Underlying deficit position  BAF23 – System failure to achieve access standards for cancer diagnosis and treatment.</p>
<p><b>Key items for assurance/noting:</b></p>	<ol style="list-style-type: none"> <li>1. As it was the first meeting the Committee took the opportunity to discuss the ToR, the cycle of meetings and a forward planner.</li> <li>2. An overview of the prioritisation process was provided for noting. This is a matrix scoring approach, designed to ensure there is an equitable approach to how new requests for funding are assessed and prioritised (including ring-fenced monies / other sources).</li> <li>3. An overview was provided of the process for how decommissioning decisions are to be made, including the detail of a Decommissioning Assessment Form (DAF) and flow chart.</li> </ol>

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Items 2 and 3 are already being used as agreed processes and the Committee was provided with the overview for information and noting.

4. The Committee received a set of five eye care service specifications which had been developed in response to a request for accreditation from an independent sector provider in line with national patient choice guidance and the provider selection regime direct aware process B. This work was undertaken by the Planned Care team, using an impartial ICB employed ophthalmic clinician and a national engagement exercise on the services. Final amendments and recommendations were made by the planned care and medicines management working Group on 28/3/24. This was approved by ICB EMT on 16/04/2024, ahead of the accreditation deadline on 26/04/24. The paper was therefore brought to the Committee for noting as the decision had to be made before this Committee had been stood up.
5. ToR for the Planned Care and Cancer Clinical Transformation Board and the Medicines Optimisation Board were shared, and members were asked to feedback prior to the next meeting, at which approval will be sought. Both Boards will report into this Committee.
6. There was a summary provided of the 2024/25 annual planning submission. The ICB Board is already sighted as it held an extraordinary meeting to approve the final submission on 29 April, prior to the final submission deadline of 2<sup>nd</sup> May (the same date as the Committee meeting).
7. A detailed report was received on progress made against the deliverables set out within the Joint Forward Plan, for the 9 months of July 2023 – March 2024. The Committee acknowledged the amount of work undertaken and progress made across the Ambitions. There were no specific escalations. It was agreed that the reporting frequency will be every six months and the reporting format was agreed. The clear alignment with other ICS strategies and the Norfolk & Waveney ICS strategy / Norfolk Health and Wellbeing Strategy was noted.
8. A detailed report was received on progress made against the deliverables within the N&W ICS clinical strategy and Year 2 focus areas for the

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	<p>six clinical strategy objectives were shared with the Committee. A decision was made to report on the Clinical Strategy every 6 months to align with the JFP. Refreshed actions for Year 3 will be brought to the Committee for approval in January 2025.</p> <p>9. The Committee was asked to consider the key national and local metrics that will be brought to this meeting. There will be an item at the June meeting to agree the proposed tabular format of validated data that will become part of the regular performance agenda at this Committee.</p>
<b>Items for escalation to Board:</b>	None
<b>Items requiring approval:</b>	None
<b>Confirmation that the meeting was quorate:</b>	Yes The Deputy Chair chaired this first meeting.

<b>Key Risks</b>	
<b>Clinical and Quality:</b>	None
<b>Finance and Performance:</b>	None
<b>Impact Assessment (environmental and equalities):</b>	Not completed
<b>Reputation:</b>	None
<b>Legal:</b>	None
<b>Information Governance:</b>	None
<b>Resource Required:</b>	Not discussed
<b>Reference document(s):</b>	N/A
<b>NHS Constitution:</b>	None
<b>Conflicts of Interest:</b>	None

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Agenda item: 18

<b>Subject:</b>	<b>Patients and Communities Committee Report</b>
<b>Presented by:</b>	<b>Aliona Derrett, Chair of the Patients and Communities Committee</b>
<b>Prepared by:</b>	<b>Rachael Parker, Executive Assistant - Norfolk and Waveney ICB</b>
<b>Submitted to:</b>	<b>Integrated Care Board – Board Meeting</b>
<b>Date:</b>	<b>22 May 2024</b>

**Purpose of paper:**

To provide the Board with an update on the work of the Patients and Communities Committee for the period to 22 May 2024

<b>Committee:</b>	Patients and Communities Committee
<b>Committee Chair:</b>	Aliona Derrett, Non-Executive Director
<b>Meetings since the previous update on 30 May 2023</b>	Monday 25 March 2024  Monday 20 May <i>*the update from this meeting will be included in July's update</i>
<b>Overall objectives of the committee:</b>	<ul style="list-style-type: none"> <li>Monitoring and coming back to the 'so what' conversation question during meetings</li> <li>As part of the deep dive sessions – all presentations and presenters must include – as a result of doing this, <b>what has changed, including experience, outcomes and access</b>. This will be a core focus of the Committee to scrutinise these metrics.</li> <li>How many people are we reaching/connecting with as part of engagement and co-production activities?</li> <li>What evidence is there to identify how health inequalities are reducing?</li> </ul>
<b>Main purpose of meeting:</b>	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

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	<p>and reduces the health inequalities experienced by individuals and communities.</p> <p>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.</p>
<p><b>BAF and any significant risks relevant / aligned to this Committee:</b></p>	<p>NA</p>
<p><b>Key items for assurance/noting:</b></p>	<p><b>Spotlight on Great Yarmouth – Insights and Experiences</b>  The Committee received an update on the Community Voices insights generated from the Great Yarmouth area, and the key themes identified. The Committee was pleased to learn that the ICB and Healthwatch Norfolk had been exploring opportunities to work together. The Committee recognised the benefit of Community Voices to the wider system and heard an example of how it was being used to help research colleagues identify the barriers for people participating in research and improving research design to make it more inclusive.</p> <p><b>Complaints Report:</b>  The Committee noted the exponential rise in formal complaints received by the ICB following the full delegation of Primary Care complaints handling from NHS England to ICBs. The committee acknowledged the challenges faced by the complaints team linked to public frustration with the services they receive, and an expectation of primary care services that cannot always be delivered.</p> <p>The Committee noted and congratulated the complaints team on the improved target response times with 78% of complaints receiving a response within target, and all complaints being acknowledged in time.</p> <p><b>Population Health Management Strategy</b>  The Committee noted the reason for developing the strategy was due to the JFP containing an objective / ambition for a strategy to be developed by the end of March 2024. The Committee noted the significant collaboration and engagement process which had identified key themes which had been incorporated throughout the strategy. The committee sought clarification of the target audience for the strategy which was confirmed as stakeholders and professionals within the ICB. The Committee also queried how local people and VCSE organisations will be involved in implementing the strategy, the Committee was advised this will be during the project planning phase. The Committee approved the Population Health Management Strategy.</p>

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**Community Voices Update**

The Committee received an overview of the Community Voices (CV) work to date. The Committee heard from a colleague at Norfolk County Council who presented the perspective of an organisation that had used the CV service for a project relating to smoking cessation and having a better understanding of what the barriers and enablers are for people who are smokers. The CV work helped NCC to understand the evidence base for the services that are currently commissioned.

**Place Board Update – West Norfolk**

The Committee welcomed the Chair of the West Place Board to the March meeting to provide an update on the Place work in west Norfolk. The Committee noted the strong and well-established Place Board and close links with the Health and Wellbeing Partnership. The complexities in the west were also acknowledged, particularly from an acute perspective and the crossover into Cambridge, Peterborough, and Lincolnshire borders.

Some positive examples were shared of projects linked to the Community Transformation Fund including out of hours palliative care support, leg ulcer nurses supporting primary care, and care home support. For the next financial year several priorities and significant areas have been identified to focus on, and having a cohesive Marmot Town framework in place will help the west to deliver some of these.

**Children and Young People’s Asthma Support in Waveney**

The Committee welcomed the Business Development Officer from Healthwatch Suffolk to the March meeting, to feedback on some research commissioned by Norfolk and Waveney linked to young people’s experiences with asthma. The research highlighted the need for three key messages around promoting the use of asthma plans, providing accessing information about asthma to families and schools, and ensuring that both appointments are accessible and there is follow up following a hospital admission and a yearly asthma review.

**Health Inequalities Framework**

The Committee noted the framework responded to the JFP requirement to develop a strategy by April 2024, and has been designed following significant engagement across the ICS with over 100 organisations contributing. The Committee further noted the framework forms a significant part of the VCSE Assembly work plan and the model the Assembly Board is working on for the next 12 months is built around the framework. The Committee endorsed the Health Inequalities Framework.

**Population Health and Inequalities Board Update**

The Committee received the update and noted the positive areas highlighted which included an acknowledgement of the ICB vaccination programme and recognition of the achievement of the vaccination team as the Covid and Flu vaccination programme this year ranked first in the East of England and third

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	<p>nationally this winter. The risk associated with there being no long-term ring fence funding of health inequalities was escalated to the Committee and the risk was added to the Patients and Communities Risk Register.</p> <p><b>Ageing Well Programme Board Update</b> The Committee received the update and noted the Ageing Well Strategic Framework had now been implemented.</p>
<b>Items for escalation to Board:</b>	None
<b>Items requiring approval:</b>	None
<b>Confirmation that the meeting was quorate:</b>	Yes

<b>Key Risks</b>	
<b>Clinical and Quality:</b>	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.
<b>Finance and Performance:</b>	The committee has attendees from the Integrated Commissioning Team to input in relation to provider performance.
<b>Impact Assessment (environmental and equalities):</b>	N/A
<b>Reputation:</b>	<p>The committee is held bi-monthly in public and includes membership from:</p> <ul style="list-style-type: none"> <li>- Healthwatch Norfolk and Suffolk</li> <li>- VCSE</li> <li>- Health and Wellbeing Boards in Norfolk and Suffolk</li> <li>- Public Health</li> <li>- Primary Care</li> <li>- Place</li> <li>- Health Inequalities</li> </ul> <p>Recruitment of Lived Experience representation is in progress</p>
<b>Legal:</b>	N/A
<b>Information Governance:</b>	N/A
<b>Resource Required:</b>	N/A
<b>Reference document(s):</b>	N/A

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<b>NHS Constitution:</b>	The report supports the Patient and Communities elements of the NHS Constitution.
<b>Conflicts of Interest:</b>	Committee member's interests are documented and managed according to ICB policy.

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Agenda item: 19

<b>Subject:</b>	<b>Remuneration, People and Culture Committee Report</b>
<b>Presented by:</b>	<b>Cathy Armor, Non-Executive Member and Chair of the Remuneration, People Culture Committee</b>
<b>Prepared by:</b>	<b>Andrew Jones – Deputy Director of People</b>
<b>Submitted to:</b>	<b>Integrated Care Board – Board Meeting</b>
<b>Date:</b>	<b>22 May 2024</b>

**Purpose of paper:**

To provide the Board with an update on the work of the Workforce directorate with regards to it works across its People functions, organisational developments, workforce transformation and efficiency and productivity for the period April 2024.

<b>Committee:</b>	<b>Remuneration, Culture and People Committee</b>
<b>Committee Chair:</b>	Cathy Amor
<b>Meetings since the previous update on 26<sup>th</sup> March 2024</b>	29 April 2024
<b>Overall objectives of the committee:</b>	<p>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:</p> <ul style="list-style-type: none"> <li>• 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.</li> </ul> <p>The ICB Board has also delegated the following functions to the Committee:</p> <p>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</p>

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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.

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<b>Main purpose of meeting:</b>	<p>To provide an update on key actions relating to the ICS workforce over the previous 1-month period. Specifically:</p> <ul style="list-style-type: none"> <li>• National Staff Survey</li> <li>• ICB Change Management Programme</li> <li>• ICS Workforce Plan</li> <li>• Improving Lives Together Programme</li> </ul>
<b>BAF and any significant risks relevant / aligned to this Committee:</b>	<p>N/A.</p>
<b>Key items for assurance/noting:</b>	<p><b>National Staff Survey</b></p> <ul style="list-style-type: none"> <li>• Embargo lifted March 24; all providers have their received their detailed reports.</li> <li>• Local Action planning at provider level following results</li> <li>• National and East of England, plan to provide targeted action planning, 2/3 key focus areas system wide working on the staff survey.</li> </ul> <p><b>ICB Change Management Programme</b></p> <ul style="list-style-type: none"> <li>• Outcome of consultation published, appeals against individual outcome status completed, and filling of posts has commenced.</li> <li>• For potential redeployments, system partners supporting in seeking suitable alternative employment.</li> </ul> <p><b>ICS Workforce Plan</b></p> <ul style="list-style-type: none"> <li>• Final submission due 2 May, with close working between HR and Finance and providers across the system</li> <li>• Plan mainly covers secondary care and excludes ECCH.</li> <li>• 0.6% (154wte) decrease in total planned staff March 24 to March 25</li> <li>• Net reduction in bank and agency staff (290wte)</li> <li>• Increase in substantive FTE for some clinical staff groups and support to clinical staff (though net reduction in registered nursing/midwifery – mainly at QEH)</li> <li>• Provider confidence in recruiting with newly qualified as well as international and domestic.</li> <li>• 24/25 Planning guidance shared with the group for awareness/information.</li> </ul> <p><b>Improving Lives Together Programme</b></p> <ul style="list-style-type: none"> <li>• Four priority areas continue to be: Recruitment, Bank &amp; Agency, Leadership &amp; Development and Contracting.</li> </ul>

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	<ul style="list-style-type: none"> <li>• Recruitment first (Financial saving limited)</li> <li>• Leadership &amp; Development – expected to give a productivity improvement.</li> <li>• Bank &amp; Agency - Working with NHS Professionals to review potential savings for each acute trust. NNUH interest in moving forward with fully managed solution.</li> <li>• Paper presented at Financial Recovery Board, and Alice Webster (CEO at QEH) confirmed as system SRO to drive forward progress.</li> </ul>
<b>Items for escalation to Board:</b>	N/a
<b>Items requiring approval:</b>	N/a
<b>Confirmation that the meeting was quorate:</b>	Yes

<b>Key Risks</b>	
<b>Clinical and Quality:</b>	N/a
<b>Finance and Performance:</b>	ICS Workforce plan includes large reduction in agency and bank costs required to meet the system finance plan
<b>Impact Assessment (environmental and equalities):</b>	N/a
<b>Reputation:</b>	N/a
<b>Legal:</b>	N/a
<b>Information Governance:</b>	N/a
<b>Resource Required:</b>	N/a
<b>Reference document(s):</b>	N/a
<b>NHS Constitution:</b>	N/a
<b>Conflicts of Interest:</b>	N/a

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Agenda item: 20

<b>Subject:</b>	<b>Conflicts of Interest Committee Report</b>
<b>Presented by:</b>	<b>David Holt</b>
<b>Prepared by:</b>	<b>Martyn Fitt, Corporate Affairs Manager</b>
<b>Submitted to:</b>	<b>ICB Board</b>
<b>Date:</b>	<b>22 May 2024</b>

**Purpose of paper:**

To provide the Board with an update on the work of the Conflicts of Interest Sub Committee for the period 26 March 2024 to 22 May 2024

<b>Committee:</b>	Conflicts of Interest Committee
<b>Committee Chair:</b>	David Holt, Non Executive Member
<b>Meetings since the previous update on 20 March 2024</b>	<ul style="list-style-type: none"> <li>19 March 2024</li> </ul>
<b>Overall objectives of the committee:</b>	The Conflicts of Interest 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.
<b>Main purpose of meeting:</b>	<p>In addition to the standing items, the main purpose of the meeting was to brief and assure the committee on the following items:</p> <p><b>1. Conflicts of Interest 2023/24 Close Down</b></p> <p>The Committee was presented with a paper to assure the committee on the work completed in 2023/24. These were as follows:</p> <ul style="list-style-type: none"> <li>Mandatory training – the ICB closed the financial year with &gt;50% compliance with the new module, which was released by NHSE in January 2024, and available to staff in February.</li> </ul>

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	<ul style="list-style-type: none"> <li>Annual DOI Process – the ICB complied with its statutory duties by closing the year with 98% of staff returns. A process to review any risks will transfer to 2024/25.</li> <li>Breaches – the committee received a report that there had been no breaches in 2023/24.</li> <li>TIAA Audit – the ICB received a reasonable assurance rating from TIAA in its annual audit, which was joined with business interests and secondary employment. The findings reported 4 recommendations – all were closed by March 2024.</li> <li>2023/24 Work Plan – the committee reviewed the close down report of the years’ work plan. Noting that the ICB delivered 78% of its overall objectives for the year. The remaining 22% related to innovation tasks, because the ICB delayed many of its digital transformation work.</li> <li>Effectiveness of the COI Committee – self-assessment of the ICB’s COI Committee and work that was undertaken/completed in 2023/24.</li> </ul>
	The Committee has responsibility for oversight of the ICB risk management process and the full Board Assurance Framework.
<b>Key items for assurance/noting:</b>	<ul style="list-style-type: none"> <li>Work Plan for 2023/24 was closed.</li> </ul>
<b>Items for escalation to the Audit and Risk Committee:</b>	None
<b>Items requiring approval:</b>	No items for approval
<b>Confirmation that the meeting was quorate:</b>	Yes

<b>Key Risks</b>	
<b>Clinical and Quality:</b>	Internal audit reports provide assurance on internal control processes
<b>Finance and Performance:</b>	The Committee monitors the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance.
<b>Impact Assessment (environmental and equalities):</b>	None
<b>Reputation:</b>	The Committee supports the ICB’s reputation by providing oversight and assurance to the Committee and Board on the adequacy of governance and internal control processes within the ICB.
<b>Legal:</b>	It is a statutory requirement for the ICB to have an audit and risk committee.

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<b>Information Governance:</b>	This Committee provides assurance to the Board that there is an effective framework in place for the management of risks associated with IG.
<b>Resource Required:</b>	None
<b>Reference document(s):</b>	None
<b>NHS Constitution:</b>	N/A
<b>Conflicts of Interest:</b>	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.

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