Meeting of the Board of Norfolk and Waveney Integrated Care Board

Wed 27 November 2024, 13:30 - 16:30

Agenda

13:30 - 13:30 ***Meeting agenda***
0 min
00. Agenda for Part 1 ICB Board 27.11.24.pdf (5 pages)

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

13:30 - 13:30 **2. Questions**
0 min
02. protocol-for-submitting-questions-to-the-icb-board.pdf (1 pages)

13:30 - 13:30 **3. Minutes from previous meeting and matters arising**
0 min
03. DRAFT NW ICB Board Part 1 Minutes 25092024.pdf (8 pages)

13:30 - 13:30 **4. Declarations of interest**
0 min
04. Board ICB COI Register Nov 24.pdf (5 pages)

13:30 - 13:30 **5. Chair's Action Log**
0 min

13:30 - 13:30 **6. Action log – things we have said we will do**
0 min
06. ICB Board Action Log Nov 2024.pdf (1 pages)

13:30 - 13:30 **7. Chair and Chief Executive's Report**
0 min
07. 2024-11-27 - Chair and Chief Executive's Board report - Final.pdf (5 pages)

13:30 - 13:30 ***Learning from People, Staff, and Communities***
0 min

13:30 - 13:30 **8. Lived Experience Item**
0 min

13:30 - 13:30 **9. Report from Patients and Communities Committee**
0 min

09. Patients and Communities Committee Report Nov 2024.pdf (3 pages)

13:30 - 13:30
0 min

Strategy and Partnerships

13:30 - 13:30
0 min

10. Review of intensive and assertive community treatment for people with severe mental health problems

10. ICB Board Report IAO Review Presentation Nov 24 final.pdf (3 pages)
10.1 Intensive and Assertive Review ICB Presentation 08.11.2024.pdf (10 pages)

13:30 - 13:30
0 min

11. Integrated Performance Report (IPR)

11. Board Performance narrative Nov 2024.pdf (5 pages)
11.1 Board KPI report Nov 2024.pdf (53 pages)

13:30 - 13:30
0 min

12. Report from the Commissioning and Performance Committee

12. Commissioning and Performance Board Report Nov 2024.pdf (9 pages)

13:30 - 13:30
0 min

Comfort Break 10 Minutes

13:30 - 13:30
0 min

13. Primary Care Access Recovery Plan

13. PCARP Paper November ICB board - FINAL - 18.11.24_.pdf (13 pages)

13:30 - 13:30
0 min

14. Winter Plan Refresh

14. ICB Board Report - Winter 2024 25.pdf (2 pages)
14.1 NWICB Board Winter Frameworrk.pdf (13 pages)

13:30 - 13:30
0 min

15. Ageing Well Programme

15. 2024.11.27 - Ageing Well Programme - ICB Public Board Report FINAL v0.5.pdf (8 pages)
15.1 Ageing Well ICB Board presentation 27.11.24.pdf (14 pages)

13:30 - 13:30
0 min

Commissioning, Delivery and Performance

13:30 - 13:30
0 min

16. Financial Report for Month 6

16. ICB Finance Report - Month 06 202425 - Board.pdf (10 pages)

13:30 - 13:30
0 min

17. Report from the Finance Committee

17. Finance Commmitee Board Report Nov 24.pdf (3 pages)

13:30 - 13:30
0 min

System Oversight

13:30 - 13:30
0 min

18. ICB Framework for System Quality Deterioration

18. 2024 11 27 Deteriorating Quality Framework Frontsheet for Board v2.0.pdf (2 pages)
18.1 2024 11 27 Deteriorating Quality Framework v2.0.pdf (9 pages)

13:30 - 13:30
0 min

19. Report from the Quality and Safety Committee

19. Quality and Safety Committee Board Nov 24.pdf (7 pages)

13:30 - 13:30
0 min

20. Board Assurance Framework

20. Risk Management Report to Board Nov 24 Part 1.pdf (3 pages)
20.1 Part 1 - App 1 - Board Assurance Framework.pdf (25 pages)

13:30 - 13:30
0 min

21. ICB Constitution Review

21. N&W Constitution Update.pdf (3 pages)
21.1 NHS NW ICB Constitution 27.11.24 v3 TRACK.pdf (51 pages)

13:30 - 13:30
0 min

Remaining Committees Reports and Questions from the public

13:30 - 13:30
0 min

22. Report from the Audit and Risk Committee

22. Audit and Risk Committee Board Report Nov 24.pdf (4 pages)

13:30 - 13:30
0 min

23. Primary Care Commissioning Committee

13:30 - 13:30
0 min

24. Report from the Remuneration, People and Culture Committee - verbal

13:30 - 13:30
0 min

25. Questions from the Public

13:30 - 13:30
0 min

26. Any other business

Norfolk and Waveney
Integrated Care Board

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

Wednesday, 27 November 2024 1.30pm – 4.30pm

Hethel Engineering Centre (Hethel Engineering Centre Chapman Way, Norwich, England, NR14 8FB)

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

Our goals:

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

Our values:

Questions

Questions relating to agenda items can be submitted via the following means:

1. Please submit questions no later than 12 noon on the 22 November 2024, via e-mail to: nwicb.contactus@nhs.net.

2. Questions will be collated and asked at the relevant item on the agenda at the discretion of the Chair.

3. Questions can also be asked during the meeting by members of the public relating to an agenda item by those present or watching live at the discretion of the Chair.

Chair: Hein van den Wildenberg (Vice Chair)

Item	Time	Agenda Item	Lead
Introductory Items			
1.	1.30	**Welcome and introductions - Apologies for absence**	Chair
2.		**Questions** Notification of any questions from members of the public on agenda items for response at the appropriate time on the agenda	Chair
3.		**Minutes from previous meeting and matters arising** To approve the part 1 public minutes of the previous Board meeting.	Chair
4.		**Declarations of interest** To declare any interests that board members may have specific to agenda items that could influence the decisions they make. Declarations made by members of the ICB Board are listed in the ICB's Register of Interests. The Register is available via the ICB's website.	Chair
5.		**Chair's Action Log** To receive an update from the Chair on actions taken since the last meeting. There are no Chairs Action to report at this meeting.	Chair
6.		**Action log – things we have said we will do** To make sure the ICB completes all the actions it agrees are needed.	Chair
7.	1.35	**Chair and Chief Executive's Report** To note an update from the Chair and the Chief Executive of the ICB about the work the ICB has done since the last meeting.	Chair and Tracey Bleakley
		Learning from People, Staff, and Communities	
8.	1.45	The lived experiences shared in this presentation will help to illustrate the resilience of our veterans and their families. It highlights the importance of making health and care services accessible and equitable for those who have served in our UK Armed Forces, especially as they transition from service to a happy and healthy civilian life.	Tricia D'Orsi
9.	2.05	**Report from Patients and Communities Committee**	Aliona Derrett

Item	Time	Agenda Item	Lead
		Strategy and Partnerships	
10.	2.10	**Review of intensive and assertive community treatment for people with severe mental health problems** To receive an update on the Intensive and Assertive Outreach Reviews, and ICB Action Plan, which systems have been mandated to conduct.	Jossy Pike Martin Keegan
11.	2.25	**Integrated Performance Report (IPR)** To provide assurance to the ICB Board and highlight significant elements of the system performance reporting.	Andrew Palmer Matt Dooley
12.	2.30	**Report from the Commissioning and Performance Committee**	Hein Van Den Wildenberg
		Comfort Break 10 Minutes	
13.	2.40	**Primary Care Access Recovery Plan** To provide an update on progress of the system capacity and access recovery plan.	Sadie Parker
14.	3.00	**Winter Plan Refresh** T**o** provide an overview of the approach to half 2 planning for urgent and emergency care.	Marcus Bailey
15.	3.10	**Ageing Well Programme** To provide an update to the Norfolk and Waveney ICB Public Board on the work of the Norfolk and Waveney Ageing Well Programme.	Dr Frankie Swords James Allen Janice Shirley
		Commissioning, Delivery and Performance	
16.	3.25	**Financial Report for Month 6** To receive a summary of the financial position as at month 6	Steven Course
17.	3.40	**Report from the Finance Committee**	Hein Van Den Wildenberg
		System Oversight	
18.	3.45	**ICB Framework for System Quality Deterioration** To present the Board with a copy of the draft Deteriorating Quality Framework for ratification.	Tricia D'Orsi
19.	3.55	**Report from the Quality and Safety Committee**	Aliona Derrett
20.	4.00	**Board Assurance Framework**	Karen Barker

Item	Time	Agenda Item	Lead
		A review of the risks (things that might go wrong and how we can alleviate them) within the Integrated Care system.	
21.	4.10	**ICB Constitution Review** To present proposed revisions to the ICB's Constitution for approval and to approve leads as set out in the paper.	Karen Barker
		Remaining Committees Reports and Questions from the public	
22.	4.15	**Report from the Audit and Risk Committee**	David Holt
23.		**Primary Care Commissioning Committee –** No report submitted as the next scheduled meeting date is after the Board meeting.	
24.	4.20	**Report from the Remuneration, People and Culture Committee - verbal**	Cathy Armor
25.		**Questions from the Public.** Where questions in advance relate to items on the agenda.	Chair
26.	4.25	**Any other business**	Chair

Date, time, and venue of next meeting: 1.30pm – 4.30pm Wednesday 29 January 2025 Meeting to be held virtually via Microsoft teams

Future ICB Board meeting dates 2025 -2026 for a diaries:

- **21 May 2025 – Virtual**
- **16 July 2025 – Face to Face**
- **24 September 2025 - Virtual**
- **26 November 2025 – Face to Face**
- **28 January 2026 – Virtual**
- **25 March 2026 – Face to Face**

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

Some explanations of terms used in this Agenda.

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

Integrated Care System (ICS) - 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 were replaced by ICBs on 1st July 2022.

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

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

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

NHS
Norfolk and Waveney
Integrated Care Board

Protocol for submitting questions to the ICB Board

The Board of NHS Norfolk and Waveney holds its meeting in public, which members of the public are welcome to attend and observe.

Questions for the Board relating to agenda items must be submitted in advance by 12 noon, three working days before the meeting.

Questions must only relate to matters within the powers and functions of the Board.

Questions shall not be responded to if the Board Chair deems that the question:

- relates to quasi-judicial matters e.g. (current or potential legal proceedings or consultations)
- relates to confidential or exempt matter
- is not about a matter for which the Board has responsibility
- is defamatory, frivolous, factually incorrect or offensive
- is substantially the same as a question put to a meeting of the Board in the previous six months, however the individual will be directed to the associated response that the Board has published on the ICB website
- is directly about party political matters
- is formed to make a statement rather than to receive information.

Questions relating to agenda items will be addressed alongside the agenda item to which they relate at the Board meeting. These will be read out at the meeting alongside the name of the questioner, where this has been provided. Where multiple questions have been submitted by different individuals or organisations regarding the same subject, key themes will be presented to the meeting with the names of all questioners read out.

A response will also be provided in writing (within 20 working days following the date of the meeting), and a copy of the response will be sent to all members of the Board and published on the ICB website.

Where questions are received that do not relate to agenda items then these will not be read out at the Board meeting but a response will be provided in writing (within 20 working days following the date of the meeting), and a copy of the response will be sent to all members of the Board and published on the ICB website.

If you would like to raise a question with regards to an agenda item this needs to be submitted in writing to the nwicb.contactus@nhs.net no later than three working days/the Friday prior to the meeting.

NHS Norfolk and Waveney Integrated Care Board

DRAFT Minutes of the meeting on Wednesday, 25 September 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
- Dr Frankie Swords (FS), Executive Medical Director, NHS Norfolk and Waveney ICB
- Patricia D'Orsi (PD'O), Executive Director of Nursing, 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
- Aliona Derrett (AD), Non-Executive Member, NHS Norfolk and Waveney ICB
- Cathy Armor (CA), Non-Executive Member, NHS Norfolk and Waveney ICB
- Cllr Bill Borett (BB), Chair, Norfolk Health and Wellbeing Board, and Chair, Norfolk and Waveney ICP
- Jonathan Barber (JBa), Partner Member – NHS Trusts (Acutes)
- Caroline Donovan (CD), Partner Member – NHS Trusts

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 Patients and Communities Director, 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

Attending to support the meeting:

- Dr Clara Yates (CY), Associate Director of Research, NHS Norfolk and Waveney ICB (for item 15)
- Chris Williams (CW), Head of the Chief Executive's Office, NHS Norfolk and Waveney ICB (Minutes)

1.	**Welcome and introductions - apologies for absence**	
	The Chair welcomed everyone to the meeting. Apologies were received from the following Board members: • Debbie Bartlett (DB), Local Authority Partner Member • Stuart Keeble (SK), Local Authority Partner Member • Dr Hilary Byrne (HB), Partner Member – NHS Primary Medical Services	

	• Emma Ratzer (ER), Voluntary, Community and Social Enterprise Sector Board Member The Chair thanked DB for her contribution to the Board and more broadly in her roles at Norfolk County Council. She added that she was delighted Ian Wake, the new Executive Director of Adult Social Services, had been appointed as new local authority partner on the Board.	
2.	**Questions**	
	The Chair noted that two questions had been received that did not relate to agenda items. She confirmed that both had been answered and the responses added to the website, as well as circulated to Board members.	
3.	**Minutes from previous meeting and matters arising**	
	Agreed: The draft minutes from the meeting held on 17 July 2024 were approved as an accurate record of the meeting.	
4.	**Declarations of interest**	
	The Chair noted that declarations of interest were kept up-to-date and were available on the ICS's website.	
5.	**Chair's action log**	
	The Chair noted she had taken one action since the last Board meeting, this was to confirm on behalf of the Board the ICB's support for approval for the multi-storey car park at the Queen Elizabeth Hospital.	
6.	**Action log**	
	KB explained that there was one outstanding action regarding the EDS2 and NHS Workforce Race Equality Standard. TB explained that HR colleagues were not able to join the Board meeting and they would provide an update at the next meeting. The report was noted.	
7.	**Chair and Chief Executive's Report**	
	The Chair welcomed the news that the Queen Elizabeth and James Paget Hospitals would continue to be part of the New Hospitals Programme. TB highlighted the ongoing work to address the financial challenges the system faced, as well as the significant efforts being made to reduce long waits for planned care. Questions and comments from Board members: • PD'O highlighted that the NHS would be offering the RSV vaccine for the first time and encouraged people who were eligible to take up the offer. The report was noted.	

	Learning from People, Staff, and Communities	
8.	**Learning from People, Staff and Communities**	
	PD'O introduced the item by thanking Healthwatch Norfolk for the video about the use of the NHS App. The Chair highlighted that the app had 34 million registered users in England, which was only a couple of years old and a real success story, in line with the kind of transformation being seen in other parts of the world. Questions and comments from Board members: • CA asked if there were plans to enable people to be able to manage other people's care via the app that weren't registered at the same GP practice. • FS commented that while the app is fantastic, it was just one front door to the NHS, adding that the app does free up staff to help people who can't access the NHS digitally. • AD asked what provisions were in place in primary care to ensure that when people received test results that were not good they also got support when they were notified of the results. She also asked about how AI could be used safely by the NHS and what measures were put in place to avoid issues. • PD'O commented that from a safety perspective, the introduction of AI could be safer than the mechanisms in place now. • FS explained that it was responsibility of whoever organised the test to ensure that test results were communicated well and people were supported. **Action: IR to explore if there are any plans to develop the NHS App to enable users to be able to manage the care of people that aren't registered at the same GP practice.** **Agreed:** The ICB Board noted the report.	**IR**
9.	**Report from Patients and Communities Committee**	
	AD introduced the item by highlighting key points from the report, including the update on FLOURISH and neurodevelopmental disorder provision, and she commended the work of Healthwatch Norfolk and Healthwatch Suffolk and the range of work they do. She noted that the findings of work done by the community voices initiative were used to inform the healthy hearts work. **Agreed:** The ICB Board noted the report.	
	Strategy and Partnerships	
10.	**ICP update and report**	
	BB introduced the item by highlighting the sense of a joint mission and the value of the ICP's meetings.	

	FS highlighted the publication of the Health Inequalities Strategic Framework for Action and all the work that had gone into writing it, as well as the Living and Working Conditions Group which would play an important role in enabling the system to address the wider determinants of health. PD'O commented on the value of looking at adults and childrens safeguarding more as one, rather than separately. **Agreed:** The ICB Board noted the report.	
11.	**Report from the Commissioning and Performance Committee**	
	HvdW introduced the item by highlighting key points from the report, including the planned introduction of an integrated performance report. **Agreed:** The ICB Board noted the report.	
	System Oversight	
12.	**Annual Reporting and Accounts 2023/24**	
	TB introduced the item by noting it was the first full year's report. DH highlighted that having gone through this process in other organisations that this was a very clean year-end and he commended the ICB's finance team. **Agreed:** The ICB Board noted the Annual Report and Accounts for NHS Norfolk and Waveney Integrated Care Board for the period 1 April 2023 to 31 March 2024.	
13.	**Board Assurance Framework**	
	KB introduced the item by highlighting key points from the report. Questions and comments from Board members: • DH noted that the revised Risk Management Framework had been through the Audit and Risk Committee. He suggested that although the Board would ultimately approve the target risk and timescale to get there, committees should be allowed to set an initial target, which the Board would then be asked to approve. • The Chair commented that it was a critical role for the Board to see the big picture and how risks related to each other, to consider what we could achieve in Norfolk and Waveney, as well as what the external factors were impacting on our performance. • CD noted that it was good to see the approach was maturing and that the alignment to committees was good. She highlighted that it was important to ensure that target delivery dates were examined to ensure they were realistic and suggested that the finance score was potentially too low.	

	• HvdW noted that the Finance Committee had discussed the previous day that the risk was about ICB finances rather than system finances. • JB recognised the effort that had gone into this work and highlighted the need to look at mitigations. He added that there needed to be cognisance of the risks in partners' risk registers. • FS commented that the ICB should also be sighted on provider risks if they were significant and that in time she would expect this would be recognised on the operational risk register. • KB noted that she had spoken to colleagues in other areas of the country to understand their approach to system risks and that there were some areas that were slightly further ahead with this and had approaches we could learn from. **Agreed:** The ICB Board noted the contents of the report and approved the revision of risk BAF02 to include primary and dentistry, as well as the closure of risks BORR01 and BORR4.	
14.	**Governance handbook**	
	KB introduced the item by highlighting key points from the report. **Agreed:** The ICB Board approved amendments to the Governance Handbook's Scheme of Reservation and Delegation, committees' terms of reference and a process for submitting questions to the Board, as set out in the report.	
	Commissioning, Delivery and Performance	
15.	**Research and Evaluation (Innovation) Annual Report**	
	FS and CY introduced the item by highlighting key points from the report, noting that 87% of GP practices were research active and over 8,000 participants had been involved in 22 studies. Questions and comments from Board members: • The Chair commended the exceptional work of the team. • CA asked if the number of ICB research teams increased then would this mean the funding available would be shared out amongst more systems. • CY noted that she was not immediately concerned as it had taken Norfolk and Waveney ten years to get to where we were now. • AD asked how we monitor if research based interventions that we put in place were having an impact in real life. • CY noted that there was not a systematic approach in place for monitoring the impact in real life and that this was a challenge nationally, but that work was ongoing to address this.	

	• The Chair commented that the proactive engagement the system was doing through its population health management work was different to the work of the research team, but that they were getting instant feedback on what was and was not working, the effectiveness of different channels and messages etc. She asked if there was an opportunity for cross fertilisation of ideas and approaches. • CY explained that the research and innovation team worked closely with the population health management team, adding that there was an opportunity to learn from them and to work on a more consumer model that provides a quicker understanding of if changes or innovations were working or not. • PD'O suggested that we should use our expertise and support for research as part of our recruitment campaigns to encourage people to come and work in Norfolk and Waveney. • CY explained that we needed to understand what the workforce wants and needs in terms of research, and that there's a national tool we could use for this. She added that we should establish a system research workforce group. **Agreed:** The ICB Board noted the report.	
16.	**Financial Report for Month 5**	
	SC introduced the item, noting that the forecast outurn position for the ICB for the year remained a break-even position in line with our plan. He explained that the forecast outurn position for the Integrated Care System was a £21m deficit and that the system was £17.6m off plan at month five. He clarified that by Integrated Care System this referred to the combined position of the five NHS trusts in Norfolk and Waveney and the ICB. Questions and comments from Board members: • The Chair commented that the more that system could use the I&I process to build on what we had already done, were doing and what we know, the better. **Agreed:** The ICB Board noted the report.	
17.	**Report from the Finance Committee**	
	HvdW highlighted that the committee could only give limited assurance that the system would achieve the financial plan for the year. He added that there had been a further meeting of the committee the previous day which had considered the strategic outline case for the Queen Elizabeth Hospital's new build, system finances and the mental health investment standard. Questions and comments from Board members:	

	• PD'O highlighted the pressure on Continuing Healthcare and that there had been an unusual increase in number of fast track referrals over the past few months which partners were working together to explore. She added that work was ongoing to address the increase in Continuing Healthcare, including working with other ICBs. She noted that the operational and finance risks needed to be bought together to ensure that there was one clear position. • HvdW commented that the Finance Committee had discussed Continuing Healthcare and suggested to AD a joint meeting with the Quality and Safety Committee may be appropriate. **Agreed:** The ICB Board noted the report.	
	Remaining Committees Reports and Questions from the public	
18.	**Report from the Quality and Safety Committee**	
	AD thanked the ICB's business intelligence team for the quality dashboard and gave an overview of the topics that the committee had discussed, which included ambulance handovers, dual diagnosis, a review equality impact assessment tools, Right Care Right Person, mental health transformation and adult eating disorder services. The report was noted.	
19.	**Report from the Primary Care Commissioning Committee**	
	HvdW noted that the committee had discussed progress with developing a primary care strategy, approved the primary care workforce plan, agreed the commissioning of pharmacies over the festive period, been updated on the process for developing the Pharmaceutical Needs Assessment, been updated on potential collective action by GPs and discussed the results of the GP patient survey where we benchmarked well as a system. Questions and comments from Board members: • CA asked if there had been an impact on the acute hospitals from the GP collective action. • JB noted that there had not yet been a significant impact at the James Paget University Hospital. • MB explained that the impact of the GP collective action was being tracked, there were weekly meetings in place and the ICB was working closely with the Local Medical Committee. He noted that it wasn't expected to have an instant impact, that it had been announced in the holidays and so there had been some delay to it being implemented. • BB questioned if funding for covering bank holidays by pharmacies should be done on a recurrent basis rather. • SC suggested that funding for bank holiday cover by pharmacies should go into the ICB's prioritisation process.	

	The report was noted.	
20.	**Report from the Audit and Risk Committee**	
	DH noted that the committee had discussed risk management and the formal auditors report from year end. He added that the Conflicts of Interest Committee had met the previous week as well and discussed the need to ensure there was a balance that enabled people to input into discussions. The report was noted.	
21.	**Report from the Remuneration, People and Culture Committee**	
	CA noted that the committee would next meet on 14 October and an update would be provided at the November Board meeting.	
22.	**Questions from the public**	
	There were no questions from the public.	
23.	**Any other business**	
	No other business was raised.	
Date, time and venue of next meeting: **Wednesday, 27 November 2024, 1.30pm – 4.30pm, Hethel Engineering Centre, Chapman Way, Norwich, England, NR14 8FB.**		
Any queries or items for the next agenda please contact: **nwicb.corporateaffairs@nhs.net**		

Minutes agreed as accurate record of meeting:

Signed: …… Date: ……...
Chair

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

Declared interests of the Board

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
Patricia Hewitt	Chair, Norfolk and Waveney ICB	FTI Consulting	X			Direct	Senior advisor, FTI Consulting	2015	Present	Since January 2022 I have not undertaken any work on healthcare or life sciences. Will declare at relevant meetings if a risk arises.
		Newnham College Cambridge			X	Direct	Honorary Associate, Newnham College Cambridge	2018	Present	No conflicts have arisen or foreseen
		Oxford India Centre for Sustainable Development			X	Direct	Chair, Advisory Board, Oxford India Centre for Sustainable Development	2018	Present	No conflicts have arisen or foreseen
		ORA Choral Ensemble			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	Declaration of interest made 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
Cathy Armor	Non-Executive Member, Norfolk and Waveney ICB	Brundall Medical Practice			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
		Educational Association			X		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
		Council, Norwich University of the Arts			X		Deputy Chair of Council, Norwich University of the Arts	2019		
		Evolution Academy Trust			X		Trustee, Evolution Academy Trust	2022		
		Cambridge University Press Pension Schemes		X			Trustee, Cambridge University Press Pension Schemes	2018		
		East of England Ambulance Service NHS Trust				Indirect	Daughter-in-law is Technician for East of England Ambulance Service NHS Trust			
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

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 Medical Practice			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
		Chair of Primadonna Literary Festival (Suffolk)			X		Chair of the board and attendee of the festival	2021	Current	No link to health and therefore no risk to mitigate
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. If there is an issue it will be raised at the time..
		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		
Dr Hilary Byrne	Partner Member - Primary Medical Services	Attleborough Surgeries	X			Direct	GP Partner at Attleborough Surgeries	2001	Present	To be raised at all meetings to discuss prescribing or similar subject. Risk to be discussed on an individual basis. Individual to be prepared to leave the meeting if necessary.
		MPT Healthcare Ltd	X			Direct	Director of MPT Healthcare Ltd	2020	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Norfolk Community Health				Indirect	Spouse is employee of NCH&C (Improvement	2021	Present	
		South Norfolk PCN				Indirect	Clinical Director of SNHIP Primary Care Network	2022	Present	
Steven Course	Executive Director of Finance, Norfolk and Waveney ICB	March Physiotherapy Ltd			X	Indirect	Wife is an employee of a physiotherapy business	Sep-15	Present	Ensure not involved in any decision making that may involve the company
Aliona Derrett	Non-Executive Member, Norfolk and Waveney ICB	Norfolk and Norwich University Hospital			X	indirect	My son-in-law, Richard Wharton, is a consultant surgeon at NNUHFT	2004	To date	Will withdraw from any discussions and decision that might directly involve the department or discipline that relates to the declared conflict.
		Norfolk Deaf Association	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	To date	Not involved in any discussions and decisions that might benefit Hear for Norfolk

NHS Norfolk and Waveney Integrated Care Board (ICB)
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			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
		Derrett Consultancy Ltd	X			indirect	I am the Director of Derrett Consultancy Ltd	2018	To date	Low risk. In the unlikely event that a risk arises I will discuss the mitigation actions with the Chair of the ICB Board.
		Norfolk & Waveney MIND	X			indirect	My husband, Robin Derrett, is the HR Director at Norfolk & Waveney MIND. MIND holds contracts with the N&W ICB	2021	To date	Not involved in any discussions and decisions that might benefit N&W Mind
		MoldovaDAR Ltd	X			indirect	I am Director of MoldovaDAR Ltd	2019	To date	Low risk and highly unlikely that a risk will arise. The company is being dissolved.
		St Stephens Gate Medical Practice			X		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	Indirect	Professional Body - RCN Union			
David Holt	Non-Executive Member, Norfolk and Waveney ICB	Ministry of Defence	X			Direct	NED Audit & Risk Assurance Committee	2022	Ongoing	
		Newberry Clinic				Indirect	Wife a Consultant Community Paediatrician	2023	Jul-24	
		Sole Bay Health Centre			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
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

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

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			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
		Beccles Medical 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
Emma Ratzer	Partner Member - VCSE	Norfolk & Wavaney Integrated Care Board	X			Direct	My employing organisation holds contracts with NWICB	2009	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards Community Access Trust
		VCSE Assembly			X	Direct	I am CEO of a voluntary sector organisation operating in NWCCG and Independent Chair of NWVCSE Assembly	2021	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
Dr Frankie Swords	Executive Medical Director, Norfolk and Waveney ICB	Long Stratton medical partnership			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
		Norfolk and Norwich University Hospital			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
		Better Help, and VCSE provider: St Martin's Housing Trust	X			Inidrect	Husband is a mental health counsellor and undertakes work independently and with the private provider Better Help, and VCSE provider: St Martin's Housing Trust	2022	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 St Martin's Housing Trust or Better Help
Hein van den Wildenberg	Non-Executive Member, Norfolk and Waveney ICB	Lakenham Surgery			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared

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	
		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
		Broadland Housing Association	X			Direct	Non-Executive Director and Board member for Broadland Housing Association	2024	Present	Will excuse myself from any decisions relating to Broadland Housing Association

NORFOLK & WAVENEY ICB Action Log Part 1 - Wednesday 27 November 2024							
No:	**Date of Meeting**	**Description**		**RESP**	**Due Date**	**ACTION / UPDATE**	**Status**
31	25-sep-24	NHS App for patients to manage the care of people that are not registered at the same GP practice	IR to explore if there are any plans to develop the NHS App to enable users to be able to manage the care of people that aren't registered at the same GP practice	IR	nov-24	IR raised the question about proxy access across a number of practices with the national team. He shared the response with CA advising that they noted that it is an issue they are aware of but currently have no plans in their roadmap to address unfortunately. Due to the way the NHS app works with individual practices as data controllers, if there are more people raising it as a problem, it is something that they may have to move up their 'to do list'.	Propose Closure of action.

Agenda item: 07

Norfolk and Waveney
Integrated Care Board

Subject:	**Chair and Chief Executive's report**
Presented by:	**Hein van den Wildenberg, Non-Executive Member and Vice Chair, NHS Norfolk and Waveney ICB** **Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney ICB**
Prepared by:	**Hein van den Wildenberg, Non-Executive Member and Vice Chair, NHS Norfolk and Waveney ICB** **Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney ICB**
Submitted to:	**Norfolk and Waveney Integrated Care Board - Board Meeting**
Date:	**27 November 2024**

Purpose of paper:

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

Executive Summary:

The report covers the following:

A. NHS finances
B. Reducing waits for planned care
C. Seasonal resilience and planning for winter
D. Developing a ten-year health plan for England
E. Evolution of our Operating Model
F. Update on Benjamin Court
G. Meetings and visits

Report

A. NHS finances

The financial position continues to be very challenging, not just for us in Norfolk and Waveney, but for systems across the country too. The NHS organisations in our system are collectively £26m behind our plan at month six. Under delivery of our programme of efficiencies for the year isn't the only factor putting us behind our plan, for example the last round of industrial action also had an impact. As an ICB we are reporting a breakeven position at month six, although there is significant pressure on our budgets.

Colleagues across the system are working incredibly hard to ensure that we are getting value for money for every pound of public money we spend and implementing measures to improve our efficiency and productivity. We are currently forecasting that by the end of March we will have made £174m of efficiencies this year, made-up of a significant programme of work, however we will need to find more.

We continue to work with partners, including NHS England, to identify and deliver the required efficiencies and productivity increases, while also working to maintain and improve outcomes. Current areas of focus that will deliver quick returns include reducing the length of stay of inpatients, reducing bank and agency staff spend, the standardisation of clinical products and the use of biosimilar drugs. We will continue to keep the Board informed of our financial position.

B. Reducing waits for planned care

A significant amount of work continues to be done to reduce waits for planned care. Overall, about 1 in 7 of our population are on a waiting list for treatment of some kind. We have made progress with reducing the longest waits for treatment and at the moment we are focused on treating people who have been waiting more than 65 weeks by December.

Orthopaedics is one of the specialties with the highest number of patients waiting. The opening of the Norfolk and Norwich Orthopaedic Centre (NaNOC) will expand operations to 2,500 cases a year, and the new orthopaedic theatres at James Paget Hospital will soon add 1,400 theatre sessions annually.

Another specialty with large numbers of people waiting is Gynaecology. We are working on multiple women's health initiatives, such as improving women's health literacy in our population, upskilling our workforce, particularly in primary care, expanding access to Long-acting Reversible Contraception (LARC), and improving access to menopause care.

We are also developing new pathways for Dermatology, and we have already put in place new pathways for Musculoskeletal services (MSK). This new self-referral and single point of access for MSK should help people help themselves and if necessary to get seen earlier, before their care becomes more complex. This in time should also help with demand for orthopaedic surgery.

On the diagnostics front, the opening of Community Diagnostic Centres at the Queen Elizabeth and James Paget Hospitals will also help ease the pressure on CT scan waiting lists, which remain the most pressing concern. A diagnostic centre at the Norfolk and Norwich Hospital is due to open early in the new year with five MRIs, four CT scanners, two X-Rays and two ultrasound rooms.

C. Seasonal resilience and planning for winter

We have been working hard over the last year as a system to ensure that we are prepared for winter, as well as other periods in the year when demand for services is higher. Here are some examples of the actions we have taken over the last year that will help us as we head into winter:

- We have made improvements and invested in the community-based intermediate care offer that will support residents this winter. For example, Norfolk County Council is planning to increase the number of people Adult Social Services supports back to their own home after going to hospital by c.5-10%, on top of a c.6% increase last year.
- In advance of this winter, we have contacted over 1,000 residents at high risk of a fall and offered interventions to reduce the likelihood of a serious fall.
- There has been a continued steady decrease in the number of cases on the Interim Care List to one of its lowest points since the COVID-19 pandemic, which indicates there is good capacity within the local home care sector.
- We have developed our unscheduled care coordination hub, which supports the ambulance service to ensure people get the right care in the right place and we avoid conveying people to hospital unnecessarily.
- Delivered the annual vaccination programme for COVID-19 and seasonal flu, as well as introduced the vaccination programme for Respiratory Syncytial Virus (RSV).
- Improved flow within our acute and community hospitals to maximise longer term outcomes and support with improvements in patient flow.

Even with all of the preparations we have made, it is likely that winter will be challenging for the NHS and local health and care services. Where we need to and can, we will be flexible and respond to the situation. Key to this will continued close working between partners. We look forward to discussing our winter planning in more detail at the Integrated Care Partnership's meeting on 4 December.

D. Developing a ten-year health plan for England

The Secretary of State for Health and Social Care has launched "the biggest ever conversation about the future of the NHS". We would encourage people to take a look and to share their views – there's lots of information here: https://change.nhs.uk/en-GB/. It doesn't matter whether you have a lot or a little to say. Your views, experiences and ideas will shape a new ten-year health plan for England.

E. Evolution of our Operating Model

On 13 November, NHS England wrote to all ICBs and NHS trusts to outline changes to the current operating framework. Lord Darzi's recent report was clear – we don't need another seismic reorganisation pulling focus from the important tasks, but the system we have does need to be refreshed to clarify some roles and responsibilities, to ensure there is a focus on 'neighbourhood health', to devolve decision-making and to enable and support leaders. We will reflect on this locally and look forward to discussing it with the Board and partner organisations.

F. Update on Benjamin Court

Since the last meeting of the Board, we have published our response to Healthwatch Norfolk's report about the future of Benjamin Court. We would like to thank everyone again who took the time to share their views. We spent time talking with the local community because we wanted to find a solution that would mean the building could continue to be used to support the health and wellbeing of north Norfolk residents.

Unfortunately, we were not able to find a solution that fits with the other services already available and the model of care we want to provide, or which is financially viable. As a result, we have returned the site to NHS Property Services, which has enabled them to look for alternative tenants.

In line with the recommendations from Healthwatch Norfolk, we have asked NHS Property Services to keep us and the local community informed of progress with the site. We will continue to keep under review the services available in north Norfolk, and if other opportunities arise to invest in services, we will explore them fully, as we have with Benjamin Court.

G. Meetings and visits

As Chief Executive, I wanted to highlight some of the meetings I've attended and visits I've made to interesting local organisations. These have included:

- There continues to be a strong focus on our finances and efficiencies, both for the ICB and the system, so I have been involved in a number of regional and local meetings about this, along with other executive colleagues.
- Reducing waiting times for elective care is a priority for the NHS and the new Government, and so I have also been involved in a range of meetings about this.
- I welcomed Matthew Taylor, Chief Executive of the NHS Confed, to Norfolk and Waveney. We showcased our excellent unscheduled care coordination hub, discussed our progress with shifting from acute to community care and highlighted a really strong example of how we are working in partnership to provide proactive care to people living in Watton.
- I was a judge in the HSJ awards for the provider collaboration of the year category, which was inspiring and provided plenty of food for thought for what more we could do locally. And I was also really pleased to help present with other ICB colleagues our entry into the HSJ awards for workforce initiative of

the year. Our entry focused on the incredible work being done with our newly qualified GP Programme.

- I attended and led a session at our ICS Conference, which was a really positive day and an opportunity to both celebrate our successes as well as work together on our vision for what we want to achieve over the next five years.
- I had an introductory meeting with Sarah Taylor, the Police and Crime Commissioner for Norfolk.
- I thoroughly enjoyed our staff event; it was great to take stock of where we are at as an organisation following the restructure, to reset and to look to the future.
- I attended a meeting with colleagues from Norfolk and Suffolk NHS Foundation Trust to brief Norfolk and Suffolk MPs on the progress being made by the trust.
- At our regular East of England meeting of chairs and chief executives of ICBs and NHS trusts we discussed the NHS ten year plan. This was a great opportunity to take a step back and to think about the long term.

Norfolk and Waveney
Integrated Care Board

Agenda item: 09

Subject:	**Patients and Communities Committee Report**
Presented by:	**Aliona Derrett, Patients and Communities Committee Chair**
Prepared by:	**Mark Burgis, Executive Director of Patients and Communities**
Submitted to:	**Norfolk and Waveney Integrated Care Board - Board Meeting**
Date:	**27 November 2024**

Purpose of paper:

To provide the Board with an update on the work of the Patient and Communities Committee held on 23 September 2024.

Committee:	**Patients and Communities**
Committee Chair:	Aliona Derrett
Meetings since the previous update on 25/09/24:	This paper provides an update from the meetings held on 22 July and 23 September 2024.
Overall objectives of the committee:	
The Committee has been established to provide the ICB with assurance that it is. delivering its functions in a way that meets the needs of patients and communities, that is based on engagement and feedback from local people and groups, and that takes account of and reduces the health inequalities experienced by individuals and communities. The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care.	
Main purpose of meeting:	**22 July 2024** • Committee Risk Register • Update on CYP & Flourish • Lived Experience Representation Proposal • Healthwatch updates • Great Yarmouth and Waveney Place Board • Complaints • Population Health and Inequalities Board Update

	• Ageing Well Programme Board Update and Focus on Dementia Services **23 September 2024** • Spotlight on Dementia including Carer Perspective • South Norfolk Place Board Report • VCSE Assembly Update • Healthwatch Suffolk Annual Report • Healthwatch Norfolk Update • Population Health and Inequalities Board Update • Ageing Well Programme Board Update **Committee Approvals for this period:** • Approach for involving people with lived experience in the work of the ICB and Patients and Communities Committee • Approved the updated Population Health and Inequalities Board Terms of Reference • Supported the integration of Community Voices and WoW bus into one outreach programme.
BAF and any Board Operational risks relevant / aligned to this Committee:	**BAF01: Health Inequalities and Population Health Management** Risk remains at 12. There is a risk that the ICB will not meet its statutory requirements to reduce Health Inequalities (HI) or use Population Health Management (PHM) techniques to their full potential in line with the PHM strategy or HI strategic framework for action. Discussion took place regarding the potential negative impact of financial challenges across the system, but the committee felt that this risk had not increased significantly since the last meeting. **BAF05: Increasing numbers and complexity of the ageing population in Norfolk and Waveney** Risk remains at 15. Across Norfolk and Waveney life expectancy is longer than the average across England and is currently 80 years for males and 84 years for females. However, ***healthy*** life expectancy across Norfolk and Waveney is lower than the average for England at 62.7 years for males and 62,4 years for males. This figure has decreased over the last few years. Key risks highlighted to the committee are: a) Services will be unable to continue to meet the increasing demand and needs of our ageing population.

	b) costs associated with care of this population will increase significantly adding to financial pressures. c) quality of care for older people may decline if a and b are not suitably mitigated. The committee discussed the need to ensure that the ICB and system partners continue to focus on keeping people well and where possible prioritise prevention. It was also acknowledged that this reinforced the importance of the ageing well programme.
Key items for Board to take note of:	**Spotlight on: Dementia** The Spotlight item at September's committee was on Dementia. The committee welcomed a carer who had lived experience of supporting an elderly parent with dementia. The committee heard about the challenges faced by families caring for a loved one with dementia, which included the time it takes for a social services assessment to be completed, or for respite to be arranged during times of crisis. The carer shared their reflections on being let down by the system and processes which aren't working. There were four points highlighted to the committee: • Lack of continuity of care was often a problem. • There often seemed little or no connection or consistency across teams and often families had to make numerous calls and referrals each time support was needed. • The social services portal is very difficult to manage and navigate. There are long delays to find out what is happening with each case. In some cases, you have to go through the whole process again. It was suggested this should be reviewed. • There were concerns raised about discharge processes from acute and community hospitals suggesting there are occasions when people go back to their homes without the right level of support being in place to meet people's needs. The committee agreed to link with the appropriate teams to highlight these concerns with a view to making improvements where necessary.
Items requiring formal approval of Board:	There were no items requiring approval from Board this month.
Confirmation that the meeting was quorate:	The July and September 2024 meetings were quorate, as defined in the Governance Handbook.

Norfolk and Waveney
Integrated Care Board

Agenda item: 10

Subject:	**N&W ICB Mental Health Intensive and Assertive Outreach Services Review and Action Plan**
Presented by:	**Martin Keegan, Adult Mental Health Senior Collaborative Lead, (N&W ICB & NSFT).**
Prepared by:	**Martin Keegan Adult Mental Health Senior Collaborative Lead, (N&W ICB & NSFT); William Snagge, Mental Health Senior Place Lead (N&W ICB); Claire Holmes, Clinical Transformation lead (NSFT); Jackie Bland, Deputy Director of Nursing - Mental Health (SNEE ICB).**
Submitted to:	**Norfolk and Waveney Integrated Care Board – Board Meeting**
Date:	**27 November 2024**

Purpose of paper:

Purpose of paper:

NHSE require all ICB Public Boards to receive an update on the Intensive and Assertive Outreach Reviews, and ICB Action Plan, which systems have been mandated to conduct during Q3/4, 24/25.

Executive Summary:

Background:

NHS England included a requirement in the 2024/25 NHS Priorities and Operational Planning Guidance that all Integrated Care Boards review community services to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up, but where engagement is a challenge.

Integrated Care Boards were asked to report any gaps and barriers to delivering good care that they identified (e.g. resourcing and workforce implications of delivering this care).

A Midlands system tool, developed further to the Valdo Calocane Nottingham tragedy, was made available to all systems to support review of current provision, and a joint Suffolk and North East Essex and Norfolk & Waveney Integrated Care Board and Norfolk and Suffolk Foundation Trust working group completed a process of reviewing local provision against the Midlands tool.

Gaps identified through the review process include: -

- Lack of ability to clearly identify the cohort, to support focused Intensive and Assertive Outreach interventions in an equitable and effective way.
- Deficit of reflection of intensive case management / assertive outreach, in policies, that supports staff to deliver consistent clinical pathways in line with Assertive Outreach function outcomes.
- Informed risk assessment and safety planning, appropriate to this cohort, could be strengthened with additional training to ensure staff are skilled and feel confident in delivery.
- Insufficient appropriately skilled and supported workforce, to deliver the outcomes of Intensive and Assertive Outreach.
- Improvements in data capture, and consistency in reporting approaches.
- An absence in policies of specific reference to the management of this cohort. For example, Discharge From Services and Did Not Attend (DNA).

Immediate ICB Priorities include: -

- Ensuring all service users in this group have been identified; review key policies and map against practice to identify any additional gaps and strengthened risk assessment and safety planning.
- Implement assurance arrangements to guarantee immediate steps are taken to address key gaps identified.
- Closely collaborate as two Integrated Care Boards - Norfolk and Waveney and Suffolk and North East Essex - taking a co-ordinated approach across the Norfolk and Suffolk footprint, and working with NHS England, Norfolk and Suffolk Foundation Trust and wider partners, to plan development of an implementation framework addressing the wider issues and barriers identified.
- Integrate and align implementation framework design and delivery with wider strategic considerations (e.g. Norfolk and Suffolk Foundation Trust service redesign, NHS England policy and 25/26 Planning).
- Recognise and prepare to respond to new NHS England guidance (due early 2025) on the provision of high-quality safe care in community mental health services, which will require implementation.
- Associated with the above, ensure effective assurance monitoring processes around the delivery of an NHS England assured action plan at 6- and 12-month intervals, are in place.

Please see action plan on slide 10 for further information.

Recommendation to the Board:

To review and share feedback.

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

Governance

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

Intensive and Assertive Outreach Review and Action Plan

Integrated Care Board Public Board Presentation

V3 7.11.24

Contents

Context

- NHS England included a requirement in the 2024/25 NHS Priorities and Operational Planning Guidance that all Integrated Care Boards review community services to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up, but where engagement is a challenge.
- Guidance developed with the support of an expert advisory group which included representatives of the Royal College of Psychiatrists and the Department of Health and Social Care, supported all Integrated Care Boards to undertake this review.
- As part of the reviews, Integrated Care Boards were asked to report any gaps and barriers to delivering good care that they identified (e.g. resourcing and workforce implications of delivering this care).
- More recently, a Midlands system tool, developed further to the Valdo Calocane Nottingham tragedy, has been made available to all systems to support review of current provision.
- A joint Suffolk and North East Essex and Norfolk & Waveney Integrated Care Board and Norfolk and Suffolk Foundation Trust working group has now completed a process of reviewing local provision against the Midlands tool.
- This report updates the Integrated Care Board Board on the key review findings, and outlines actions identified by Suffolk and North East Essex and Norfolk & Waveney Integrated Care Board, in partnership with Norfolk and Suffolk Foundation Trust, to address the gaps and barriers to delivering good care identified.

Review Timeline

2024 Milestones	What
January	NHS England (NHSE) Planning Guidance requires systems to conduct review of Intensive and Assertive Outreach with further details to follow.
July	The National Team publish new Intensive & Assertive Outreach guidance in line with the Care Quality Commission (CQC) enquiry into the rapid review of Nottingham Healthcare Foundation Trust following the conviction of Valdo Calocane in January 2024.
August	Norfolk and Waveney Intensive & Assertive Outreach Review Group (Provisional) Membership Core Review Group confirmed to NHSE
August - September	Joint Suffolk and North East Essex and Norfolk and Waveney Integrated Care Board led Maturity Index Review commenced, in partnership with Norfolk and Suffolk Foundation Trust
September	Review findings submitted to NHS England. Notified of requirement to present findings to Integrated Care Board Public Board
October	Joint Suffolk and North East Essex and Norfolk and Waveney Integrated Care Board and NHS England meeting to discuss findings, development of an action plan, and agreed date to present findings to Norfolk and Waveney Integrated Care Board Public Board
October	Suffolk and North East Essex and Norfolk and Waveney Integrated Care Board, collaborated with Norfolk and Suffolk Foundation Trust to develop high level action plan.
November	Board presentation and action plan refined and presented - 27/11/24

Characteristics of the cohort of patients using the services in scope of the review

- Presenting with psychosis (but not necessarily given a diagnosis of psychotic illness)
- May not respond to, want or may struggle to access and use ‘routine’ monitoring, support and treatment that would minimise harms
- Vulnerable to relapse and/or deterioration with serious related harms associated (esp. but not limited to violence & aggression)
- Multiple social needs (housing, finance, self-neglect, isolation etc)
- Likely to present with co-occurring problems (e.g. drug and alcohol use/dependence)
- May have had negative (e.g. harmful and/or traumatic) experiences of mental health services or other functions of the state (e.g. the criminal justice systems)
- May have been subject to concerns raised by family/carers

Services in scope

- Although the cohort characteristics suggest that in most cases the outcomes patients require are likely to be aligned with the work of Community Mental Health Teams, several other services are also in scope and potentially supporting this group. For example :-

    - Early Intervention in Psychosis (EIP)
    - Community and Inpatient Forensic Services
    - Homelessness teams
    - Teams supporting veterans
    - Community and Inpatient Rehabilitation teams
    - Severe Mental Illness Health Care Teams

Gaps identified through the review process

- Lack of ability to clearly identify the cohort, to support focused Intensive and Assertive Outreach interventions in an equitable and effective way.
- Deficit of reflection of intensive case management / assertive outreach, in policies, that supports staff to deliver consistent clinical pathways in line with Assertive Outreach function outcomes.
- Informed risk assessment and safety planning, appropriate to this cohort, could be strengthened with additional training to ensure staff are skilled and feel confident in delivery.
- Likely insufficient appropriately skilled and supported workforce, to deliver the outcomes of Intensive and Assertive Outreach.
- Improvements in data capture, and consistency in reporting approaches.
- An absence in policies of specific reference to the management of this cohort. For example, Discharge From Services and Did Not Attend (DNA).

Barriers and challenges identified through the review

- noting these issues are not unique to NSFT and occur nationally to varying degrees.

- Available resources - both financially and in relation to workforce, to implement the potential changes necessary.
- A lack of coordination formally identifying the cohort across services, and consistent data capture of this information, for reporting purposes.
- A current lack of a specific dedicated Assertive Outreach function in Community Mental Health Teams, and ability of the teams to work proactively with this user group, as caseloads are not reduced and ringfenced.
- Rehabilitation approaches that are not system wide, and do not offer time unlimited support.
- Workforce understanding around applying the Mental Health and Mental Capacity Act - especially regarding the practicalities of current legislation and the limitations of Community Treatment Orders.
- The need for improved carer engagement and dialogue was also identified.

Immediate ICB Priorities

- Ensure: -
  - All service users in this group have been identified and there are mechanisms to identify new people on an ongoing basis
  - Review key policies and map against practice to identify any additional gaps
  - Strengthened risk assessment and safety planning

- Implement assurance arrangements to guarantee immediate steps are taken to address key gaps identified.
- Closely collaborate as two Integrated Care Boards - Norfolk and Waveney and Suffolk and North East Essex - taking a co-ordinated approach across the Norfolk and Suffolk footprint, and working with NHS England, Norfolk and Suffolk Foundation Trust and wider partners, to plan development of an implementation framework addressing the wider issues and barriers identified.
- Integrate and align implementation framework design and delivery with wider strategic considerations (e.g. Norfolk and Suffolk Foundation Trust service redesign, NHS England policy and 25/26 Planning).
- Recognise and prepare to respond to new NHS England guidance (due early 2025) on the provision of high-quality safe care in community mental health services, which will require implementation.
- Associated with the above, ensure effective assurance monitoring processes around the delivery of an NHS England assured action plan at 6- and 12-month intervals, are in place.

ICB Action Plan

	Scope	Lead	Deadline
Implement quality improvement approach to address immediate provider priorities	Develop a plan, in collaboration with wider system partners, to ensure all service users in this group are identified, across all domains and relevant service lines, including 18-25s with mechanisms to do so on an ongoing basis	Chief Transformation Officer NSFT	Q3, 24/25
	Deliver plan to ensure all service users in this group are identified.	Chief Transformation Officer NSFT	Q4, 24/25
	Review key policies.	Chief Transformation Officer NSFT	Q4, 24/25
	Provide assurance against policy implementation in practice.	Chief Transformation Officer NSFT	Q4, 24/25 - Q1, 25/26
	Strengthen risk assessment and safety planning through immediate and medium-term training scheme.	Chief Transformation Officer NSFT	Q1, 25/26
Governance	Implement robust assurance arrangements to guarantee immediate steps are taken to address key gaps identified.	Interim AD Adult Mental, Health N&W ICB Deputy Director of Nursing, SNEE ICB	Q3, 24/25
	Ensure lived experience and carer voice informs quality improvement measures and strategic planning response.	Chief Transformation Officer NSFT	Q3, 24/25
Strategic Delivery	Plan and execute development of a medium-term implementation framework that responds to wider review recommendations in the context of macro local and NHSE/national policy considerations.	Chief Transformation Officer NSFT	Q2, 25/26

Norfolk and Waveney
Integrated Care Board

Agenda item: 11

Subject:	ICB Performance Report
Presented by:	Andrew Palmer - Deputy Chief Executive Officer Executive Director of Strategy Matt Dooley - Executive Director of Commissioning and Performance
Prepared by:	ICB Commissioning and Performance team with contributions from teams working in subject areas.
Submitted to:	ICB Board
Date:	27 November 2024

Purpose of Paper:

To provide assurance to the ICB Board and Commissioning and Performance Committee and highlight significant elements of the system performance reporting.

Executive Summary:

The report provides additional context and description to assure the Board and Committee of performance against national objectives.

Report

The narrative below provides context and other commentary to metrics, such as interdependencies, to compliment the performance slide deck.

1. Cancer

As reported by the trusts for the October system Cancer Highlight report and recent trust tiering meetings:

Queen Elizabeth Hospital: 28-day performance was 71% just 0.1% below the trajectory and 62-day was 59% which is below their 63% trajectory for August 2024. Histopathology performance is improving although still impacting on delivery. Dermatology is a challenge due to high levels of referrals. Nurse led clinics are freeing consultant time to support and locums coming in. Telederm due to commence in the next few months.

Norfolk & Norwich University Hospital: 28-day performance was 59% which is below the 66% trajectory and 62-day was 61%, exceeding their 60% trajectory for August 2024. Skin cancer pathway challenges with workforce due to retention and sickness. Locums coming in to support and stabilise during October and November. Cancer Alliance funding supporting radiology and endoscopy for lower Gastro-Intestinal. 62-day performance continuing to improve and tumour site improvement plans in place for any area below 60%. Additional chemotherapy agency staff commence September and additional substantive staff to deliver treatment from October onwards and support additional chair capacity and SACT delivery time. Tiering bid submitted to the Cancer Alliance on 4 November 2024.

James Paget University Hospital: 28-day performance was 77% exceeding their 70% trajectory and 62-day 61% against a 63% trajectory for August 2024. An insourced provider continues to provide additional weekend activity and a plastics locum commenced end October, to support 28-day Faster Diagnostic Standards (FDS) and 62-day performance for skin. Tiering bid submitted to the Cancer Alliance on 4 November 2024. Recruitment to project manager post to support the FDS work is ongoing, with interviews being held mid-November. However, JPUH are now in Tier 1 for their elective and cancer performance.

Lifestyle and health inequalities impact significantly on awareness of cancer signs/symptoms and benefits of cancer screening and informs ongoing focus areas.

2. Diagnostics and Elective care

Elective Recovery continues to try to treat all patients who have waited more than 65 weeks by December 2024. Each trust has individual plans to mitigate the remaining long waiters which are frequently monitored and have proposed various interventions to help overcome this challenge. Further commissioning agreements and contracts are taking place across the ICS to provide additional capacity and support from various Independent Sector Providers (ISPs); however, these remaining patients (2,710) are highly complex and may be unsuitable for Mutual Aid transfers to ISPs or for weekend Waiting List Initiatives. Teams are in place at all trusts to actively scrutinize outcomes and clinical coding to ensure optimal management and prioritization of patients who are remaining.

The opening of the new state-of-the-art Community and Diagnostic Centre's (CDCs), (initially in the Great Yarmouth area), has received and scanned their first patient. The Northgate CDC will formally open in January 2025. The CDC at the QEH is also operational, whilst the CDC at NNUH is scheduled to be completed in February 2025. Sharing best practices amongst peer groups, and standardising procedures, processes and pathways and the use of digital innovations, will enable an increase in productivity, efficiencies and clinical quality, this will help drive activity and performance up to reach the 95% target of offering a diagnostic test within six weeks.

The opening of the Surgical Elective Hubs (NNUH orthopaedic hub opened July 2024, JPUH hub due to open spring 2025) will provide theatre capacity, increase productivity and contribute to patients being treated more quickly. It will also allow an increase in 'day case' elective procedures to take place, help release more beds in the hospitals and prevent late minute cancellations of planned care procedures due to Urgent Emergency Care type patients.

Additional work has taken place across the System, as the activity target of (103.1%) is met by an increase of 12.4% (115.5%). This shows that Norfolk and Waveney are treating more patients compared to 19/20 targets (pre-pandemic), however, it is not enough to treat the entire backlog within the target set by NHS England of December 2024. Regular monitoring of activity against these targets at both Trust and System level will remain.

3. Maternity, Neonatal and Women's Health

A full review of performance against the Maternity and Neonatal Three-Year Plan was undertaken September 2024, good progress is being made. Key dependencies are the ICB Commissioning requirements in the plan and commissioning capacity as well as maternity digital systems dependence on the Electronic Patient Record implementation. Work is underway to present data on metrics in a meaningful way.

The Women's Health Hub is on track with the 8 core services in place by December 2024.

4. Mental Health

Out of Area Placement: Inappropriate out of area placement position is challenged. However, length of stay in out of area placement has decreased. Service users are moved to appropriate placements as soon as possible, which supports closer working with community teams to facilitate a smooth discharge process.

Dementia diagnosis: Demand and capacity study discussions continue within Norfolk and Suffolk Foundation Trust to enable future planning of the Dementia Assessment and Treatment Service.

5. People with a Learning Disability and Autistic People

Health checks: As of the end of September 2024, year-on-year delivery is 280 more than September 2023, at 27.1% of the total Learning Disabilities register. Five practices are yet to do their first checks this year and the ICB is contacting these practices to establish if support is needed, or plans are in place – these are practices with a relatively small register size and the risk of non-delivery has been assessed as minimal. Health Action Plans have been completed for 95% of the Health Checks delivered.

Inpatient care: Adult inpatient numbers continue to exceed target due to challenging discharge options and difficulties in commissioning appropriate bespoke accommodation in line with *Building the Right Support,* and with consideration of complex risks that may include forensic history. Actions will not have immediate impact.
Performance is also impacted by decisions made by the court system in regard to patients in forensic care.

6. Prevention and Health Inequalities

A set of metrics are being determined to measure progress to reduce health inequalities – these will align with national guidance.

7. Primary and Community Services

GP appointments: Norfolk & Waveney has seen an increase in the percentage of appointments within 2 weeks. Our data shows that there are more face-to-face appointments being offered than the national average and patient satisfaction is high. However, with regards to the 2 week's appointment, Norfolk & Waveney are currently slightly below the average in the East of England region. The 2024 GP Patient Survey results for Norfolk & Waveney ICB showed that 70% of patients feel that the wait for their appointment was "about right". This is higher than the national average of 66%. There were 31 practices across the ICS which received less than the national average, and the majority of these were in Norwich and the South Locality.

Dental: The national performance target for dental access is to restore activity to pre-covid levels. With a shift towards flexible commissioning and use of sessional payments for new pathways including access improvement, this target will be a challenge to meet. Using "number of new patients" as a measure of success is preferred outcome measure by the ICB. Regulatory changes in 2024 to allow dental therapists to carry out simple treatments under dentist oversight may improve access delivery. In October, the ICB released £1.5m investment to NHS providers to improve access for new patients in areas of geographical need (approximately equivalent to 12,000 new patients able to be seen).

Community Services: In August 2024 there were 860 patients waiting over 52 weeks in community services, and we are working to reduce this. Overall, the services are meeting waiting time requirements, but there are a few areas such as wheelchairs or Children and Young People neurodevelopmental which have long waiting times. For these services, joint commissioner and provider working groups are taking place to plan recovery.

8. Urgent and Emergency Care

The focus of the UEC Programme Board plans for 24/25 have been based around the national requirements for UEC recovery. The plan has 4 key measures of success:

- Achieving minimum 78% 4hr ED performance with a stretch to 80%
- Acute G&A Bed Occupancy at 92% or lower
- 80% Virtual Ward Occupancy
- Maximum 30min 'mean' response time for C2 category calls

Overall performance of the system has been improving and as a result our System is no longer in the National Tier 1 category but has dropped to Tier 2.

Although there is a general improving trend of UEC performance the system still has operational pressures and shorter-term pressures. To mitigate these pressures investment in the Urgent Care Coordination Hub has been confirmed by region and this resource has been secured for the remainder of the year. Additional work on Length of Stay and discharge is being led by UEC Programme Board Chair as part of financial recovery and the "sprint" work. These plus a number of other smaller mitigations should ensure that the overall trend continues to improve and that we smooth out spikes in operational pressure providing greater system resilience.

Handover 45 is currently not mandated by NHS regional teams however planning has begun for this within N&W, looking to begin the process from the 28th of November 2024. An agreement has been received in principle from the COO's, the ICB is currently undertaking site visits which will allow for more operational analysis on how this will be delivered and achieved across the 3 acute sites.

9. Workforce, use of resources and Quality & Safety

Norfolk and Waveney are committed to aspiring that every learner feels included, valued and supported to succeed with resilient and adaptive clinical learning environment. Long term workforce plans reach to 2031/32 with key work to streamline apprenticeship offering across Norfolk and Waveney and increase apprenticeship routes by 22% by 2031/32. To enable sufficient clinical placements digital placement system is in development which will allow baselining and tracking, alongside scoping with Trusts to establish current position.

Primary Care Workforce Strategy and Operational Delivery plan approved by the Primary Care Commissioning Committee. Increase in GP Trainees of 17.3% in the last 12 months. Retention of primary care staff is at 71.7% as of August 2024. Highest % of leavers are within nursing profession due to age demographic of staffing group. Increase of GP medical expansion placements by 3.4% in last Quarter.

Recommendation to the Board:

A focus should be taken on continued challenges with:

- Cancer times to diagnosis and treatment
- Diagnostics
- Elective care time to treatment
- Inpatient provision for both mental health and people with learning disability and autistic people
- Dental activity
- Ambulance response and Accident and Emergency department waiting times.
- Financial position

Risks are captured through the risk registers and Board Assurance Framework. Associated BAF:

- BAF03: Barriers to Full Delivery of the Mental Health Transformation Programme (CYP)

- BAF04: Barriers to Full Delivery of the Mental Health Transformation Programme (Adults)

- BAF06: System / Urgent & Emergency Care (UEC) Pressures

  BAF07: Elective Recovery

Governance

Committee Approval	Commissioning and Performance Committee Agenda Item, November 2024.

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IPR: National Planning Metrics

ICB Board, 27th November 2024

Contents

This pack reports against the 2024/25 national planning objectives and associated metrics.

Section 1 (slides 3-6) – Overview

This section provides a high-level overview and draws committee attention to key areas:

- Areas for development – those areas which require further clarification / metric reporting (focus slides provide further detail).
- National planning objective metrics (24/25) that show cause for some concern
- Most recent performance against the national planning objective metrics

Section 2 (slides 7-53) – reporting against metrics, collated by area.

These slides provide a detailed position of each metric aligned to the planning objectives, with root causes and corrective actions identified, where the metric is not on plan / trajectory.
This includes metrics that may wish to be viewed to provide additional context and insights.

National Planning Objectives (24/25) requiring development

The following require local work on data quality and/or clarification of target/metric as there is currently either no clear target, no reporting method or data does not robustly inform the position:

- Improve patients' experience of choice at point of referral (Elective Care) – The Office for National Statistics (ONS) Health Insights Survey data is expected, from October 2024, to inform this metric.

- Improve the working lives of doctors in training by increasing choice and flexibility in rotas, and reducing duplicative inductions and payroll errors:
  National Payroll Improvement Guidance has been finalised and released. National colleagues are gathering both quantitative and qualitative metrics to evaluate the programme's effectiveness and its impact on staff and sharing of best practices and blueprints from early implementors will be shared in 2025.

- Improve community service waiting times, with a focus on reducing long waits:
  Local work is ongoing to ensure data is of robust quality, aligned across the system and reported in a meaningful way to allow focused improvement.

Davey Heidi 21/11/2024 13:18:42

Metrics have been taken from national planning for 24/25: [NHS England » 2024/25 priorities and operational planning guidance]

Metrics that are underachieving against plan / local trajectory

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Delivery area	Metric – national planning objective metrics (24/25) that show cause for some concern	Target (local trajectory target as appropriate)	Actual (to latest reporting period, as per linked slide)	Linked slide
Cancer	62-day standard to 70% by March 2025	61.5%	61.7 % (Aug '24)	Slide 8
	28-day Faster Diagnosis Standard to 77% by March 2025	73.5%	64.3 % (Aug '24)	Slide 9
	Increase the percentage of cancers diagnosed at stage 1 and 2 to 75% by 2028	75%	56.6 % (12m to June '24)	Slide 10
Diagnostics and Elective	Diagnostic tests within 6 weeks at 95% by March 2025	95%	66.8% (Aug '24)	Slide 12
	Eliminate waits of over 65 weeks for elective care by September 2024	1,861	2,710 (Aug'24)	Slide 13
	Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25	46%	44.2% (Aug '24)	Slide 15
Mental Health	Eliminating Out of Area placements	6	15 (Aug'24)	Slide 23
	Achieve the Dementia Diagnosis Rate by March 2025	63%	62.1 % (Sept '24)	Slide 26
People with learning disability and autistic people	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12-15 under 18s for every 1 million population	23	34	Slide 34
Prevention and Health Inequalities	Continue to address health inequalities and deliver on the Core20PLUS5 approach	Mastering	Foundation	Slide 36
	Increase vaccination uptake for children and young people year on year	95 %	89-96% (Q4 '23-24)	Slide 39
Primary and Community Services	Increase dental activity improving units of dental activity (UDAs) towards pre-pandemic levels	Increase	Decrease	Slide 43
UEC	Improve A&E Waiting Times, compared to 2023/24, with a minimum of 78% of Patients seen within 4 hours in March 2025	80%	73.1% (Sept '24)	Slide 45
	Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25	18 min (30 min interim)	44.8 min (Sept '24)	Slide 46
Use of Resources	Reduce agency spend to a maximum of 3.2% of the total pay bill across 24/25	£41.2m	£45.8m (Forecast year)	
	Deliver a balanced financial position for 24/25	£0	£26.2m (Sept '24)	Slide 52

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National Planning Metrics – overview (1/2)

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Area	Objective	Date	ICB/ICS	Has Plan	Reporting Value	On Plan	On Target	Capability	Variation
Quality and Patient Safety	Implement the Patient Safety Incident Response Framework (PSIRF)		ICB						
Urgent and Emergency Care	Improve A&E Waiting Times, compared to 2023/24, with a minimum of 78% of Patients seen within 4 hours in March 2025	September 2024	ICB	✓	73.1%	✗	✗	F	H
Urgent and Emergency Care	Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25	September 2024	ICB	✗	43.7		✗	?	L
Primary and Community Services	Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are accessed the same or next day according to clinical need	September 2024	ICB	✓	81.2%	✓			H
Primary and Community Services	Improve community services waiting times, with a focus on reducing long waits		ICB	✗					
Primary and Community Services	Increase dental activity by implementing the plan to recover and reform NHS dentistry, improving units of dental activity (UDAs) towards pre-pandemic levels		ICB						
Elective Care	Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)	August 2024	ICB	✓	2,710	✗	✗	F	L
Elective Care	Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%	July 2024	ICB	✓	115.5%	✓	✓		
Elective Care	Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25	August 2024	ICB	✓	44.2%	✗	✗		
Elective Care	Improve patients' experience of choice at point of referral		ICB						
Cancer	Improve performance against the headline 62-day standard to 70% by March 2025	August 2024	ICB	✓	61.7%	✓	✗	F	
Cancer	Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026	August 2024	ICB	✓	64.3%	✗	✗	?	
Cancer	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028?	June 2024	ICB	✗	56.6%		✗		
Diagnostics	increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	August 2024	ICB	✓	66.8%	✗	✗	F	
Maternity, neonatal and women's health	Establish and develop at least one women's health hub in every ICB by December 2024, working in partnership with local authorities		ICB						
Mental Health	Improve patient flow and work towards eliminating inappropriate out of area placements	August 2024	ICB	✓	15	✗	✗	F	
Mental Health	Increase the number of people accessing transformed models of adult community mental health (to 400,000)	March 2024	ICB	✓	8,235	✓	✓		
Mental Health	Increase the number of people accessing perinatal mental health (to 66,000)	August 2024	ICB	✓	1,020	✓	✓	?	L

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National Planning Metrics – overview (2/2)

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Area	Objective	Date	ICB/ICS	Has Plan	Reporting Value	On Plan	On Target	Capability	Variation
Mental Health	Increase the number of people accessing children and young people services (345,000 additional CYP aged 0-25 compared to 2019)	August 2024	ICB	✓	13,970	✓	✓	P	H
Mental Health	Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement	August 2024	ICB	✓	69.9%	✓	✓	?	
Mental Health	Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 48% achieving reliable recovery	August 2024	ICB	✓	49.2%	✓	✓	?	
Mental Health	Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025	June 2024	ICB	✓	63.8%	✓	✓		
Mental Health	Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2026	September 2024	ICB	✓	62.1%	✗	✗	F	H
People with a learning disability and autistic people	Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025	September 2024	ICB	✗	27.2%		✗		
People with a learning disability and autistic people	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12-15 under 18s for every 1 million population		ICB						
Prevention and health inequalities	Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people		ICB						
Prevention and health inequalities	Increase the % of patients with hypertension treated according to NICE guidance to 80% by March 2025		ICB						
Prevention and health inequalities	Increase the percentage of patients aged 25-84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 2025		ICB						
Prevention and health inequalities	Increase vaccination uptake for children and young people year on year towards WHO recommended levels		ICB						
Workforce	Improve the working lives of all staff and increase staff retention and attendance through systematic implementation of all elements of People Promise retention interventions		ICB						
Workforce	Improve the working lives of doctors in training by increasing choice and flexibility in rotas, and reducing duplicative inductions and payroll errors		ICB						
Workforce	Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the NHS Long Term Workforce Plan		ICB						
Use of Resources	Deliver a balanced net system financial position for 2024/25	September 2024	ICS	✓	£0	✓	✓		
Use of Resources	Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25	September 2024	ICS	✓	3.4%	✗	✗		

Cancer – summary

Metric Description	Target	Actual	Regularity of reporting	Reporting period	Date report updated	Board with assurance oversight	Risk to escalate to Commissioning and Performance Committee?	Related Board Assurance Framework risk? (provide reference)
Improve performance against the headline 62-day standard to 70% by March 2025	61.5%	61.7%	Monthly	Aug '24	14/11/24	Cancer Oversight Group	No – deep dive completed November 2023	BAF07 – Elective Recovery
Improve performance against the 28-day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026	73.5%	64.3%	Monthly	Aug '24	14/11/24		No - deep dive completed November 2023	BAF07 – Elective Recovery
Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	75%	56.6%	Rolling 12 monthly	June '24	14/11/24		No	N/A
Local Metrics as indicated by exception								
Timely cancer diagnosis and treatment (including medical staffing in oncology)			Bi-monthly	To Nov 24	14/11/24	Cancer Oversight Group		BAF07 – Elective Recovery

Davey Heidi 21/11/2024 13:10:42

Green or red shading is used to identify where current delivery is on (green) or off (red) the plan or trajectory.

Link back to overview of underachieving metrics slide

National KPI: Improve performance against the headline 62-day standard to 70% by March 2025

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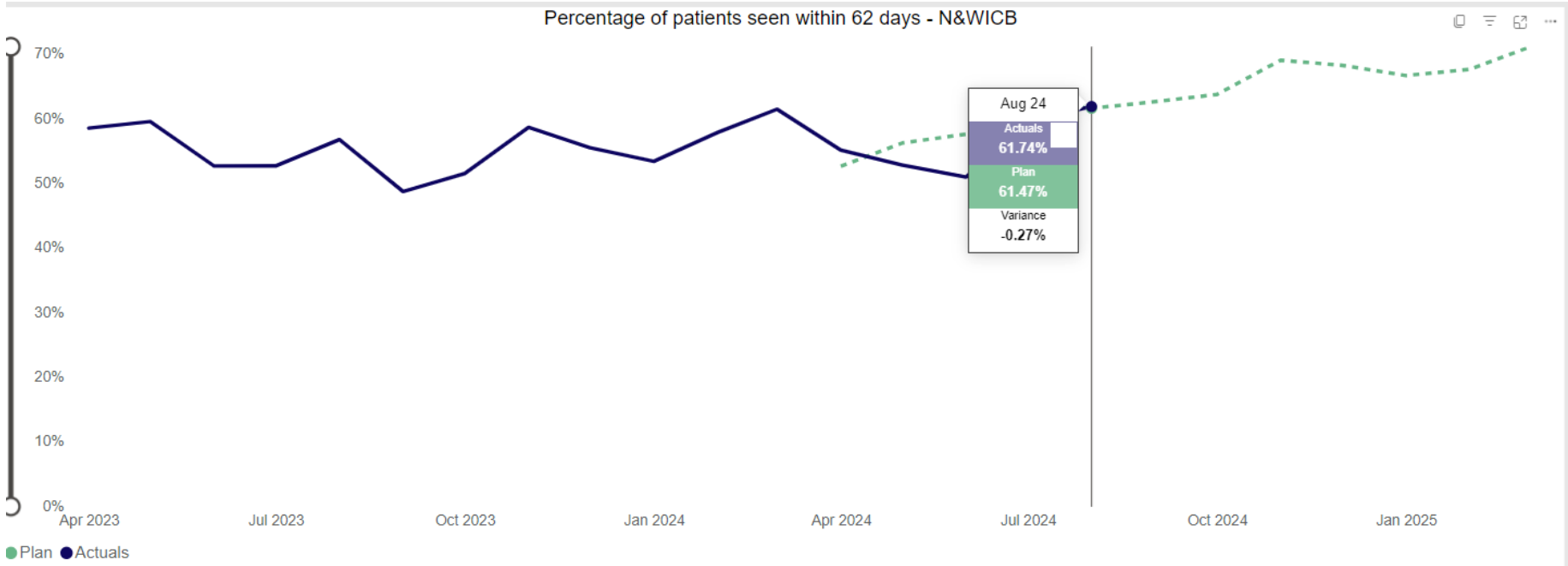
Link back to overview of underachieving metrics slide



Trust	Actuals Trend	Latest Month	Actuals	Plan	Latest Gap To Plan	YTD Value	YTD Plan	YTD Gap To Plan	End FY Plan	Variance Trend
N&WICB		Aug 24	61.7%	61.5%	-	56.0%	58.5%	62	70.8%	

Description of the metric

Percentage of patients having their first cancer treatment no later than 62 days from their referral for suspected cancer. This should be 70% of patients by March 2025.

Description of performance

62-day performance at 61.7% against the trajectory of 61.5% for August 2024. All but the breast, skin and haem pathways are challenged.
Year to date achieved is 56% against plan of 58.5% - this equates to an additional 62 people being treated

Is performance meeting national KPI?	No	If no above, is performance meeting recovery trajectory?	No	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
Backlog Variation in demand Capacity of the oncology medical workforce.	Regional and national tiering support meetings, allocation of additional Cancer Alliance funding to support backlog clearance. Workforce redesign steering group progressing medium to long term solutions. Oncology speciality network creating their 5-year action plan.	Cancer Programme Board and Cancer Alliance.	Acutes to work towards meeting their planned trajectories ending March 2025 when the standard is required to be met.	The continued surges in Urgent Suspected Cancer demand continue to provide a challenge for trusts to manage while clearing backlogs.

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National KPI: Improve performance against the 28-day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026

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Norfolk and Waveney Integrated Care System

Select View: Provider View | ICB View

Select Baseline: Plan | Revised Plan

Performance:

Total Latest Month - August

64.3%	73.5%	-9.2%
Actual	Plan	Vs Plan

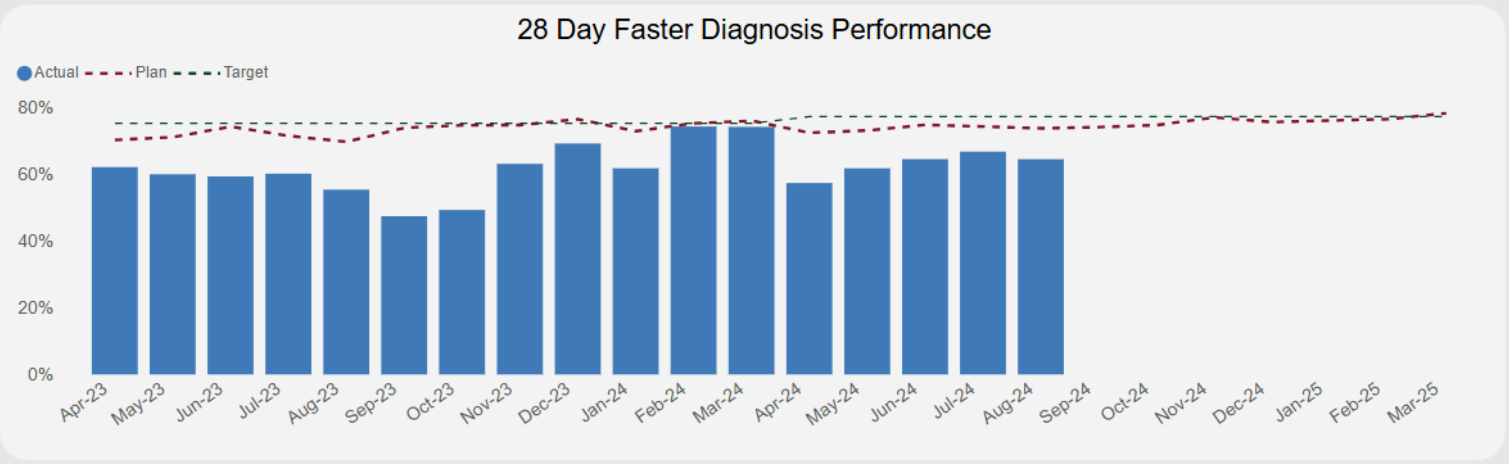
Activity:

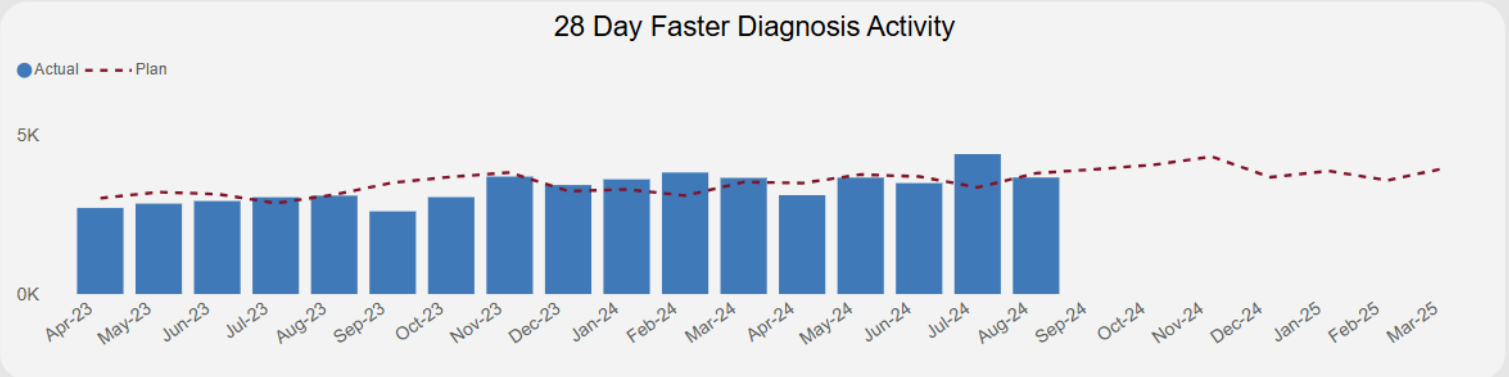
Total Latest Month - August

3,670	3,807	96.4%
Actual	Plan	Vs Plan

Latest Month By Suspected Cancer Type

Suspected Cancer Type	%
Brain	72.7%
Breast	96.3%
Childrens	85.7%
Gynaecology	51.8%
Haematological	44.0%
Head & Neck	72.8%
Leukaemia	0.0%
Lower Gastrointestinal	49.2%
Lung	53.8%
Sarcoma	53.8%
Skin	53.2%
Testicular	93.9%
Unknown	0.0%
Upper Gastrointestinal	89.9%





Link back to overview of underachieving metrics slide

Description of the metric

The NHS Faster Diagnosis Standard (FDS) requires patients who have been referred urgently by their GP for suspected cancer, to receive a communication of their diagnosis or have cancer ruled out no later than 28 days from the referral.

Description of performance

FDS is 64.8% against the trajectory of 73.5% for August 2024. With gynae, haem, lower GI, lung and skin being the most challenged pathways.

Is performance meeting national KPI?	No	If no above, is performance meeting recovery trajectory?	No	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
Backlog. Variation in demand. Histopathology delays. Incomplete implementation of best practice timed pathways.	Regional and national tiering support meetings, allocation of additional Cancer Alliance funding to support backlog clearance. Focus on FDS project with the Cancer Alliance. Completion of pathway analysers. Introduction of a Quality Improvement approach to Best Practice Times Pathways. Review of histopathology action plans at NNUH.	Cancer Programme Board and Cancer Alliance.	Acutes to work towards meeting their planned trajectories ending March 2025 when the standard is required to be met.	The continued surges in demand. Access to action / improvement plans for all providers where required, with focus on histopathology.

National KPI: Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028

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Link back to overview of underachieving metrics slide

Around 60% of patients are diagnosed at an early stage in the East of England
Breast and **malignant melanoma** have the highest early stage proportions
The **upper GI and haematological** cancers have the lowest early stage proportions
The % of unknowns has improved from 31% in 2019 to 20% in 2023

	Trend: Jul 2023 to Jun 2024	Latest Rolling 12 Months	Forecast for March 2025 (+3% based on rolling 12 month data up to Oct 23)
BLMK		64.7%	67.6%
C&P		59.8%	63.9%
HWE		61.6%	63.3%
MSE		56.5%	56.5%
N&W		56.6%	60.5%
SNEE		62.5%	62.8%
East of England		60.1%	62.3%

This trajectory is managed by the East of England Cancer Alliance
TBC frequency of updates.

Regional view of stage 1 and 2 diagnosis by Cancer pathway

Cancer Pathway	2022			2023			2024 YTD*		
	Early Stage - Unknowns Excluded	Early Stage - Unknowns Included	Unknown %	Early Stage - Unknowns Excluded	Early Stage - Unknowns Included	Unknown %	Early Stage - Unknowns Excluded	Early Stage - Unknowns Included	Unknown %
Breast	86%	72%	17%	84%	72%	15%	86%	74%	14%
Colorectal	52%	42%	18%	51%	42%	17%	50%	40%	20%
Gynaecological	66%	45%	33%	62%	50%	19%	65%	50%	22%
Haematological	33%	10%	71%	33%	16%	51%	28%	14%	50%
Lung	29%	26%	12%	34%	31%	8%	38%	35%	9%
Melanoma	89%	67%	25%	90%	78%	13%	93%	73%	21%
Oesophago-gastric	25%	17%	31%	32%	24%	23%	31%	24%	23%
Prostate	58%	39%	33%	59%	49%	16%	60%	50%	17%
Upper GI excl OG	28%	16%	42%	26%	16%	39%	23%	14%	38%
Urological excl prostate	71%	34%	51%	66%	38%	42%	69%	38%	45%
Grand Total	59%	43%	27%	59%	47%	20%	60%	48%	21%

*Please note the data for 2024 is up until June 2024

Description of the metric

Stage 1: early-stage cancer
Stage 2: localised spread

The 2019 NHS Long Term Plan for Cancer requires that by 2028, 75% of people with cancer will be diagnosed at an early stage (stage 1 or 2)
Achieving this means more people each year will survive their cancer for at least five years after diagnosis.

Description of performance

Up to June 2024 Norfolk and Waveney achieved 56.6 % earlier diagnosis. This has improved from 53.4% from the beginning of the programme in 2019. The current trajectory shows a position of 60.5% for Norfolk and Waveney by March 2025.

Is performance meeting national KPI?	No	If no above, is performance meeting recovery trajectory?	No	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
There is variation in urgent suspected cancer (USC) referrals and a variable awareness of NG12 and early detection of cancer.	Local campaigns to raise awareness of signs and symptoms of benefits of screening. Engagement with Core20+5 groups to gain insight into challenges. Review of USC referral forms and implementation of *C the Signs*. Piloting Community Pharmacy Access for USC referrals. Non-site-specific cancer pathway in place.	Cancer Programme Board.	Trajectories in place for March 2025.	Variable patient uptake of awareness raising and engagement activities. Fixed term funding for C the Signs, Community Pharmacy and NSS pathway.

Diagnostics and Elective Care – summary

Metric Description	Target	Actual	Regularity of reporting	Reporting period (to)	Date report updated	Board with assurance oversight	Risk to escalate to Commissioning and Performance Committee?	Is there a related Board Assurance Framework risk? (provide reference)
Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	95%	66.8%	Monthly	Aug '24	8/11/24	Scheduled Care Board	No	BAF07 – Elective Recovery
Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest	1,861	2,710	Monthly	Aug '24	8/11/24		No	BAF07 – Elective Recovery
Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%	103.1%	115.5%	Monthly	July '24 (see slide 14)	8/11/24		No	BAF07 – Elective Recovery
Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25	46%	44.2%	Monthly	Aug '24	8/11/24		No	BAF07 – Elective Recovery
Improve patients' experience of choice at point of referral	-	-	See slide 16		8/11/24		No	BAF07 – Elective Recovery
Local Metrics as indicated by exception								

Green or red shading is used to identify where current delivery is on (green) or off (red) the plan or trajectory.

National KPI: Increase percentage of patients that receive a diagnostic test or procedure within six weeks in line with the March 2025 ambition of 95%

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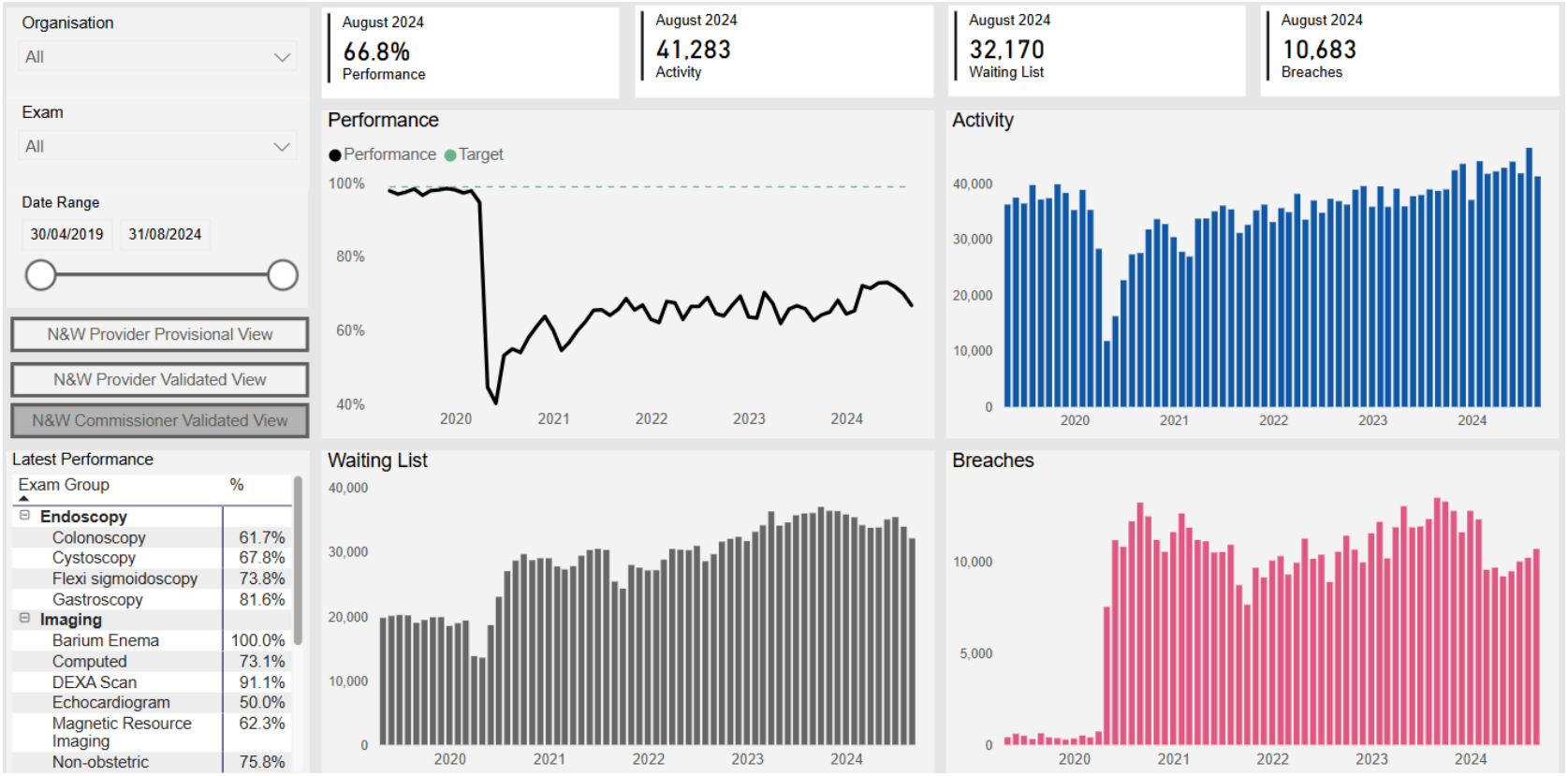

[Link](#) **back to overview of underachieving metrics slide**

Description of the metric

Increase the percentage of patients that receive a diagnostic test or procedure within six weeks.
This should be 95% of patients by March 2025.

Description of performance

Activity has continued to underachieve plan at Month 5 (August).

Is performance meeting national KPI?	no	If no above, is performance meeting recovery trajectory?	no	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
• Discontinued and decommissioned Independent Sector Provider (ISP) activity. • Capacity and demand. • Histopathology capacity. • Echocardiogram ISP contract cancelled.	• Use of Locums (Aug.), reinstate ISP (Sept). • CT, MRI and Ultrasound capacity plans including MRI onsite. at NNUH. Community Diagnostic Centres' and Norfolk And Norwich Orthopaedic Centre programmes across system to provide additional capacity. • Histology – Outsourcing, Artificial Intelligence assisted processes, escalation to Senior Responsible Officer and long waits review. • Locum to provide.	• Provider Performance and Planning Oversight Group (PPPOG). • Scheduled Care Board.	31/3/2025	• Community Diagnostic Centre support behind schedule • Accrued Time Off In Lieu of staff due to Elective Recovery work

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National KPI: Eliminate waits of over 65 weeks for elective care as soon as possible and by (30th) September 2024 at the latest

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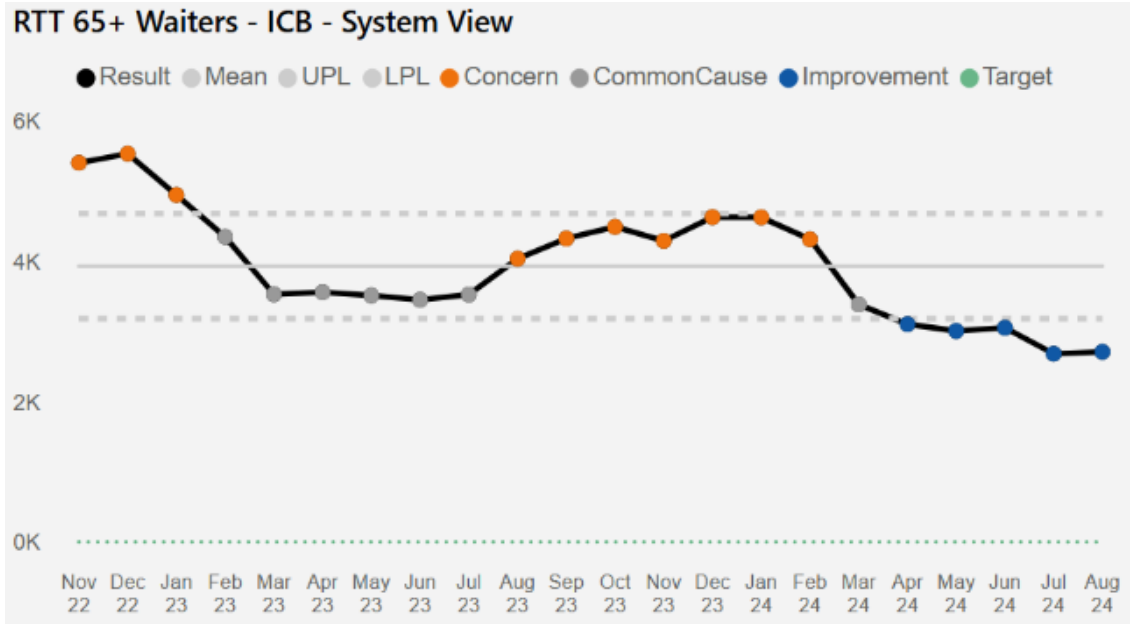

August 2024	August 2024	August 2024
53.3%	148,738	69,419
Performance	RTT Incomplete Pathways	RTT Breaches

August 2024	August 2024	August 2024	August 2024
10,061	2,710	326	0
52+ Waiters	65+ Waiters	78+ Waiters	104+ Waiters

Link back to overview of underachieving metrics slide

Description of the metric

Elective care is clinical care, often surgery, which is planned.

Since September 2024, no patient should wait longer than 65 weeks for elective care.

Description of performance

Activity has continued to underachieve plan at Month 5 (August).

Is performance meeting national KPI?	no	If no above, is performance meeting recovery trajectory?	no	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
• Wait list validation. • Grip & control. • Theatre utilisation. • UEC impact. • Workforce power is unsustainable. • Mutual Aid offering is limited due to patient complexities.	• Patient Tracker List (PTL) non-clinical validation / data quality across system. • PTL oversight weekly / monthly including with Independent Sector Providers. • Super clinics (T&O and ENT) / additional outpatients all lists. Mutual Aid and Outsourcing/Insourcing. 7 day working implemented at JPUH and NNUH considering. Getting It Right First Time team support and system-wide best practice. • Theatre steering group working with model hospital to ensure data accuracy and efficiencies.	• Provider Performance and Planning Oversight Group. • Scheduled Care Board.	December 24	• Collaborating with neighbouring Systems and across the Region for additional support. • Surgical Hubs being built to provide additional capacity.

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National KPI: Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%

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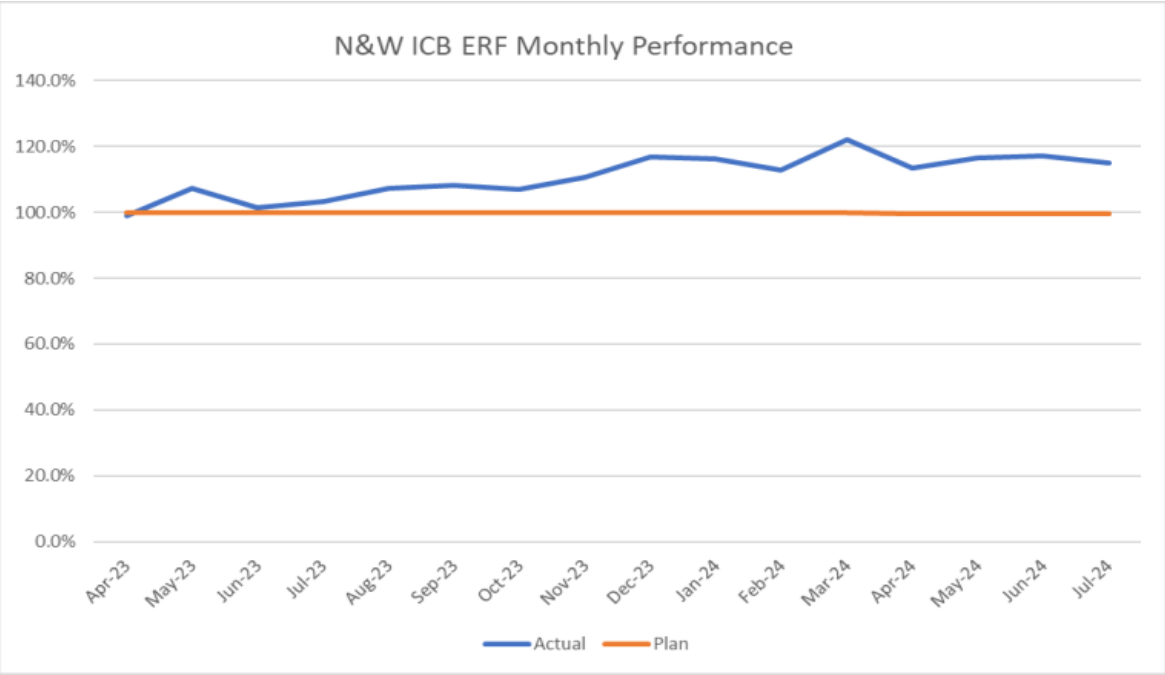
Link back to overview of underachieving metrics slide



Description of the metric

Norfolk and Waveney is required to deliver more elective (planned) care activity in 2024/25 than it did in 2019/20. This is to help reduce long waiting times. The 2024/25 target for Norfolk and Waveney is for: 103.1% of the activity from 2019/20.

Description of performance

Activity is higher than pre-pandemic levels, however, due to the overall backlog, there remains significant challenge to meet this target.

Is performance meeting national KPI?	Yes	If no above, is performance meeting recovery trajectory?	Yes	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
• Current backlog excessed available capacity • Remaining patients who have been waiting over 52 weeks, have high acuity levels and high BMI ranges, making it difficult to utilise Independent Sector providers for additional capacity.	• Surgical Hubs and Community Diagnostic Centres are being built to provide additional capacity across the System to help treat patients more quickly • Super clinics (T&O and ENT) / additional outpatients all lists. Mutual Aid and Outsourcing/Insourcing. • 7 day working implemented at JPUH and NNUH considering. Getting It Right First Time team support and system-wide best practice. • Theatre steering group working with model hospital to ensure data accuracy and efficiencies. • Advice and Guidance to be increased between primary and secondary care.	• Provider Performance and Planning Oversight Group. • Scheduled Care Board.	31/03/2025	• Elective Recovery Funding stopping. • Patients being too complex safely to Independent Sector Providers • Not being unable to recruit for the Surgical Hubs and Community Diagnostic Centres.

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National KPI: Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25

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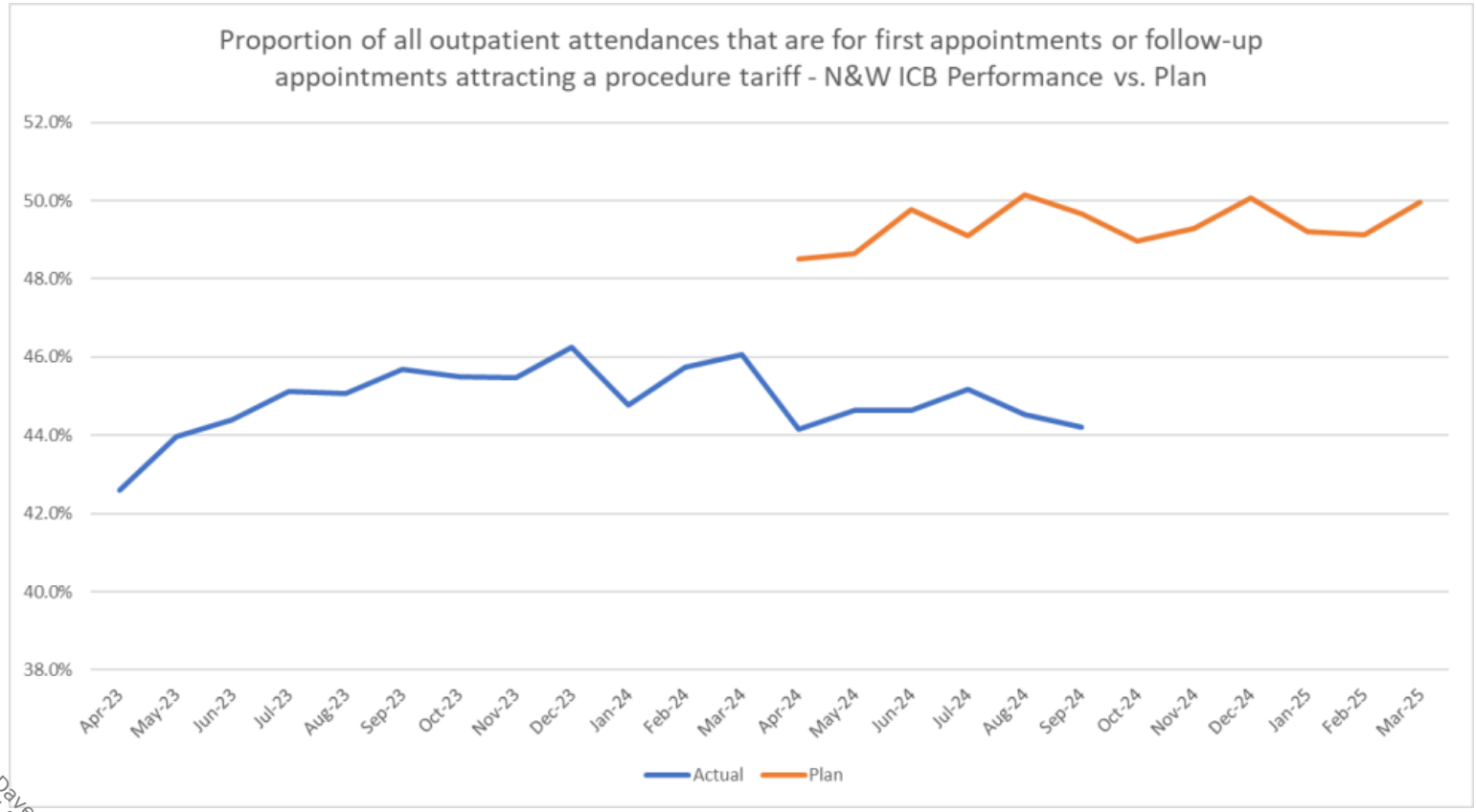

Description of the metric

Increasing the proportion of appointments that have a procedure as part of a clinical intervention adds value to individuals' care and treatment pathway.
Appointments without a procedure are typically of less clinical value.

Description of performance

A continued increase in the number of episodes on an active PIFU pathway, however a slight flattening-out of episodes discharged to PIFU. However, slightly below target.

Is performance meeting national KPI?	no	If no above, is performance meeting recovery trajectory?	no	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
• Clinic utilisation improvements.	• Implementation of Patient Engagement Portal at JPUH. • Move 5% of all Outpatient Attendance, onto Patient Initiated Follow Ups (PIFU). • Improve virtual consultations to 25%. • 25% reduction in follow up appointments.	• Provider Performance and Planning Oversight Group. • Scheduled Care Board.	31/03/2025	• Implementing Electronic Patient Records across the three acute Trusts may impact workforce availability.

National KPI: Improve patients' experience of choice at point of referral

Link back to overview of underachieving metrics slide

The Office for National Statistics (ONS) Health Insights Survey data is expected, from October 2024, to inform this metric.

Description of the metric
To be defined nationally.

Description of performance
Not available.

Is performance meeting national KPI?	no	If no above, is performance meeting recovery trajectory?	no	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
Reporting will commence once a method of data collation has been confirmed.				

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Maternity, Neonatal and Women's Health – summary

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Metric Description	Target	Actual	Regularity of reporting	Reporting period	Date report updated	Board with assurance oversight	Risk to escalate to Commissioning and Performance Committee?	Is there a related Board Assurance Framework risk? (provide reference)
Continue to implement the Three-year delivery plan for maternity and neonatal services	25/26	On track	Bi-annual	Sep 24	14/11/24	LMNS	No	No
Progress towards the national safety ambition	-	-	Bi-annual	-	14/11/24	LMNS	No	No
Increasing fill rates against funded establishment (less than 9% vacancies)	<9%	3.35%	Bi-annual	August 24	14/11/24	LMNS	No	No
Establish and develop at least one women's health hub in every ICB by December 2024, working in partnership with local authorities	Dec '24	On track	Monthly	Aug 2024	8/11/24	Planned Care and Long-Term Conditions Clinical Transformation Oversight Group	No	
Local Metrics as indicated by exception								

Davey,Heidi
21/11/2024 13:10:42

Green or red shading is used to identify where current delivery is on (green) or off (red) the plan or trajectory.

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National KPI: Continue to implement the Three-year delivery plan for maternity and neonatal services

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Plan Theme	Key points	RAG
Theme 1 – Listening to and working with women and families with compassion 1. Care that is personalised 2. Improve equity for mothers and babies 3. Work with service users to improve care	A number of MNVP requirements are already completed Work is progressing well on: • Achieving UNICEF Baby Friendly Initiative • Commissioning & delivering personalised care and support plans • Commissioning and implementing perinatal pelvic health services by the end of March 2024 • Commissioning and implementing community perinatal mental health services • MNVPs to reflect ethnic diversity of local population and reach out to seldom heard groups	
Theme 2-Growing, retaining and supporting our workforce 4. Grow our workforce 5. Value and retain our workforce 6. Invest in skills	Systemwide work is underway and progressing well to: • Maximise student placements • Monitor and address workforce planning requirements, staff training and compliance with core competency framework • Sharing best practice Area s where work has commenced but require further work include: • ICB to commission and fund safe staffing across the system • ICB to Align commissioning of services to meet the ambitions outlined in this delivery plan with the available workforce capacity	
Theme 3: Developing and sustaining a culture of safety, learning and support 7. Develop a positive safety culture 8. Learning and improving 9. Support and oversight	Systemwide work is underway and progressing well to: • Monitor, support and share learning on culture • Respond effectively and openly to patient safety incidents using PSIRF, with effective quality oversight and improved data analysis Area s where work has commenced but require further work include: • ICB to Commission services that enable, safe, equitable and personalised maternity care for the local population.	
Theme 4-Standards and structures that underpin safer, more personalised and more equitable care 10. Standards to ensure best practice 11. Data to inform learning 12. Make better use of digital technology in maternity and neonatal services	Systemwide work is underway and progressing well to: • Implement and assure compliance to Saving Babies Lives Bundle 3, Maternity Incentive Schemes and National Standards including CNST (Clinical Negligence Scheme for Trusts) • Using data to compare their outcomes to similar systems and understand any variation and where improvements need to be made • Digital strategies, Procurement of EPR that meets Maternity and Neonatal requirements, supporting regional digital maternity leadership networks Area s where work has commenced but require further work include: • Commission care with due regard to NICE guidelines • Support women to set out their personalised care and support plan through digital means	

Link back to overview of underachieving metrics slide

Description of the metric

The 4 Themes of the 3-year Plan are embedded across the Local Maternity and Neonatal System (LMNS) programme delivery quadrants: Transformation, Quality & Safety, Strategy, Business as Usual, detailed in the LMNS Blueprint

Description of performance

As a system good progress is being made against delivery of the 3 Year plan requirements.

Is performance meeting national KPI?	no	If no above, is performance meeting recovery trajectory?	no	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
Commissioning Support women to set out their personalised care and support plan through digital means	Commissioning review to commence in line with ICB restructure. System procurement of Electronic Patient Record (EPR) to address digital maturity challenges	Commissioning and Performance Committee EPR Team	March '26 March '26	Commissioning capacity National Patient Safety Alert (NPSA) for NNUH & JPUH digital systems

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National KPI: Progress towards the national safety ambition

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The LMNS October 24 Board received the following updates:
The LMNS team are working with the ICB Commissioning Team to provide reports on metrics that show progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injury as defined in the NHS England priorities and operational planning guidance 24/25.

Metrics on stillbirth and neonatal mortality, are reviewed quarterly but further work is underway to develop trajectories. Maternal Deaths are reviewed and reported annually.

During 2024 LMNS Board has received Deep Dive reports on Mortality and Morbidity (Stillbirths, Preterm Births and Neonatal Deaths) and Maternal Deaths. With recommendation and actions. A progress report on actions and systemwide priorities was submitted to September LMNS Board – an overview can be shared to committee.

Description of the metric as
The NHS Long Term Plan for Maternity and Neonatal requires a 50% reduction, by 2025, in rates of stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury

Description of performance

Is performance meeting national KPI?		N/A	If no above, is performance meeting recovery trajectory?	N/A	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):

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National KPI: Increasing fill rates against funded establishment

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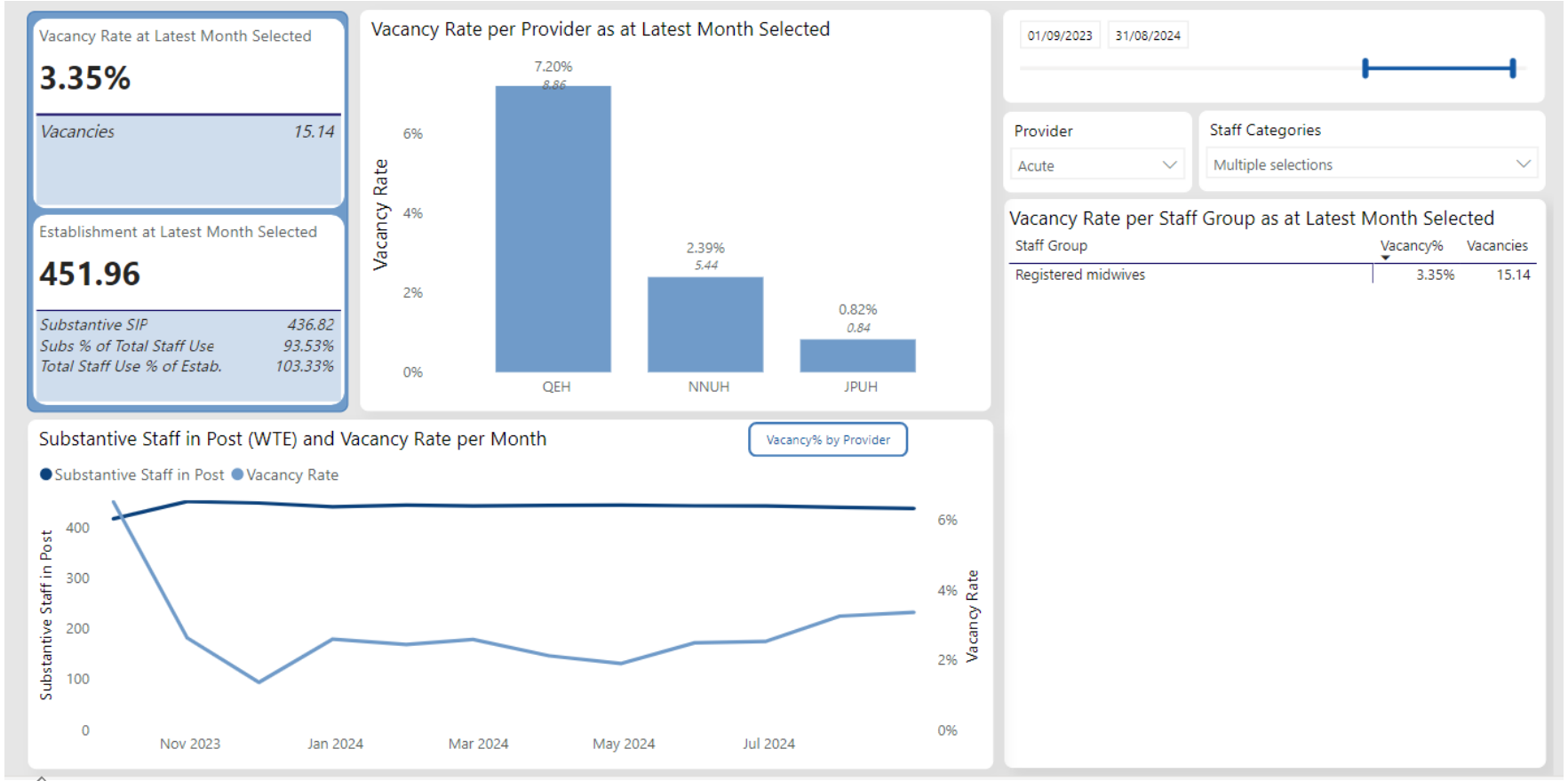

[Link](#) **back to overview of underachieving metrics slide**

Description of the metric

This metric requires better and more recruitment and retention of midwifery staffing so that services are as fully staffed as they can be. Vacancies in maternity services should be consistently below 9% of that total service workforce

Description of performance

ICB workforce dashboard; Midwifery Vacancies, reported to LMNS Board 28 August 2024.

Vacancy rate 3.35%

Dave Vaidi 21/11/2024 10:42

Is performance meeting national KPI?	Yes	If no above, is performance meeting recovery trajectory?	N/A	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
N/A	N/A			

National KPI: Establish and develop at least one women's health hub in every ICB by December 2024, working in partnership with local authorities

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Link back to overview of underachieving metrics slide

Are you on track to have at least one operational WHH in your ICS providing at least 2 core services (as outlined in the WHH core specification) by end of July 2024?	Yes
Are you on track to have at least one operational WHH in your ICS providing all 8 core services (as outlined in the WHH core specification) by end of December 2024?	Yes

Description of the metric

Women's health hubs bring together healthcare professionals and existing services to provide integrated women's health services in the community, centred on meeting women's needs across the life course. Hub models aim to improve access to and experiences of care, improve health outcomes for women, and reduce health inequalities.

Description of performance

Delivery is on track.

Is performance meeting national KPI?	Yes	If no above, is performance meeting recovery trajectory?		(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
N/A	N/A			

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Mental Health – summary

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Metric Description	Target	Delivery	Regularity of reporting	Reporting period	Date report updated	Board with assurance oversight	Risk to escalate to Commissioning and Performance Committee?	Is there a related Board Assurance Framework risk? (provide reference)
Improve patient flow and work towards eliminating inappropriate out of area placements	6	15	Monthly	Aug '24	8/11/24	Mental Health Integrated Delivery Group (Governance under review)	no	BAF04
Increase the number of people accessing perinatal mental health (to 66,000)	1,018	1,020	Monthly	Aug '24	8/11/24		no	BAF04
Work towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025	60%	63.8%	Quarterly	Q2 24/25	8/11/24		no	BAF04
Increase the dementia diagnosis rate to 66.7% by March 2025	63.0%	62.1%	Monthly	Sept '24	8/11/24		no	BAF04
Increase the number of people accessing transformed models of adult community mental health (to 400,000)			Monthly	n/a	8/11/24		no	BAF04
Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with • At least 48% of those achieving reliable recovery • At least 67% of those achieving reliable improvement	(14,000 annual) 1,259 48% 67%	1,605 49.2% 69.9%	Monthly	Aug '24 Aug '24 Aug '24	8/11/24		no	BAF04
Increase the number of people accessing children and young people services (345,000 additional CYP aged 0-25 compared to 2019)	12,951	13,970	Monthly	Aug '24	8/11/24		no	BAF03

Local Metrics as indicated by exception

Green or red shading is used to identify where current delivery is on (green) or off (red) the plan or trajectory.

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National KPI: Improve patient flow and work towards eliminating inappropriate out of area placements

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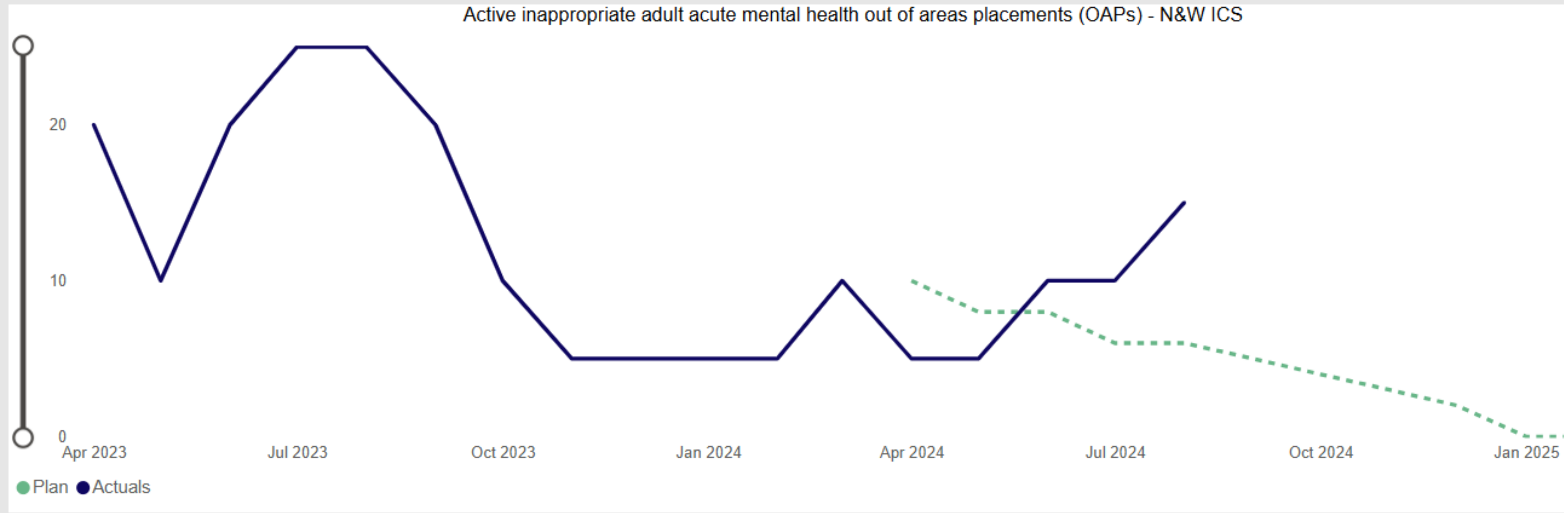

Trust	Actuals Trend	Latest Month	Actuals	Plan	Latest Gap To Plan	YTD Value	YTD Plan	YTD Gap To Plan	End FY Plan	Variance Trend
NSFT		Aug 24	15	6 ⊗	9	45	38 ⊗	7	0 ⊗	

Description of the metric

The number of people who are inappropriately in mental health beds outside of the Norfolk and Waveney system.
An appropriate placement out of the local area would include specialised care.

Description of performance

Target of 6 was exceeded an increasing trend. Actual numbers of people in out of area placement: 15

Is performance meeting national KPI?	**No**	**If no above, is performance meeting recovery trajectory?**	**no**	(if no to either/both, complete below)

Root cause(s) identified:	**Corrective Action(s):**	**Action owner(s):**	**Delivery date for action(s):**	**Risk to delivery of corrective action(s):**
• Demand, with significant demand from A&E • Length of Stay variation and patient complexity. • Provider internal capacity constraints • Provider operational challenges / inconsistencies	• Strengthening crisis management pathways within the Trust and focus on reducing A&E referrals for mental health patients. • Multi Agency Discharge Events (MADE) and re-introduction of out of area placement matron to oversee the quality of care. • Improved joint working with community teams. • Improving clinical leadership and engagement in decision making and explore any best practice methods from other Trusts.	Norfolk & Suffolk Foundation Trust. Mental Health Integrated Delivery Group.	November 24/25 – 26/27	Acuity and demand levels

National KPI: Increase the number of people accessing perinatal mental health to 66,000

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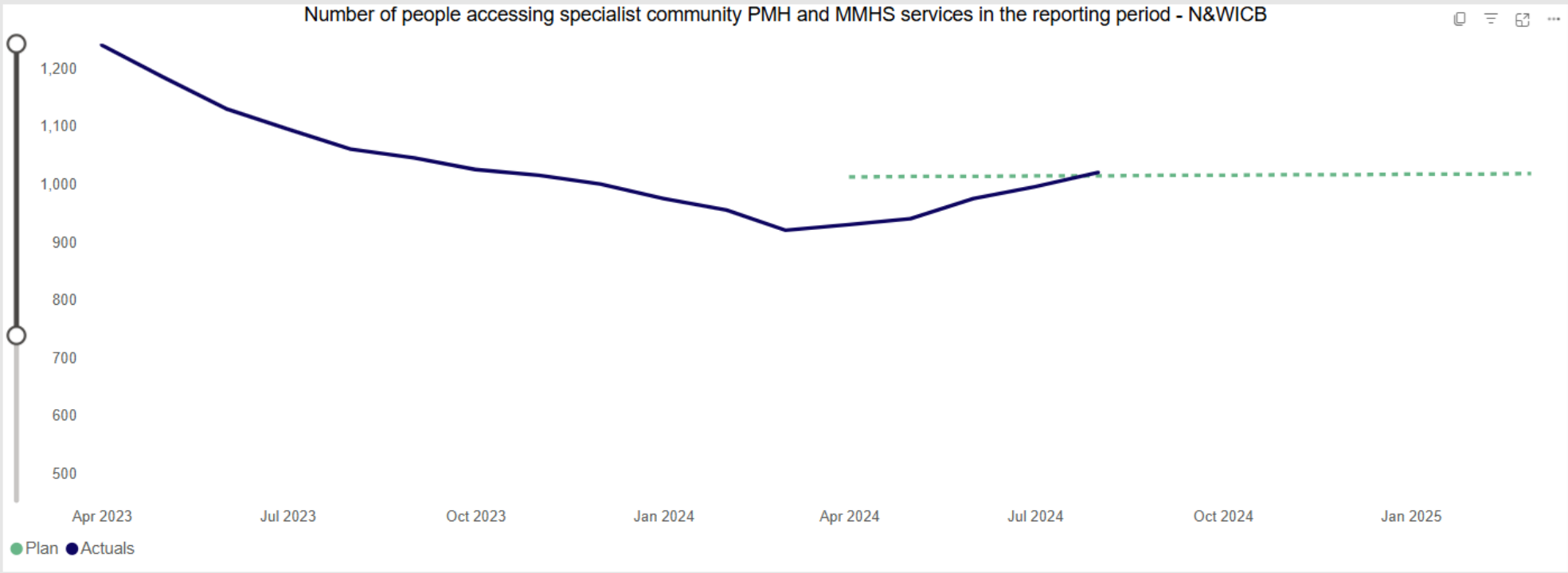
Link back to overview of underachieving metrics slide



Trust	Actuals Trend	Latest Month	Actuals	Plan	Latest Gap To Plan	YTD Value	YTD Plan	YTD Gap To Plan	End FY Plan	Variance Trend
N&WICB		Aug 24	1,020	1,014	-	-	-	-	1,018	

Description of the metric

Perinatal mental health (PMH) problems are those which occur during pregnancy or in the first year following the birth of a child and covers a wide range of conditions.

The minimum number of mums expected to access PMH services in Norfolk and Waveney is 1,018, based on birth rate.

Description of performance

The service is currently meeting target.

Is performance meeting national KPI?	Yes	If no above, is performance meeting recovery trajectory?	N/A	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
N/A	N/A	N/A	N/A	N/A

PMO
Project Management across Norfolk and Waveney

National KPI: Work towards 75% of people with severe mental illness (SMI) receiving a full annual physical health check, with at least 60% receiving one by March 2025

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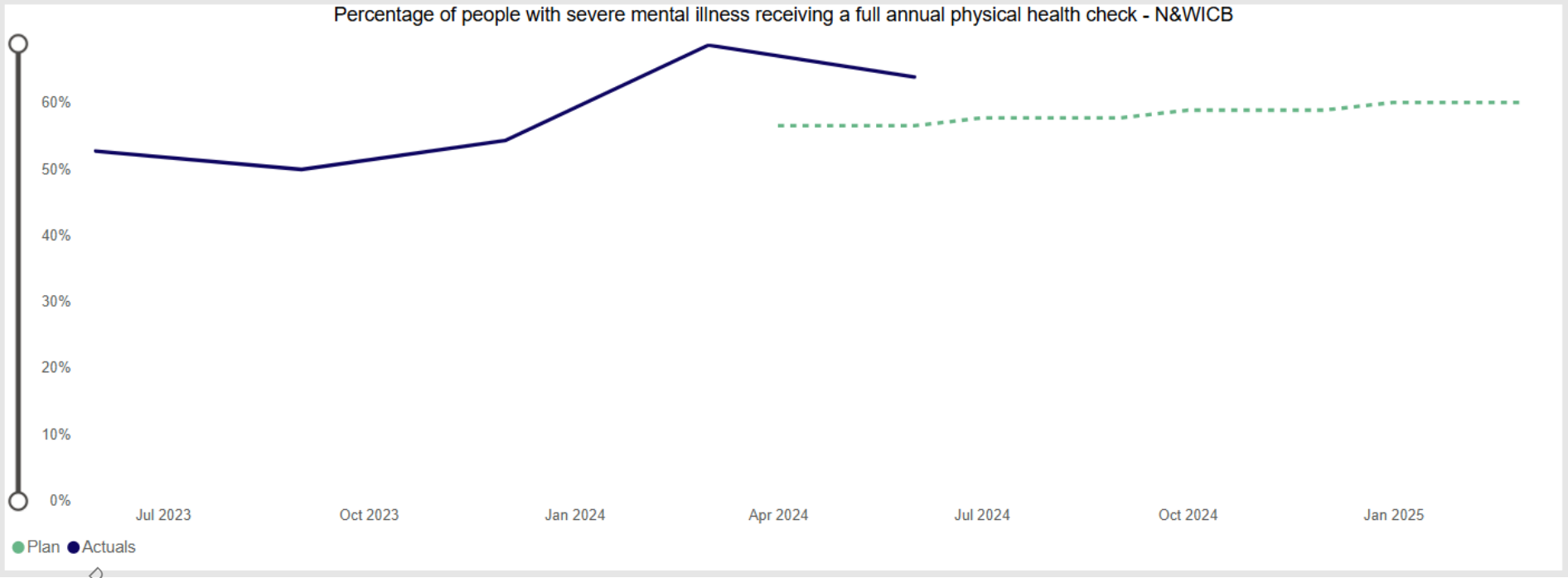
National transition of data extraction for the Physical Health check for SMI will be undertaken through GPES from Q1 24/25, replacing the PHSMI SDCS.

Link back to overview of underachieving metrics slide



Description of the metric
All GP Practices retain a register for their patients living with a severe mental illness. People on this register should have a full physical health check every year. The ambition is that by March 2025 75% of eligible people have this check, with a national target of at least 60%.

Description of performance
The service is currently meeting target.

Is performance meeting national KPI?	Yes	If no above, is performance meeting recovery trajectory?	NA	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
NA	NA	NA	NA	NA

PMO
Project Management across Norfolk and Waveney

National KPI: Increase the dementia diagnosis rate to 66.7% by March 2025

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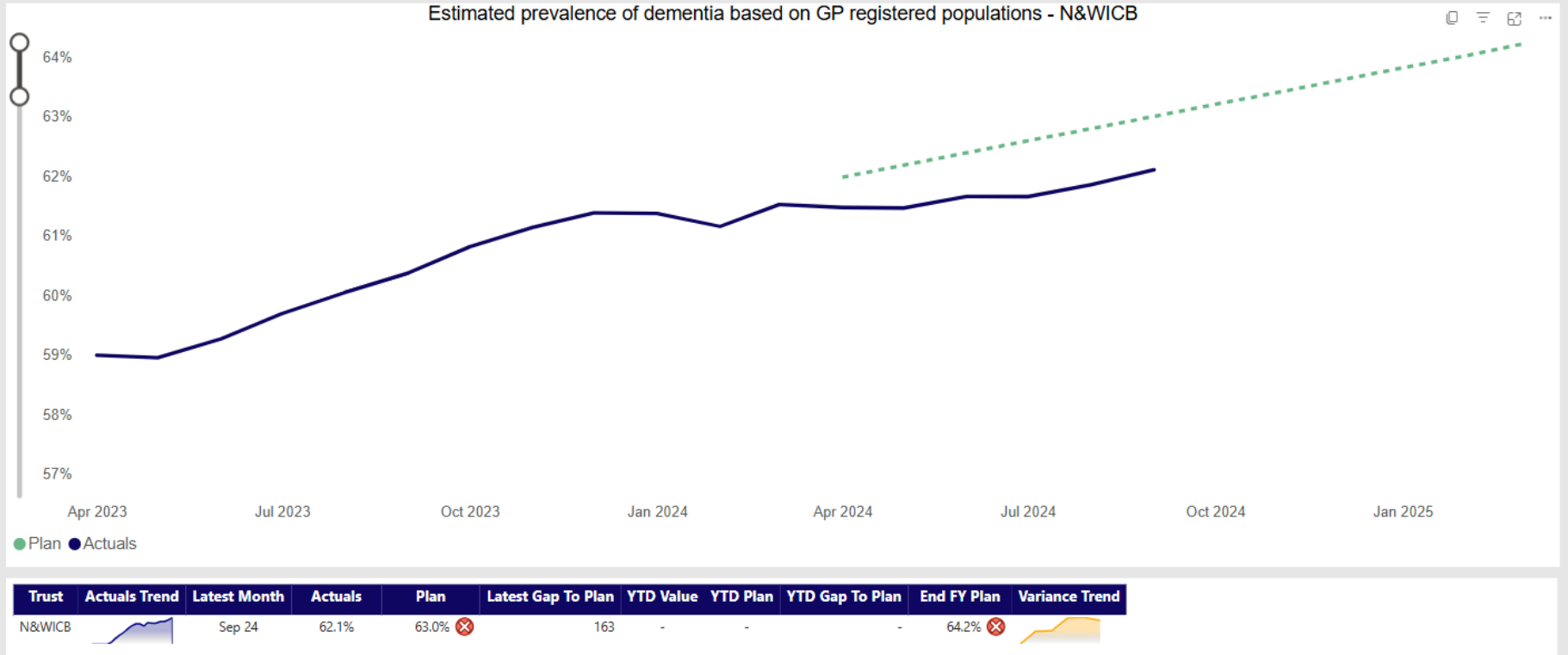
Link back to overview of underachieving metrics slide



Trust	Actuals Trend	Latest Month	Actuals	Plan	Latest Gap To Plan	YTD Value	YTD Plan	YTD Gap To Plan	End FY Plan	Variance Trend
N&WICB		Sep 24	62.1%	63.0%	163	-	-	-	64.2%	

Description of the metric

Diagnosis of 66.7% of the total number of people aged 65 years or older, that NHS England estimates suggest are living with a form of dementia.

N&W ICS committed to achieving 64.2% by the end of the financial year (24/25) and 66.7% by end of 25/26.
August plan to deliver to 63%, with 62.1% achieved and an upward trajectory continues to be achieved

Is performance meeting national KPI?	No	If no above, is performance meeting recovery trajectory?	No	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
Significant Place variation, which is also replicated across Dementia Assessment Treatment Services (DATS).	New standard operating procedure for memory assessment ratified and New Dementia listening in action workstream across Trust, and action plan developed.	Mental Health Integrated Delivery Group		Delays to demand and capacity studies impact on delivery of timely plan to boost performance in line with agreed trajectory, in year.

National KPI: Increase the number of people accessing transformed models of adult community mental health to 400,000

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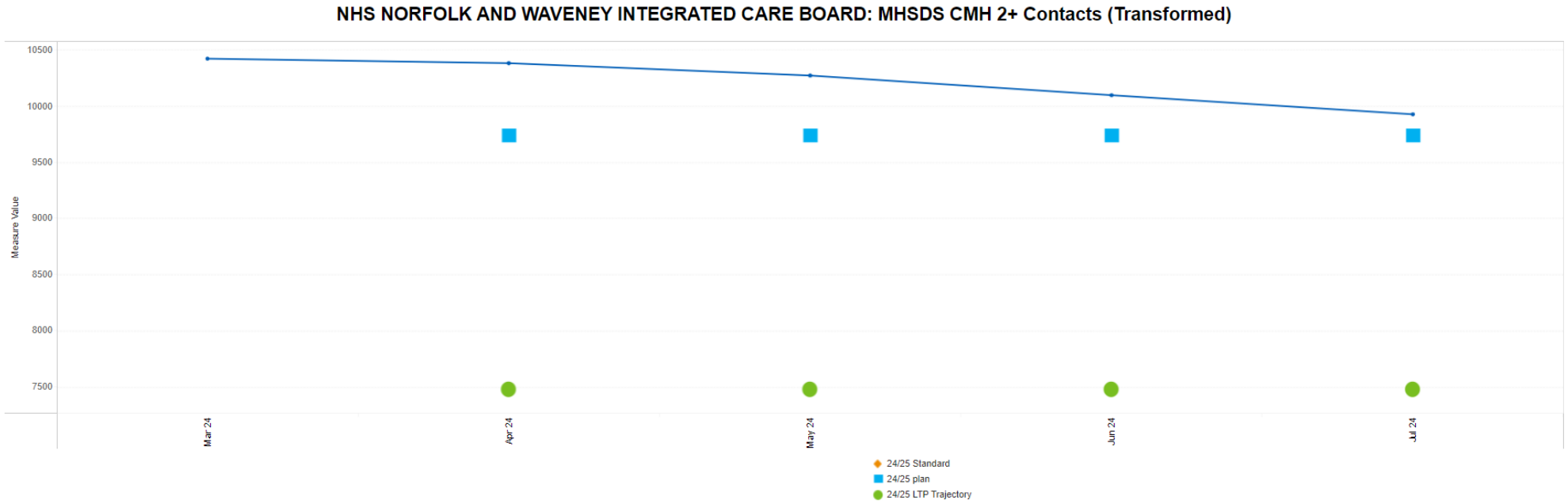
Link back to overview of underachieving metrics slide

Nationally published data view used while local data feeds are re-established from the refreshed mental health data source.



Description of the metric

400,000 ambition is for the whole of England. Norfolk and Waveney ambition is: 9,735

The number of adults living with severe mental illness who have access to community mental health services.

Description of performance

There is a national reporting issue at present and the reporting is to move from monthly to quarterly.

During Q1 performance is above national KPI.

Is performance meeting national KPI?	Yes	If no above, is performance meeting recovery trajectory?	N/A	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
N/A	N/A	N/A	N/A	N/A

PMO
Project Management across Norfolk and Waveney

National KPI: Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000.

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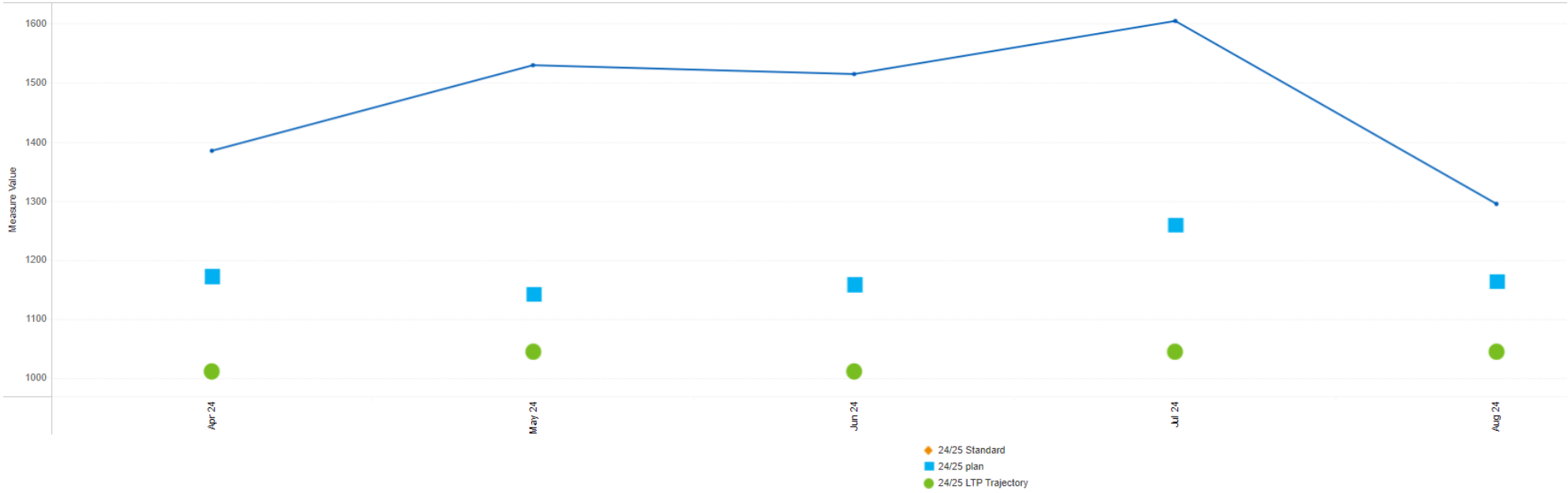
Link back to overview of underachieving metrics slide

Nationally published data view used while local data feeds are re-established from the refreshed mental health data source.

NHS NORFOLK AND WAVENEY INTEGRATED CARE BOARD: NHS Talking Therapies Completing a Course of Treatment



Description of the metric
700,000 ambition is for the whole of England. Norfolk and Waveney ambition is: 14,000 This measures the numbers of patients completing a course of treatment by accessing at least 2 treatment contacts.

Description of performance
The service is currently meeting target

Davey, Heidi 21/11/2024 10:42

Is performance meeting national KPI?	Yes	If no above, is performance meeting recovery trajectory?	NA	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
NA	NA	NA	NA	NA

PMO
Project Management across Norfolk and Waveney

National KPI: At least 48% of those completing a course of treatment via NHS Talking Therapies achieving reliable recovery

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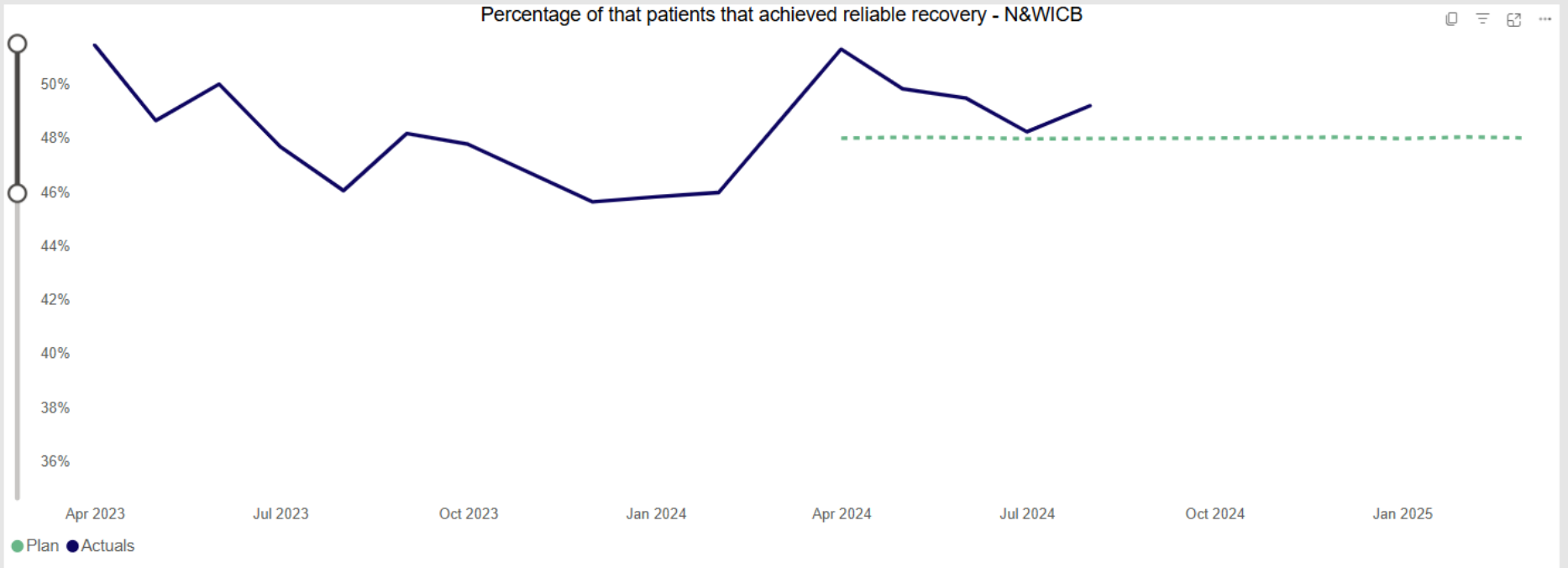
Link back to overview of underachieving metrics slide



Trust	Actuals Trend	Latest Month	Actuals	Plan	Latest Gap To Plan	YTD Value	YTD Plan	YTD Gap To Plan	End FY Plan	Variance Trend
N&WICB		Aug 24	49.2%	48.0%	-	49.6%	48.0%	-	48.0%	

Description of the metric

A patient shows reliable recovery if their anxiety or depression shows significant improvement so that by the end of their treatment (2 or more contacts with the service) it is no longer classed as a clinical condition.

By March 2025, the number of people who achieve a reliable recovery should be at least 48% of those patients who have had a course of treatment

Description of performance

The service is currently meeting target

Is performance meeting national KPI?	Yes	If no above, is performance meeting recovery trajectory?	N/A	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
N/A	N/A	N/A	N/A	N/A

National KPI: At least 67% of those completing a course of treatment via NHS Talking Therapies achieving reliable improvement

PMO
Project Management across Norfolk and Waveney

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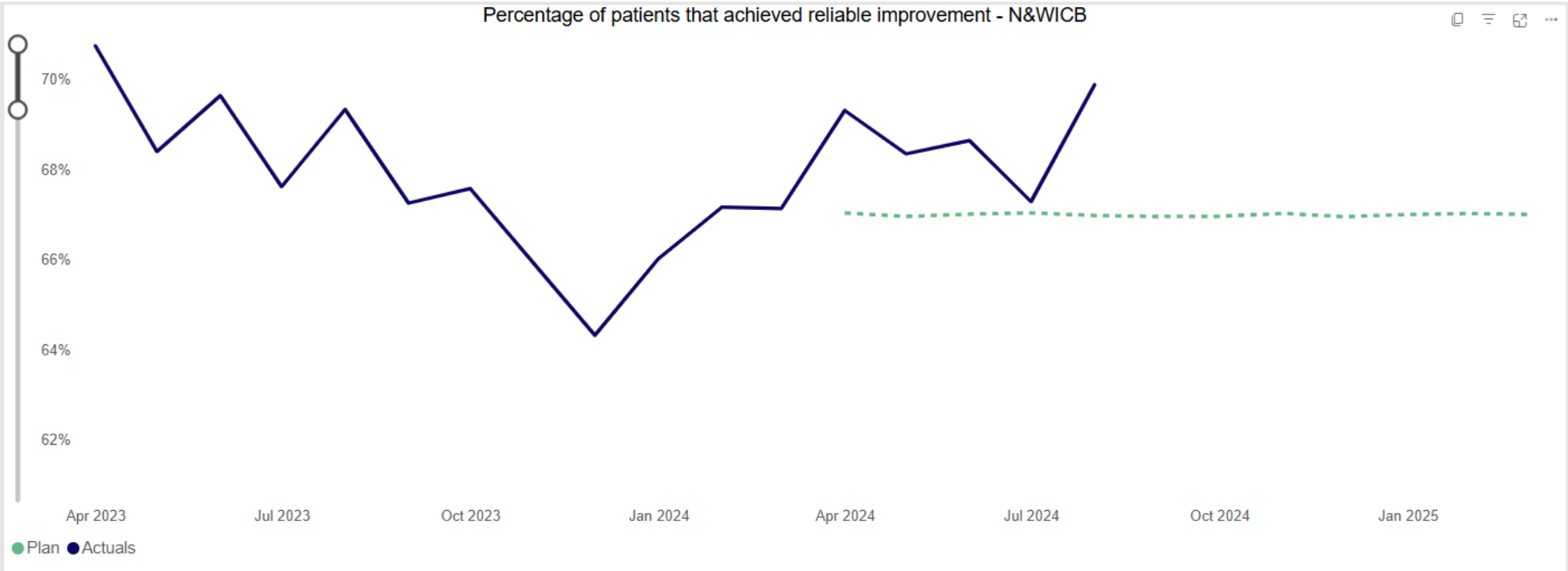
Link back to overview of underachieving metrics slide



Trust	Actuals Trend	Latest Month	Actuals	Plan	Latest Gap To Plan	YTD Value	YTD Plan	YTD Gap To Plan	End FY Plan	Variance Trend
N&WICB		Aug 24	69.9%	67.0%	-	68.6%	67.0%	-	67.0%	

Davey Heidi 21/11/2024 10:42

Description of the metric

A patient shows reliable improvement when there is a significant improvement in their condition following a course of treatment (2 or more contacts with the service). This improvement is measured using a scoring tool.
By March 2025, the number of people who achieve a reliable improvement should be at least 67% of those patients who have had a course of treatment

Description of performance

The service is currently meeting target

Is performance meeting national KPI?	Yes	If no above, is performance meeting recovery trajectory?	N/A	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
N/A	N/A	N/A	N/A	N/A

PMO
Project Management across Norfolk and Waveney

National KPI: Increase the number of people accessing children and young people services (345,000 additional CYP aged 0-25 compared to 2019)

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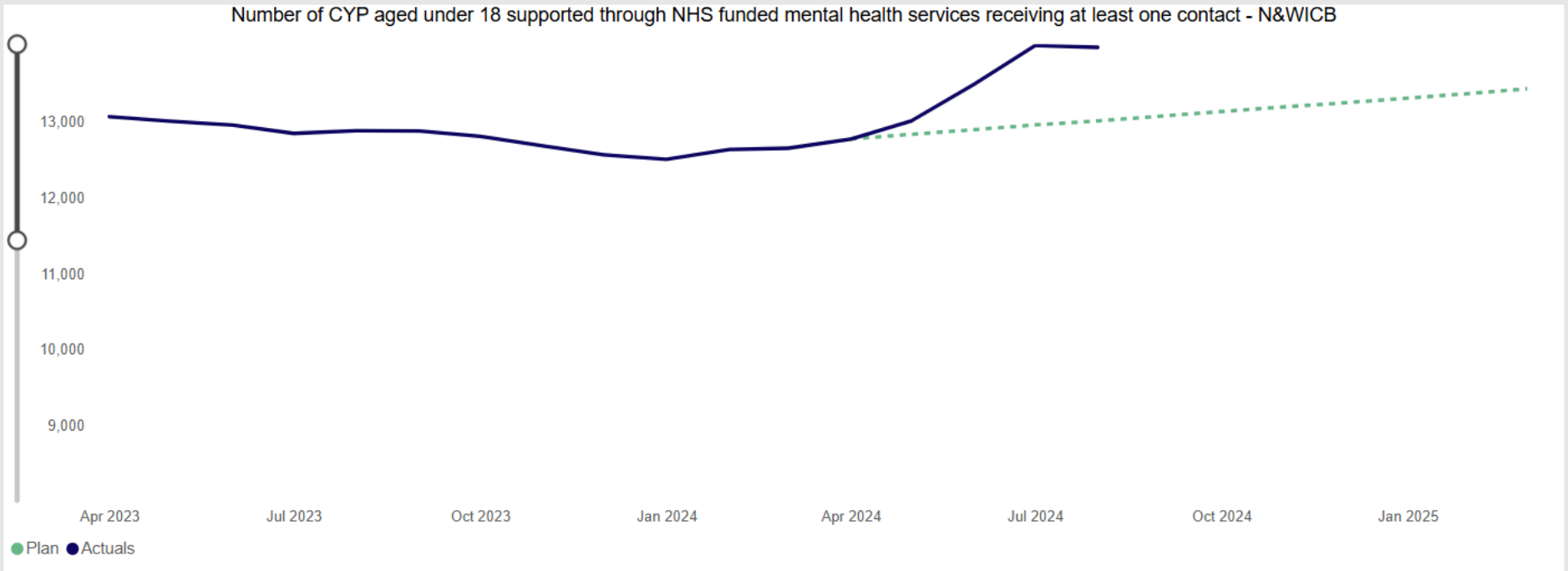
Link back to overview of underachieving metrics slide



Trust	Actuals Trend	Latest Month	Actuals	Plan	Latest Gap To Plan	YTD Value	YTD Plan	YTD Gap To Plan	End FY Plan	Variance Trend
N&WICB		Aug 24	13,970	13,004	-	-	-	-	13,426	

Davey Brindi 21/11/2024 10:42

Description of the metric

(345,000 is a national ambition)

In Norfolk and Waveney, the annual target for mental health access currently sits at 11,609 (see green dotted line to left)

Description of performance

August 2024 data shows continual over achievement of target with 13,970 CYP accessing mental health support, above a target of 13,004, during the rolling year.

Is performance meeting national KPI?	Yes	If no above, is performance meeting recovery trajectory?	NA	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
NA	NA	NA	NA	NA

PMO
Project Management across Norfolk and Waveney

People with a Learning Disability and Autistic people – summary

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Metric Description	Target	Actual	Regularity of reporting	Reporting period	Date report updated	Board with assurance oversight	Risk to escalate to Commissioning and Performance Committee?	Is there a related Board Assurance Framework risk? (provide reference)
Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025	75%	27.1%	Monthly	Sept '24	8/11/24	Learning Disabilities and Autism Programme Board	no	
Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12-15 under 18s for every 1 million population	23	34	Monthly	October '24	9.10.24		no	

Local Metrics as indicated by exception

Davey,Heidi
21/11/2024 13:10:42

Green or red shading is used to identify where current delivery is on (green) or off (red) the plan or trajectory.

PMO
Project Management across Norfolk and Waveney

National KPI: Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025

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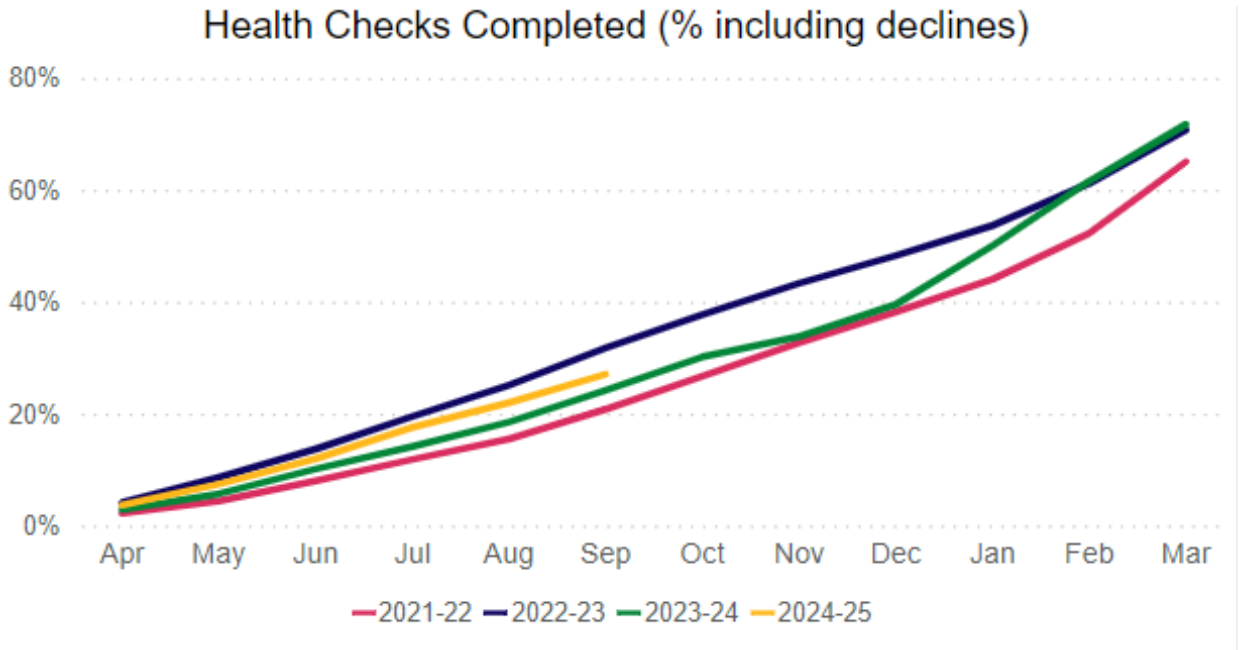
Link back to overview of underachieving metrics slide



As of the end of September 2024, 2,038 Learning Disabilities Health Checks have been delivered.

Description of the metric

All GP Practices retain a register of their patients with a learning disability (aged 14 years plus). By March 2025, 75% of patients on this register should have had a full annual physical health check.

Description of performance

This is year to date reporting, so delivery towards the full year ambition must be viewed. At September, delivery is 27.1% with indications that the full-year objective is on plan.

Is performance meeting national KPI?	N/A	If no above, is performance meeting recovery trajectory?	N/A	Delivery to September indicates annual target will be met.

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
There is variation in activity across practices and PCNs, with the majority, particularly in the North, delivering the bulk of activity in Q4. This variation reflects differences in arrangements and timings for delivering checks by practices and primary care networks	The Health Improvement for Learning Disabilities (LD) Team continue to provide support & training to practices & support patients in accessing their checks. Regular communication with practices and systems partners to share information and data.	Learning Disability & Autism Programme Board, Primary Care Commissioning Committee	Ongoing support as described as well as promotion & engagement events to boost take up (particularly focusing on 14–17-year-olds).	- Limited resource in the Health Improvement for LD Team (2 team members for 105 practices). - Practice resilience & capacity

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Project Management across Norfolk and Waveney

National KPI: Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12-15 under 18s for every 1 million population

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Link back to overview of underachieving metrics slide

ICB Commissioned Inpatients	2024								
	Q1			Q2			Q3		
Source Data	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Plan	12	12	12	12	12	12	12	12	12
Actual	12	13	14	13	14	14	20		
Performance	0	1	2	1	2	2	8		
Admissions	1	2	1	1	1	0	6		
Discharges	4	1	0	2	0	0	0		
Cumulative Admissions	1	3	4	5	6	6	12		
Cumulative Discharges	4	5	5	7	7	7	7		

Provider Collabotive Commissioned Secure Adult Inpatients	2024								
	Q1			Q2			Q3		
Source Data	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Plan	11	11	11	11	11	11	11	11	11
Actual	17	17	17	16	14	14	14		
Performance	6	6	6	5	3	3	3		
Admissions	0	0	0	0	0	1	0		
Discharges	0	0	0	1	2	1	0		
Cumulative Admissions	0	0	0	0	0	1	1		
Cumulative Discharges	0	0	0	1	3	1	4		

ICB Current Status

Provider Collaborative Current Status

Description of the metric

Reducing the reliance on inpatient settings and enabling people with a learning disability and autistic people to live as independently as possible within their local community.
The target is 23 or below, split to:

- ICB inpatient trajectory: 12
- Provider Collaborative inpatient trajectory: 11

Description of performance

Current position is 34, split to:

- ICB inpatient total: 20.
- Provider Collaborative inpatient total: 14

The Provider Collaborative is responsible for the budget and commissioning of specialised mental health, learning disability and autism services for children and young people inpatient services, adult secure services and adult eating disorder services. It is NHS led and includes providers from a range of backgrounds including the NHS trusts, independent sector providers and voluntary sector. They report directly to NHS England.

Is performance meeting national KPI?	no	If no above, is performance meeting recovery trajectory?	no	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
There are insufficient experienced care providers and suitable single occupancy accommodation and social registered landlords within our area.	Process is in hand for the purchase and adaptation of bespoke accommodation and identification of new care providers	Norfolk County Council lead on identification of property and care providers in the community	12 to 18 months	Housing market conditions and identification of social registered landlords. Identifying care providers with required experience to support complex individuals

Prevention and Health Inequalities – summary

Metric Description	Target	Actual	Regularity of reporting	Reporting period	Date report updated	Board with assurance oversight	Risk to escalate to Commissioning and Performance Committee?	Is there a related Board Assurance Framework risk? (provide reference)
Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people	Maturity index	Foundation	TBC	Sept 2024	9.11.24	Health Inequalities Steering Group	no	BAF01
Increase the % of patients with hypertension treated according to NICE guidance to 80% by March 2025	80% by 31.3.25	69%	Quarterly	June 24	9.11.24	Cardio-Vascular Disease and Respiratory Board	no	BAF01
Increase the percentage of patients aged 25-84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 2025	65% by 31.3.25	59%	Quarterly	June 24	9.11.24		no	BAF01
Increase vaccination uptake for children and young people year on year towards WHO recommended levels	95%	89% - 96%	Quarterly	Q4 23/24	9.10.24	Norfolk and Waveney Health Protection Assurance Board (Public Health)	no	
Local Metrics as indicated by exception								

Green or red shading is used to identify where current delivery is on (green) or off (red) the plan or trajectory.

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Project Management across Norfolk and Waveney

National KPI: Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people (CYP)

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Link back to overview of underachieving metrics slide

A national maturity matrix for the system which identifies the system position in addressing health inequalities and delivery of Core20PLUS5 for adults has been submitted to NHSE and is shown below – a Children's and Young People (CYP) equivalent is currently being developed. The position is as follow for September 2024:

Priority 1: Restoring services.	Priority 2: Digital exclusion.	Priority 3: Complete datasets.	Priority 4: preventative programmes.	Priority 5: Leadership.	Funding.	HIID and data.	Anchors and inclusion health.
→	→	→	→	→	→	→	→

Maternity.	Severe mental illness (SMI).	Chronic respiratory disease (COPD).	Early Cancer Diagnosis.	Hypertension case finding.	Smoking cessation.	Covid and flu vaccine uptake.	LD health checks.
→	→	→	→	→	→	→	→

Description of the metric

Measures will monitor the difference in access, experience and outcomes for those identified nationally and locally to have an inequality in these areas, to focus actions to reduce differences.

RAG Rating
Mastering (Implemented)
Developing (developing – implementation)
Foundation (concept – development)
Preliminary (Data review – concept)
Work not yet started
No update provided

Is performance meeting national KPI?	no	If no above, is performance meeting recovery trajectory?	no	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
Full dataset not yet defined	Dashboard in development, aligning to national guidance.	Population Health and Inequalities Board	Q3 24/25	
CYP ambitions not yet included	Active work to assess system maturity and include CYP in dashboard.	Population Health and Inequalities Board	Q3 24/25	

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Project Management across Norfolk and Waveney

National KPI: Increase the % of patients with hypertension treated according to NICE guidance to 80% by March 2025

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Link back to overview of underachieving metrics slide

Data for period: 12 months to June 2024

CVDP007HYP: Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months. Proportion %

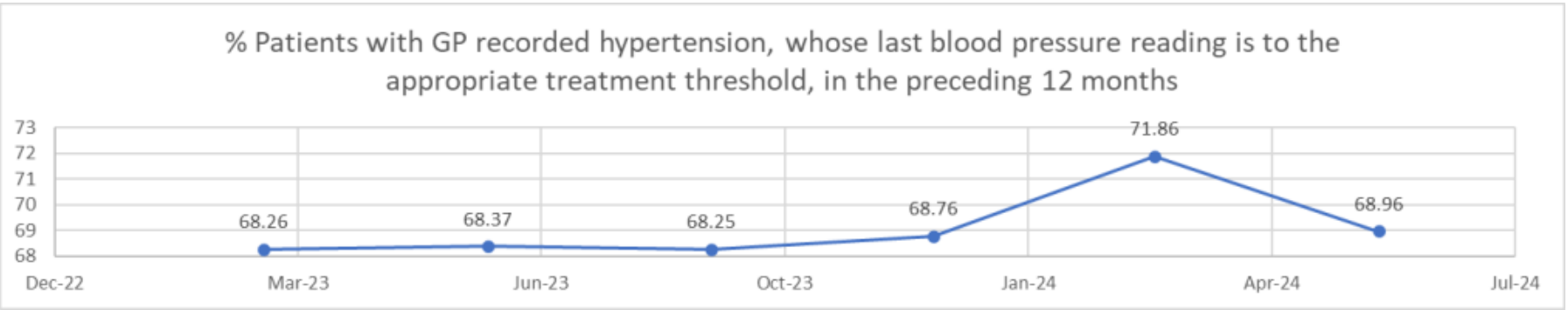
Explore Data | Data Extract | Metadata

Sex: Persons
Persons

71.86% ↓
Area value

70.87%
System median

Min: 61.65%
Max: 75.74%



Description of the metric

Hypertension is also known as high blood pressure. Patients with hypertension should receive care in line with the National Institute for Health and Care Excellence (NICE) guidelines.
By March 2025, 80% of patients known to have hypertension should be treated to their age-appropriate blood pressure target.

Description of performance

N&W is the 2nd highest regionally, and for Hypertension Control

Is performance meeting national KPI?	no	If no above, is performance meeting recovery trajectory?	no	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
- Sustained and significant primary care pressure - Ageing population - Scale of challenge – reaching target requires optimising *tens of thousands* of patients.	- Cardiovascular Disease (CVD) Prevention Project 24/25 in final stages of design for Q3 implementation	- CVD-R Clinical Programme Board	- Ongoing, but aim to reach 80% in 25/26 FY - Recognition from EoE Cardiac Network this is a stretching target.	- Local Medical Council not supportive of proposed corrective actions. Discussion being held with senior levels on progress.

National KPI: Increase the percentage of patients aged 25-84 years with a Cardiovascular Disease (CVD) risk score greater than 20% on lipid lowering therapies to 65% by March 2025

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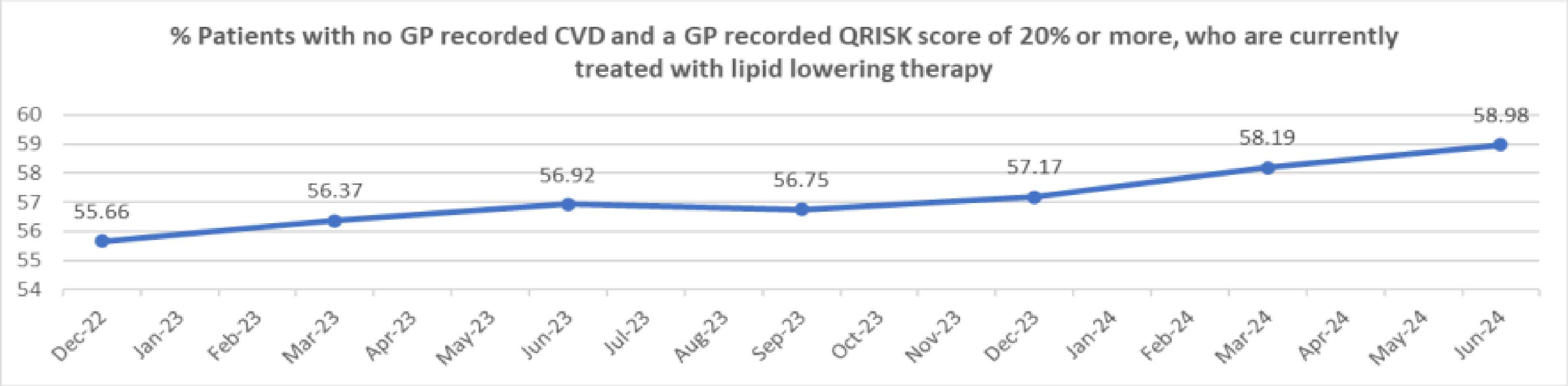
Link back to overview of underachieving metrics slide

Data for period: 12 months to June 2024

CVDP003CHOL: Patients with no GP recorded CVD and a GP recorded QRISK score of 20% or more, who are currently treated with lipid lowering therapy Proportion %

Explore Data | Data Extract | Metadata

Sex: **Persons** (Persons)	**58.98%** ↑ ◆ Area value	**62.14%** ● System median	Min: 53.85%	Max: 71.17%



Description of the metric

Proactively identifying patients who are at risk of Cardiovascular Disease and optimising their treatment through appropriate use of lipid lowering therapy (e.g. Statins) contributes to improving health outcomes for patients.

By March 2025, 65% of patients with a coronary risk score over 20% should be on lipid lowering therapy

Description of performance

Attainment in the 12 months to end of June 2024: 58.98%.

Is performance meeting national KPI?	no	If no above, is performance meeting recovery trajectory?	no	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
- Sustained and significant primary care pressure - Ageing population - Scale of challenge – *tens of thousands* of eligible patients to reach and prescribe	- Cardiovascular Disease (CVD) Prevention Project 24/25 in final stages of design for Q3 implementation	- CVD-R Clinical Programme Board	- Ongoing, aim to reach 65% in FY 25/26	- LMC not supportive of proposed corrective actions. Discussion being held with senior levels on progress.

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Project Management across Norfolk and Waveney

National KPI: Increase vaccination uptake for children and young people year on year towards WHO recommended levels

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		23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Difference
12 months	DTaP / IPV / Hib	94.8%	95.2%	94.7%	93.4%	↓
	Meningitis B	94.4%	95.2%	94.5%	93.2%	↓
	Rotavirus	91.3%	93.3%	91.4%	91.7%	↑
	Pneumococcal	96.6%	96.9%	95.8%	95.3%	↓
24 months	DTaP / IPV / Hib	96.2%	95.2%	95.6%	96.0%	↓
	Hib / Men C booster	94.7%	93.6%	93.4%	94.4%	↓
	Men B booster	93.8%	92.8%	91.6%	92.0%	↓
	MMR dose 1	94.2%	93.8%	93.1%	94.1%	↓
	Pneumococcal booster	94.3%	93.2%	92.5%	93.3%	↓
5 years	DTaP/IPV/Hib	96.9%	96.2%	96.2%	95.8%	↓
	MMR dose 1	96.3%	95.3%	95.8%	95.6%	↓
	MMR dose 2	91.9%	89.7%	91.2%	90.4%	↓
	DTaP/IPV booster	91.1%	88.1%	89.8%	89.1%	↓
	Hib / Men C booster	94.1%	92.3%	93.6%	92.3%	↓

Link back to overview of underachieving metrics slide

Description of the metric

The World Health Organisation requires childhood immunisations have a target delivery of 95%.

Delivery of these are with NHSE Regional team.

Q1 24/25 data is not yet available.

Description of performance

Performance varies between vaccination.

Is performance meeting national KPI?	no	If no above, is performance meeting recovery trajectory?	no	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
Practice level variation	Child Health Information Centre sending practice level dashboards. Focus on Did Not Attend and time between immunisations.	Child Health Information Centre / NHSE Norfolk and Waveney Health Protection Assurance Board	March 2025	Primary Care capacity

Primary and Community Services – summary

Metric Description	Target	Actual	Regularity of reporting	Reporting period	Date report updated	Board with assurance oversight	Risk to escalate to Commissioning and Performance Committee?	Is there a related Board Assurance Framework risk? (provide reference)
Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are accessed the same or next day according to clinical need	Improve	81.2%	Monthly	Sept '24	8/11/24	Primary Care Commissioning Committee	No	
Improve community services waiting times, with a focus on reducing long waits	Improve	860	Monthly	Aug '24	14/11/24	Various dependent on service	No	
Increase dental activity by implementing the plan to recover and reform NHS dentistry, improving units of dental activity (UDAs) towards pre-pandemic levels*	Increase	Decrease	Quarterly	Aug '24	12.9.24			
Local Metrics as indicated by exception								

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Green or red shading is used to identify where current delivery is on (green) or off (red) the plan or trajectory.

* Data to follow in future reporting.

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National KPI: Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are accessed the same or next day according to clinical need

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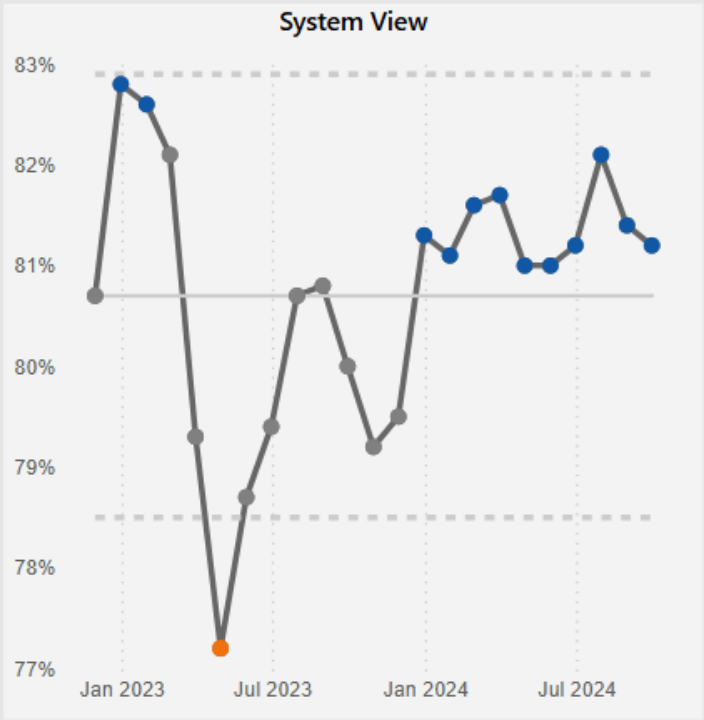
Link back to overview of underachieving metrics slide

Sep-24
81.2%
Variance
Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.
Target
N/A
Assurance
Assurance cannot be given as there is no target.



Description of the metric

Everyone should be able to get a routine appointment with their GP Practice within 2 weeks and an urgent appointment on the same or next day.

Description of performance

In August 2024, the average for East of England is 86% and Norfolk and Waveney is 81.4%.

Note – a data quality / discrepancy with the Integrated Performance Report.

Is performance meeting national KPI?	**no**	**If no above, is performance meeting recovery trajectory?**	**no**	(if no to either/both, complete below)

Root cause(s) identified:	**Corrective Action(s):**	**Action owner(s):**	**Delivery date for action(s):**	**Risk to delivery of corrective action(s):**
Working to establish an accurate data set which will show 2-week appointment progress.	Development of ICS dashboard, with interim use of national and regional benchmarking to demonstrate our baseline.	Primary Care Commissioning Committee	TBC	Data consistency.

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National KPI: Improve community services waiting times, with a focus on reducing long waits

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Link back to overview of underachieving metrics slide

There are two main providers of community services in Norfolk & Waveney. In general Norfolk Community Health and & Care cover Central and West Norfolk, and East Coast Community Health cover Great Yarmouth & Waveney.

The two organisations provide data to the ICB in different formats and a standard community waiting time dashboard is in development by Norfolk & Waveney ICB Business Intelligence (BI) team. In the interim, performance is monitored through provider reports and ad-hoc reporting produced by the ICB BI team. There have been some data quality issues using this method, where commissioner and provider reports do not align, and this is being investigated by BI. Providers have also made us aware of some internal data quality issues they are investigating, for example on Musculoskeletal waiting times.

Different services have different waiting time standards and levels of performance. Overall, the services are meeting requirements, but there are a few such as wheelchairs or Children and Young People neurodevelopmental which have long wait times. Where this is identified, joint commissioner and provider working groups are taking place to plan recovery.

Description of the metric
Number of patients waiting over 52 weeks.

Description of performance
In August 2024 there were 860 patients waiting over 52 weeks, and we are working to reduce this.

Is performance meeting national KPI?	no	If no above, is performance meeting recovery trajectory?	no	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
Data consistency and quality. Demand and capacity.	ICB working with providers to address.	Commissioing and Performance Committee	31/3/2025.	Capacity across teams.

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National KPI: Increase dental activity by implementing the plan to recover and reform NHS dentistry, improving units of dental activity (UDAs) towards pre-pandemic levels

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Link back to overview of underachieving metrics slide

The ICB's primary aim is to improve access for new patients.

- Overall activity delivered as of 31 Oct 2024 is 41.60%. Forecast is that the ambition to restore activity to 2019 activity levels will not be met by year end.
- During October, there were approximately 9000 new patients seen compared to 5000 in September 2024. New patient data to end October 2024 is therefore approximately 39,000, an increase of 13,000 since end August 2024.
- Action plans for providers forecast to underachieve this year have been released to the ICB to assess and to agree contract renegotiations releasing funds for reinvestment in 2025/2026.

Description of the metric
To recover and reform dentistry, making dental services faster, simpler and fairer. Increase local dental appointments back to levels seen in 2019. This should be achieved by March 2029

Description of performance
New patient data is estimated pending confirmation from NHSBSA

Is performance meeting national KPI?	no	If no above, is performance meeting recovery trajectory?	no	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
Availability of dental workforce. Loss of dental contracts. Lack of resilience & stability. Use of flexible commissioning.	Long Term Dental Plan Primary Care Workforce Strategy & Plan for 2024/25 Access Improvement Initiative. Provider action plans where they are failing individual targets.	Primary Care Commissioning Committee	5-year dental plan to Mar 2029 14/11/24	

Urgent and Emergency Care – summary

Metric Description	Target	Actual	Regularity of reporting	Reporting period	Date report updated	Board with assurance oversight	Risk to escalate to Commissioning and Performance Committee?	Is there a related Board Assurance Framework risk? (provide reference)
Improve A&E Waiting Times, compared to 2023/24, with a minimum of 78% of Patients seen within 4 hours in March 2025	80%	73.1%	Monthly	Sept 2024	8/11/24	UEC Board	No	BAF06
Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25	30min	44.8min	Monthly	Sept 2024	8/11/24	UEC Board	No	BAF06
Local Metrics as indicated by exception								

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Green or red shading is used to identify where current delivery is on (green) or off (red) the plan or trajectory.

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National KPI: Improve A&E Waiting Times, compared to 2023/24, with a minimum of 78% of Patients seen within 4 hours in March 2025

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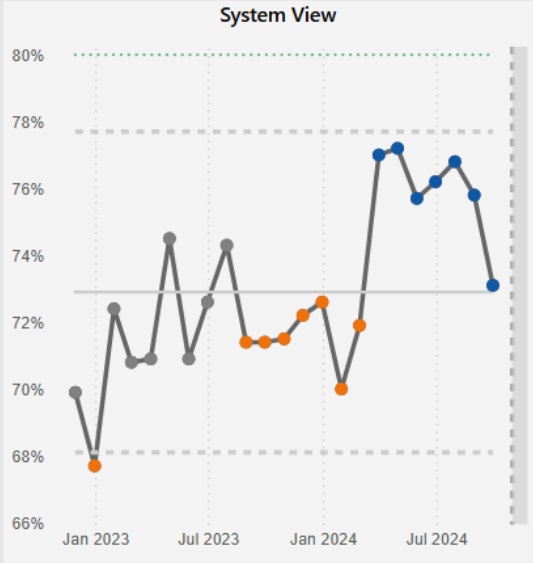
Link back to overview of underachieving metrics slide

Sep-24
73.1%

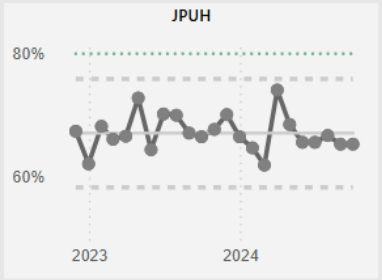
Variance
Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.

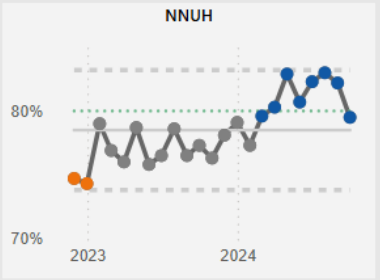
Target
80.0%

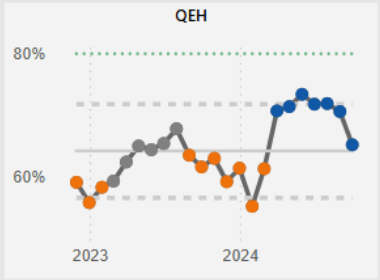
Assurance
This process is not capable and will FAIL the target without process redesign.



MetricName	View By Level	Latest Date	Result	Variance	Assurance	Target	Mean	LCL	UCL
Total A&E 4hr Performance	System View	Sep-24	73.1%			80.0%	72.9%	68.1%	77.7%
Total A&E 4hr Performance	JPUH	Sep-24	65.3%			80.0%	67.1%	58.3%	75.9%
Total A&E 4hr Performance	NNUH	Sep-24	79.5%			80.0%	78.5%	73.8%	83.2%
Total A&E 4hr Performance	QEH	Sep-24	65.2%			80.0%	64.2%	56.6%	71.8%







Disclaimer: The axis on the charts may differ between organisations.

Description of the metric

The percentage of all A&E attendances that are admitted, transferred or discharged within 4 hours of attending Accident & Emergency (A&E). This includes all department types.

Description of performance

System performance: 73.1%

JPUH performance: 65.3%
NNUH performance: 79.5%
QEH performance: 65.2%

Is performance meeting national KPI?	no	If no above, is performance meeting recovery trajectory?	no	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
Front Door model is sub-optimal as Norfolk & Waveney has no Urgent Treatment Centre provision. Exit block from A&E impedes flow and is due to high bed occupancy and is further exacerbated by long length of stay due to sub optimal discharge processes and in some areas (health & social care) lack of onward capacity.	Urgent and Emergency Care (UEC) transformation plan focussing on "right place, right care whenever the need arises"	Urgent and Emergency Care Programme Board	Current plan in place until March 2025, which will be refreshed in Q4 following review of impact	Insufficient capacity in the community to deliver urgent care services at sufficient scale that would achieve "right care right place, whenever the need arises" which would prevent avoidable conveyance / walk-ins to A&E. No Urgent Treatment Centre in place as part of our strategic approach to the front door of our acute hospitals

National KPI: Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25

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Link back to overview of underachieving metrics slide

Sep-24

44.8

Variance

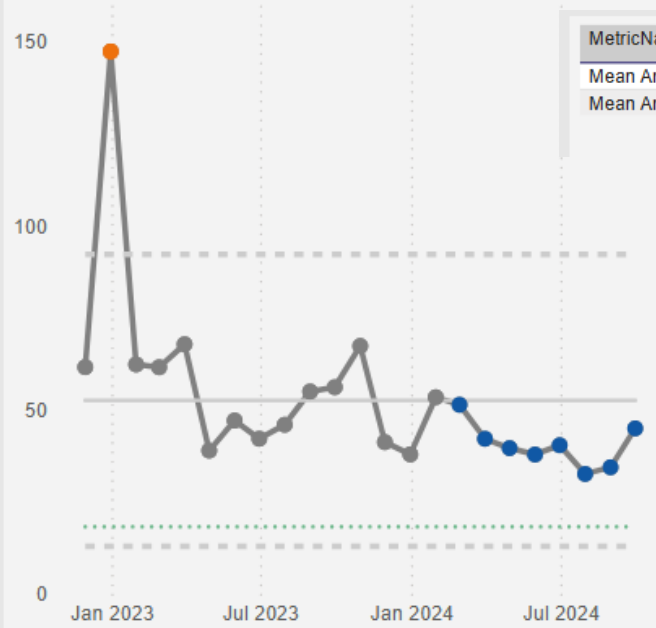
Special cause variation of an IMPROVING nature where the measure is significantly LOWER.

Target

18.0

Assurance

This process will not consistently HIT OR MISS the target as the target lies between process limits.



MetricName	View By Level	Latest Date	Result	Variance	Assurance	Target
Mean Ambulance Response Times (Mins) - C2	System View	Sep-24	44.8			18.0
Mean Ambulance Response Times (Mins) - C2	EEAST	Sep-24	44.8			18.0

Description of the metric

Respond to category 2 calls in an average time of 18 minutes.
Interim recovery target: 30 minutes.

Description of performance

Ambulance C2 response times for N&W system 44.8 minutes.

Is performance meeting national KPI?	no	If no above, is performance meeting recovery trajectory?	no	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
• Long ambulance handover delays at hospital • Long lengths of time on scene • Insufficient access and capacity at our acute hospitals for direct access pathways such as SDEC that would allow crews to appropriately bypass Accident and Emergency.	Urgent and Emergency Care (UEC) Recovery Plan focussing on 10 High Impact Actions linked to the East of England Ambulance Service NHS Trust Operational Performance Improvement Plan. UEC Transformation Plan "right care, right place, whenever the need arises"	Urgent and Emergency Care Programme Board	Current plan in place until March 2025, which will be refreshed in Q4 following review of impact.	Insufficient capacity in the community to deliver urgent care services at sufficient scale that would achieve "right care right place, whenever the need arises" which would prevent avoidable dispatch and conveyance which in turn will release EEAST capacity. Insufficient direct access pathways to specialty / capacity due to "bedding" to speed up offload by avoiding A&E

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Workforce, Use of Resources and Quality & Safety – summary

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Metric Description	Target	Actual	Regularity of reporting	Reporting period	Date report updated	Board with assurance oversight	Risk to escalate to Commissioning and Performance Committee?	Is there a related Board Assurance Framework risk? (provide reference)
Improve the working lives of all staff and increase staff retention and attendance through systematic implementation of all elements of People Promise retention interventions	<0	+0.5%	TBC	Aug '24	8.11.24	People Board	no	
Improve the working lives of doctors in training by increasing choice and flexibility in rotas, and reducing duplicative inductions and payroll errors	TBC	-	TBC	N/A	8/11/24	People Board	no	
Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the NHS Long Term Workforce Plan	TBC	-	TBC	N/A	8/11/24	People Board	no	
Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25	£44.1m	£45.8m (forecast FY)	Monthly	M6 (Sept)	10.11.24	People Board	no	
Deliver a balanced net system financial position for 2024/25	£0	+£26.2m	Monthly	M4 (Sept)	11.11.24	Finance Committee	no	
Implement the Patient Safety Incident Response Framework (PSIRF)	Implement	In place	Bi-annual	August '24	8/11/24	Quality and Safety Committee	no	
Local Metrics as indicated by exception								

Green or red shading is used to identify where current delivery is on (green) or off (red) the plan or trajectory.

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National KPI: Improve the working lives of all staff and increase staff retention and attendance through systematic implementation of all elements of People Promise retention interventions

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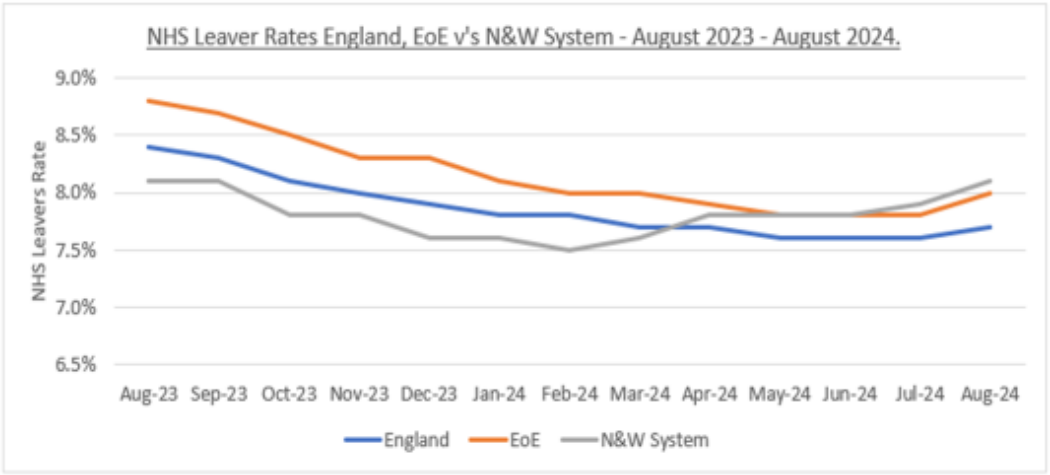
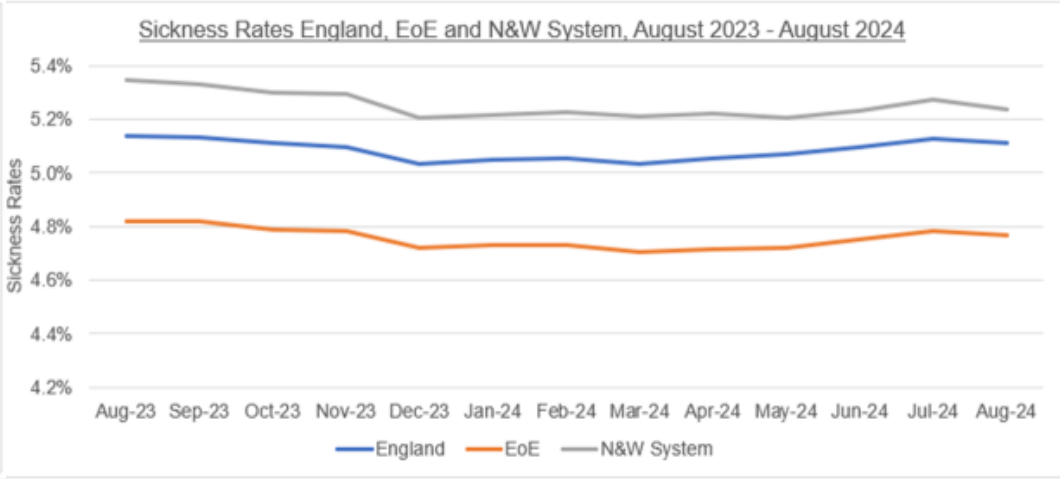
Link back to overview of underachieving metrics slide





Description of the metric

Retention is the ability of an organisation to retain quality employees. NHS leavers- as opposed to staff moving between trusts - are the primary measure of retention.

Attendance refers to employees showing up for work.

The 0.5% increase in leavers year to date is driven by Admin & Clerical staff (+1.5%), with AHPs (+0.5%) the only other staff group that has increased this year. The increase is largest in the community providers (+2%) and the Integrated Care Board (+5%) and reflects major restructuring programmes there - the majority of Integrated Care Board staff are Admin & Clerical.

Across the system, sickness rates have been consistent at 5.3%. However, 12-month sickness rates at ECCH, JPUH and QEKL are 5.9% or above. At 4.6%, absence at NNUH is significantly below the system rate. As covid vaccinations are no longer funded, there is a risk of absence increasing because of infection. NNUH have committed to fund covid vaccinations for their staff..

Description of performance

Leavers has increased slightly.
Sickness rates are above averages

Is performance meeting national KPI?	yes	If no above, is performance meeting recovery trajectory?	n/a	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
Culture. Employment flexibility & higher sensitivity to broader socioeconomic climate of "Unregistered" staff. A larger than normal proportion of leavers are "unvoluntary" due to the restructuring programme.	With the increased financial pressures on the NHS locally, planned restructuring is likely to increase leaver rates over the next 12 months The system's Retention Plan is currently being updated.	People Board	March '25	Admin & Clerical staff are increasingly likely to leave in response to reduced budgets or as a consequence of planned restructuring.

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National KPI: Improve the working lives of doctors in training by increasing choice and flexibility in rotas, and reducing duplicative inductions and payroll errors

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Link back to overview of underachieving metrics slide

The system has approved the Primary Care Workforce Strategy and Delivery Plan (at Primary Care Commissioning Committee 10/9/24) and an ICB Readiness Plan has been submitted to NHSE for Clinical Workforce Expansion. These will inform next steps in measuring achievement against these objectives. These strategies and delivery plans have been aligned to the NHSE Long Term Workforce Plan.

Further work is underway to disaggregate components of the workforce objectives and determine the reporting mechanisms available against these.

Description of the metric
This will be determined from the recently published National Payroll Improvement Guidance.

Description of performance
Nil available at this time.

Is performance meeting national KPI?	no	If no above, is performance meeting recovery trajectory?	no	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
Health and Wellbeing – Primary Care GP Contract Changes – Collective Action	Health and Wellbeing Fellow in place to support development of programmes and review outcome of the NHS Primary Care Staff Survey. Continue to monitor GP Collective Action outcome of national GP contract changes	Primary Care Commissioning Committee and People Board	March 2025	Nationally lead decision on GP Contract

National KPI: Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the NHS Long Term Workforce Plan

Link back to overview of underachieving metrics slide

In response to the Long-Term Workforce Plan aspiration, we aim to provide training for clinical staff through apprenticeship routes at the levels of:

- 16% by 2028/29
- 22% of all by 2031/32

November 2024:
A digital placement system is in development which will allow baselining and tracking, alongside scoping with Trusts to establish current position. New approaches to learning opportunities for students is concurrently being explored.

Description of the metric
In line with the Clinical Learning Strategy across East of England we aim to grow capability and quality of learning across the region and ensure we train enough staff in the right roles and widen access opportunities for people form all backgrounds to join the NHS.

Description of performance
There is currently no route for measurement.

Is performance meeting national KPI?	no	If no above, is performance meeting recovery trajectory?	no	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
Current position on both is not held centrally. An increased need for more clinical placements and apprenticeships.	Scoping exercise for both placement capacity and current apprenticeship volumes Digital placement system to identify all areas. Increased supervisors and models to support learners and supervisors. Roll out of the Collaborative Learning in Practice model. Work with Apollo and Centre of Excellence, Academy to increase apprenticeship pipeline. Increase opportunities in new areas - Social Care and Voluntary, Community, Faith and Social Enterprise.	People Board	Q1 25/26	Expense of training route., financial pressures and current workforce pressures

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National KPI: Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25

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Staff Costs £m	Plan			Actual			Variance		
M6 YTD	Substantive & Bank	Agency	Total	Substantive & Bank	Agency	Total	Substantive & Bank	Agency	Total
Medical & Dental	158.18	8.72	166.89	172.46	9.34	181.80	(14.28)	(0.62)	(14.91)
Non-Medical Clinical	376.53	13.33	389.85	377.00	13.34	390.35	(0.48)	(0.02)	(0.49)
Non-Medical Non-Clinical	110.88	0.92	111.80	121.20	0.99	122.19	(10.32)	(0.07)	(10.39)
Total before Capitalised Costs	**645.59**	**22.96**	**668.55**	**670.67**	**23.67**	**694.34**	**(25.08)**	**(0.71)**	**(25.79)**
Capitalised Staff Costs	1.54	0.00	1.54	3.35	0.31	3.66	(1.81)	(0.31)	(2.12)
N&W System Total - Providers	**647.13**	**22.96**	**670.09**	**674.02**	**23.98**	**698.00**	**(26.89)**	**(1.01)**	**(27.91)**

Staff Costs £m	Plan			Actual			Variance		
Forecast (@ Month 6)	Substantive & Bank	Agency	Total	Substantive & Bank	Agency	Total	Substantive & Bank	Agency	Total
Medical & Dental	315.74	16.37	332.11	319.71	18.76	338.47	(3.97)	(2.39)	(6.36)
Non-Medical Clinical	761.62	23.20	784.82	752.42	25.12	777.54	9.20	(1.92)	7.28
Non-Medical Non-Clinical	218.61	1.58	220.19	226.22	1.99	228.21	(7.61)	(0.40)	(8.02)
Total before Capitalised Costs	**1,295.97**	**41.15**	**1,337.12**	**1,298.36**	**45.86**	**1,344.22**	**(2.39)**	**(4.71)**	**(7.10)**
Capitalised Staff Costs	3.08	(0.00)	3.08	4.90	0.33	5.23	(1.81)	(0.33)	(2.14)
N&W System Total - Providers	**1,299.05**	**41.15**	**1,340.20**	**1,303.25**	**46.19**	**1,349.45**	**(4.20)**	**(5.04)**	**(9.24)**

The system agency expenditure M6 Year To Date (YTD) excluding Capitalised Staff Costs (CSC) was £23.7m, £0.7m above plan. £0.6m of the variance is within Medical & Dental mainly due to the overspend on consultants at JPUH.

Forecast is a £4.7m overspend against plan (exc. CSC), mainly due to the forecast total agency overspend at JPUH of £2.9m (consultants £1.7m, registered nursing, midwifery & health visiting staff £1.0m) and QEH of £1.8m (trainee grades £0.9m, other scientific, therapeutic and technical staff £0.7m, infrastructure support £0.5m).

The forecast spend of £45.86m is £4.71m above the agency cap.

Link back to overview of underachieving metrics slide

Description of the metric

The 2024/25 agency cap for N&W is £44.15m, excluding Capitalised Staff Costs.
The intention is to reduce aggregate agency spending for all trusts to 3.2% as a proportion of the total NHS pay bill in 2024/25. The 2024/25 cap is calculated based on reported spending in 2023/24 (Forecast Out-Turn at month 9).

Description of performance

Plan is set to: £41.2m
Current FOT is: £45.9m

Monitoring is at Trust level, with differing achievement and corrective actions.

Is performance meeting national KPI?	No	If no above, is performance meeting recovery trajectory?	No	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
Delays in commencing some temporary pay efficiency scheme. Special Observation needs of patients	Implemented and plan to balance over months 7-12. Vacancy controls.	Trust owned	March 2025 with monthly monitoring at finance	Agency spend reducing but this brings pressures to bank staff use.

National KPI: Deliver a balanced net system financial position for 2024/25

Link back to overview of underachieving metrics slide

The position M6 Year To Date (YTD) is a £32.6m deficit, which is £26.2m adverse against plan. At M5 the system was £17.6m off plan. The forecast outturn (FOT) for the system is break even per the plan, although there is a reported £102m net risk to this position which needs careful mitigation if the plan is to be achieved.

The YTD QEH variance of £12.8m is mainly due to slippage within Cost Improvement Programme (CIP) delivery, bank spend and below plan activity levels. JPUH variance of £2.5m is mainly due to under delivery of CIP and the impact of industrial action. NNUH variance of £9.5m is mainly due to overspends on pay and under delivery of CIP.

Revenue surplus/(deficit) £m	Month 6 YTD			Forecast Outturn		
Organisation	Plan	Actual	Variance	Plan	Actual	Variance
JPUH	2.6	0.1	(2.5)	(1.1)	(1.1)	0.0
NNUH	(3.5)	(13.1)	(9.5)	0.0	0.0	0.0
QEH	(6.1)	(18.9)	(12.8)	(0.8)	(0.8)	0.0
NSFT	0.6	(0.9)	(1.5)	0.0	0.0	0.0
NCH&C	(0.0)	(0.0)	0.0	1.5	1.5	0.0
Provider Subtotal	**(6.6)**	**(32.8)**	(26.2)	**(0.4)**	**(0.4)**	0.0
ICB	0.2	0.2	0.0	0.4	0.4	0.0
N&W System Total	**(6.4)**	**(32.6)**	(26.2)	**0.0**	**0.0**	0.0

Description of the metric

Deliver a balanced financial position.

Description of performance

The position M6 YTD is a £32.6m deficit, which is £26.2m adverse against plan. The forecast outturn is per plan, although there is a reported £102m net risk to this.

Is performance meeting national KPI?	no	If no above, is performance meeting recovery trajectory?	no	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
Increased staff costs, resulting from sickness / vacancies. Cost Improvement Programme (CIP) slippage. Industrial action.	Workforce plan. Triple Lock process. CIP overview.	Finance Committee		At month 6, the system is forecasting to meet plan at year end. Finance Committee will oversee progress.

National KPI: Implement the Patient Safety Incident Response Framework (PSIRF)

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Link back to overview of underachieving metrics slide

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems for responding to patient safety incidents for the purpose of learning and improving patient safety.

The PSIRF is a contractual requirement under the NHS Standard Contract and as such is mandatory for services provided under that contract, including acute, ambulance, mental health, and community healthcare providers. This includes maternity and all specialised services. Primary care providers may also wish to adopt PSIRF, but it is not a requirement at this stage.

All providers within Norfolk & Waveney Integrated Care System have implemented PSIRF with ICB Quality oversight in place and reporting of learning from adverse incidents to Quality & Safety Committee.

Description of the metric
Implementation of the PSIRF.

Description of performance
PSIRF has been implemented in all required areas.

Is performance meeting national KPI?	no	If no above, is performance meeting recovery trajectory?	no	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):

Norfolk and Waveney
Integrated Care Board

Agenda item: 12

Subject:	**Commissioning & Performance Committee Report**
Presented by:	**Hein van den Wildenberg – Committee Chair**
Prepared by:	**Diane Smith, Head of Collaborative Commissioning and Performance**
Submitted to:	**Norfolk and Waveney Integrated Care Board – Board Meeting**
Date:	**27 November 2024**

Purpose of paper:

To provide the Board with an update on the work of the Commissioning and Performance Committee for the period 19th September – 17th October 2024.

Committee:	Commissioning and Performance Committee
Committee Chair:	Hein van den Wildenberg
Meetings since the previous update on 25th September 2024	Meeting held in private on 19th September 2024 0900 – 1130 via MS Teams. Meeting held in private on 17th of October 2024 0900 – 1200 via MS Teams.
Overall objectives of the committee:	• 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. • To consider and make decisions on clinical policies as recommended by the Clinical Policy Development Group. • To consider and make decisions on recommendations from the medicines optimisation programme board. • To oversee and gain assurance on the operational arrangements that support the commissioning of services. • Oversee the process of any further delegation of commissioning responsibilities from NHS to the ICB.

	• Provide oversight to the Individual Funding Request panel. • 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. • Ensure that innovation, best practice, evidence and evaluation and the impact on health inequalities consistently informs our commissioning decisions. • Approve the application of the Provider Selection Regime process for the procurement of any business cases that it approves under its delegation.
Main purpose of meeting:	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.
BAF and any significant Board Operational Risks relevant / aligned to this Committee:	The following risks are the responsibility of this Committee, which will be making commissioning decisions and managing performance: • BAF03 – Barriers to full delivery of the mental health transformation programme (Children and Young People) • BAF04 – Barriers to full delivery of the Mental Health Transformation Programme (Adults) • BAF06 – System Urgent & Emergency Care (UEC) pressures • BAF07 - Elective Recovery These are the risks that are part of the reviewed BAF, signed off by the ICB public Board in July, and aligned to the 8 ambitions in the Joint Forward Plan. The Committee noted that BAF06 may need to better reflect system variance, and this has been fed back to the risk owner. Board Operational Risks (BOR) • BORR10 - Neuro-Developmental Service (NDS) Children and Young People The Committee reviewed the BAF risks in September – the timetable for BAF review did not allow the Committee to review any changes to the BAF risks in October. The BOR were reviewed in October and are in the process of formally being transferred to the Commissioning and Performance Committee. Committee made a number of observations that have been shared back to risk owners to incorporate into further reviews of these risks: • Where unmitigated and mitigated risks are the same risk rating, assurance is needed on this and rationale is clearly recorded.

	• Risks and the controls/actions should be aimed at the right strategic level, not repeating risk management at other levels. • Risks must be kept contemporaneous and do not need to hold old information. The Committee proposed risks, including BAF risks, are reviewed in the agenda following a review of the performance report. This will inform discussion on risks and enable Committee to make informed challenge to system performance.
Key items for Board to take note of:	1. The Committee has extended the regular meeting time to 3 hours, with a 10-minute break. This reflects the complexity and breadth of the agenda and scope of Committee. 2. The Committee received a governance structure which outlines the Programme Boards that feeds into it and the other Committees that sit alongside it and feed into the ICB Board. This included the changes to governance in regard to the oversight of 'scheduled care' and altered structures. These are shown in appendix 1. 3. A draft Performance Management Framework was shared with the Committee. This progresses actions to fulfil a recommendation from a recent audit of the ICB. The draft was circulated to executive lead for each 'feeder' programme board for comment as well as other key stakeholders. 4. The Performance Report was reviewed in each meeting of the Committee, and October included an accompanying Word report to provide further contextual information and opportunity to identify interdependencies or strategic forward planning. The report in October highlighted the following key areas and summary discussion: ➢ **Elective**: Industrial action during June has had an impact on system performance. The 65-week trajectory for acute services is on track to be achieved by November at James Paget University Hospital and December at Norfolk and Norwich University Hospital. This is being closely monitored. As at the end of July 2024 there were 2570 people waiting over 65 weeks for elective care. This is a slowly improving position but is behind the planned reduction in waits. To recover to 18-week waiting times in the long-term, there needs to be a whole system strategic plan which acknowledges the size and complexity of this work and which would need to be delivered as part of a much wider plan to deliver new models of care. This approach to delivering care differently is underpinned by three key strategic shifts:

- From hospital to community
- From analogue to digital
- From sickness to prevention

Alongside this is the overall premise of proactive management and intervention, reducing unwarranted variation and use of data to identify and engage those at the highest risk. Ultimately the goal is to predict the need for care, where this is possible, and then deliver this care how and when residents want it as part of a 'neighborhood health service' approach.

- **Cancer**: performance has been mixed across different types of cancer pathways at the three hospitals. Backlog reduction has been slow with increases in referrals in some areas also impacting performance.
  The national FDS (Faster Diagnostic Standard) was introduced to speed up cancer diagnosis and improve patient experience. This is impacted by the challenges in diagnostics. Per July 2024 the 28-day FDS performance is at 63%, against a March 2025 target of 77%
- **Mental health**: Previously unreported areas now have nationally published data. Key highlights include:
  - The number of people in mental health beds outside of the local system is rising against a planned drop. There is ongoing system work to ensure all crisis options in the community are utilised to appropriately avoid admissions to offset increased demand for inpatient admission – locally this reflects the national trends. Bed profiling has been undertaken with NHS National Benchmarking team to optimise local bed use.
  - The Dementia Diagnosis Rate is steadily improving, recovering along national trends while remaining behind the national ambition.
- **Community**: work is underway with providers to be able to provide the relevant and required performance information for community services. This includes addressing data quality challenges and establishing consistent standards.
- **Learning Disability and Autism:** an increase in the number of people admitted to inpatient care has increased, with a significant proportion of delays to discharge due to waits for appropriate discharge arrangements.
- **Urgent & Emergency Care (UEC)**: Winter planning is underway and forms part of supporting the UEC delivery, with focus on admission avoidance and supporting timely discharge and those with complex needs and/or frailty. N&W UEC team is continuing to work with the regional team on the New Models of Care workstream that is

	focussed on Urgent Care Co-ordination Hubs. Per August 75.8% of patients were seen within 4 hours of arrival at A&E (target 80%). Category 2 ambulance response times were 34.2 minutes in August 2024 verses interim target of 30 minutes. Both metrics show an overall improving trend with variation month-on-month. ➢ The NHSE Head of Acute Specialised Commissioning was unavailable for the October meeting. A paper update was provided, with no issue raised that requires escalation. ➢ **Areas unreported:** clarity has been provided on national development of 2 areas without a reportable position to date. These are: o Improve patients' experience of choice at point of referral – The Office for National Statistics (ONS) Health Insights Survey data is expected, from October 2024, to inform this metric. o Improve the working lives of doctors in training by increasing choice and flexibility in rotas, and reducing duplicative inductions and payroll errors. National Payroll Improvement Guidance has been finalised and released. National colleagues are gathering both quantitative and qualitative metrics to evaluate the programme's effectiveness and its impact on staff and sharing of best practices and blueprints from early implementors will be shared in 2025. ➢ Work is underway with reporting leads, Business Intelligence teams and the Commissioning and Performance team to develop a report which will include more automation and resilience for reporting from 2025/26. A first event to collaborate on this is taking place early November. 5. Planning for any service changes from 1st April 2025 is underway and will be considered alongside national planning / financial planning information, which is still to be received for 2025/26. Impact Assessments have been completed or are underway for any proposed changes and also operate within the *Triple Lock* process. 6. There were several updates from feeder groups and some escalation: ➢ The September meeting received an update to a procurement exercise for specialist community services for those with Learning Disabilities and Autism. ➢ The September meeting received an updated assessment for Lynch testing, reflecting national expectation for this to be available. ➢ Standardisation of approaches to Type 1 Diabetes technologies is being progressed.

	➢ Tier 3 weight management procurement requires further clarity of funding to be able to progress. 7. A paper was received on community Orthodontics provision and a piece of work will be picked up to identify the currently commissioned services and any further join up needed. 8. An update was received to the Joint Forward Plan progress and the Clinical Strategy. No escalations were identified. Some key areas of work may be mapped into ambitions moving forwards, such as new hospital builds.
Items requiring formal approval of Board:	None
Confirmation that the meeting was quorate:	Yes.

Key Risks – of performance that falls short of expected national or local standards, constitutional requirements and/or plans	
Clinical and Quality:	The impact of commissioning decisions on Clinical and Quality are integral part of decision making, and a clear process of assessing this impact is in place. Performance which falls short of expected national or local standards, constitutional requirements and/or plans will frequently have an impact on the clinical care and/or quality of care that can be provided and risks negatively impacting experience and outcomes. Performance review includes the perspective of clinicians, quality leads and people with lived experience.
Finance and Performance:	Performance and Financial risk are inherently linked. Financial envelope impacts room for performance improvement initiatives Most discretionary spend decision require sign-off through triple-lock process.
Impact Assessment (environmental and equalities):	Equalities and other relevant impact assessments are completed and reviewed at regular intervals and inform risk management processes.
Reputation:	If performance falls short of expected national or local standards, constitutional requirements and/or plans, this will have a negative impact on reputation of NHS Norfolk and Waveney.
Legal:	Legal risk in general may exist with commissioning decisions, and more broadly new Providers regime.
Information Governance:	None
Resource Required:	Not discussed
Reference document(s):	N/A
NHS Constitution:	Commissioning and Performance Committee seeks to assure we meet NHS Constitutional performance standards.
Conflicts of Interest:	Conflicts of interests is managed carefully, in view of the decision making authority of this committee.

Appendix 1

Governance Structure Commissioning & Performance Committee, Including governance structure for Scheduled Care Board

Norfolk and Waveney ICB Governance Structure
Tier 1 and Tier 2

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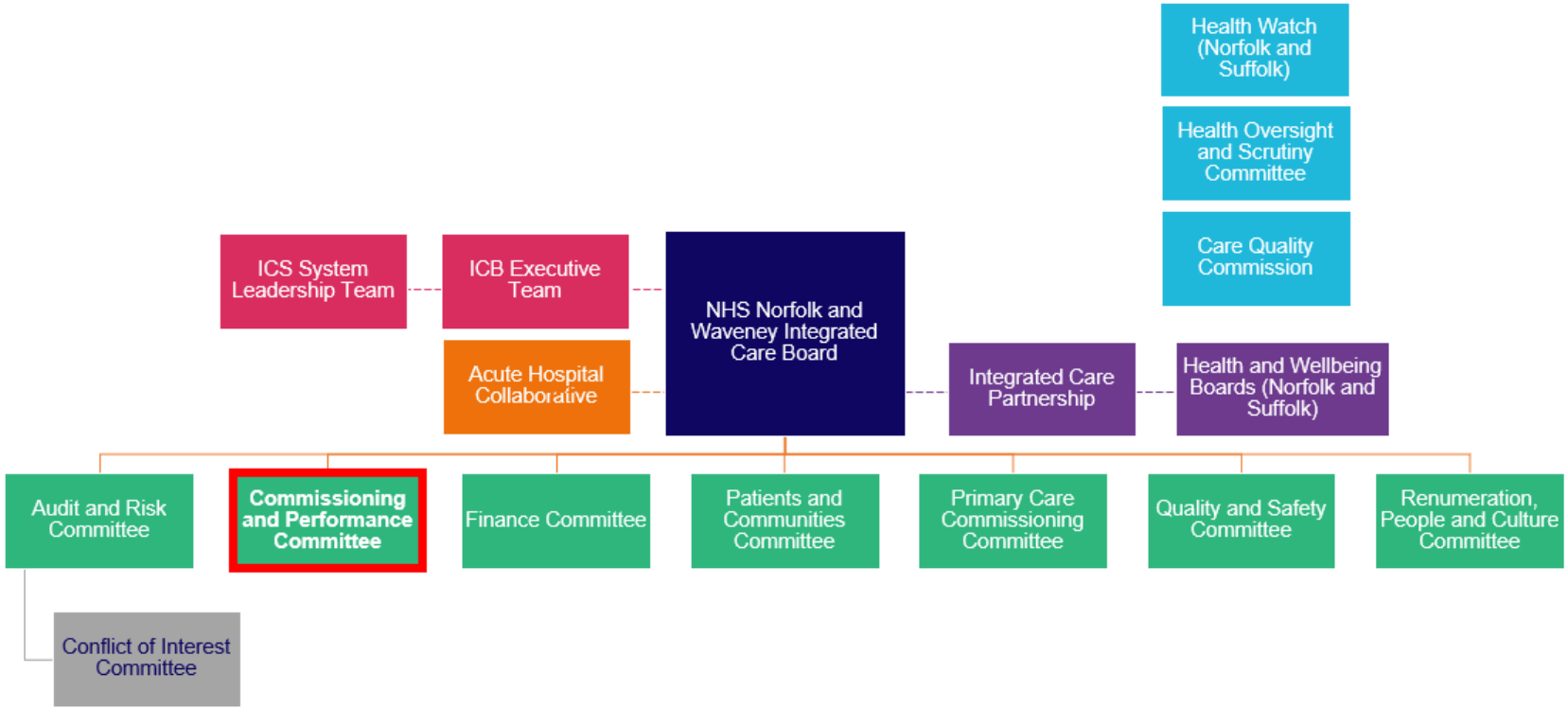
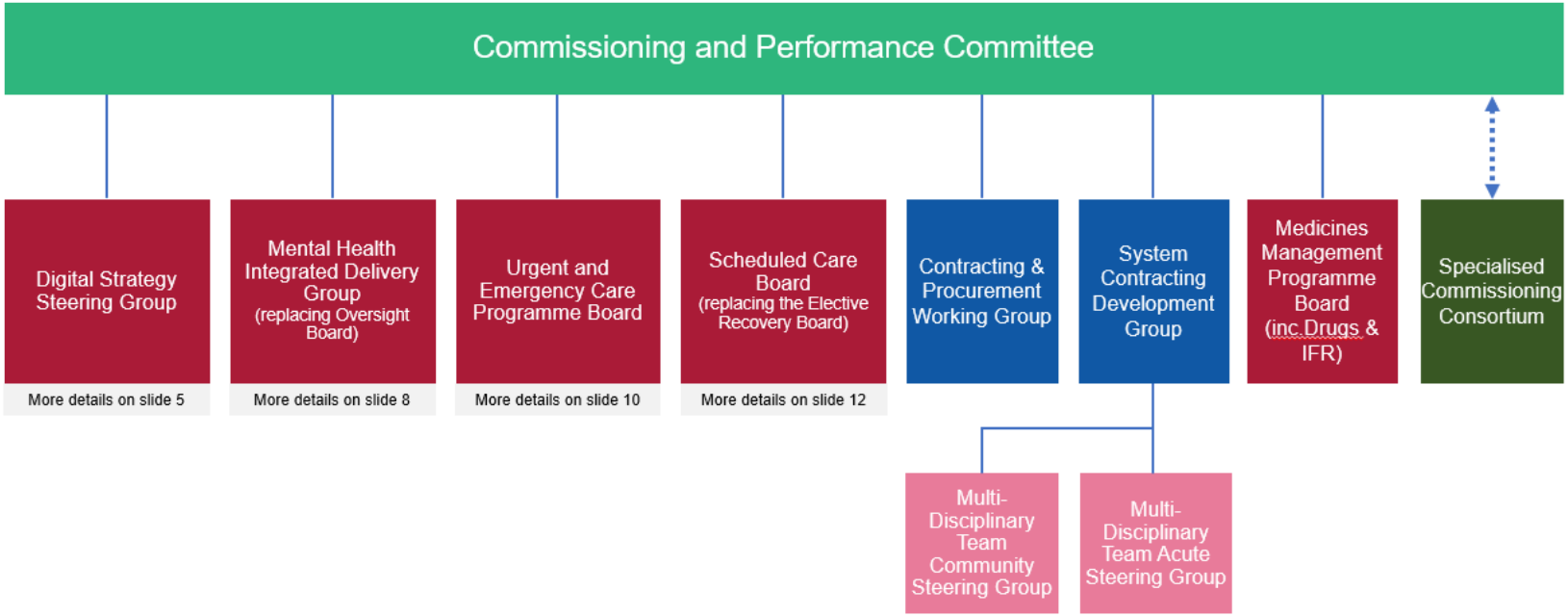
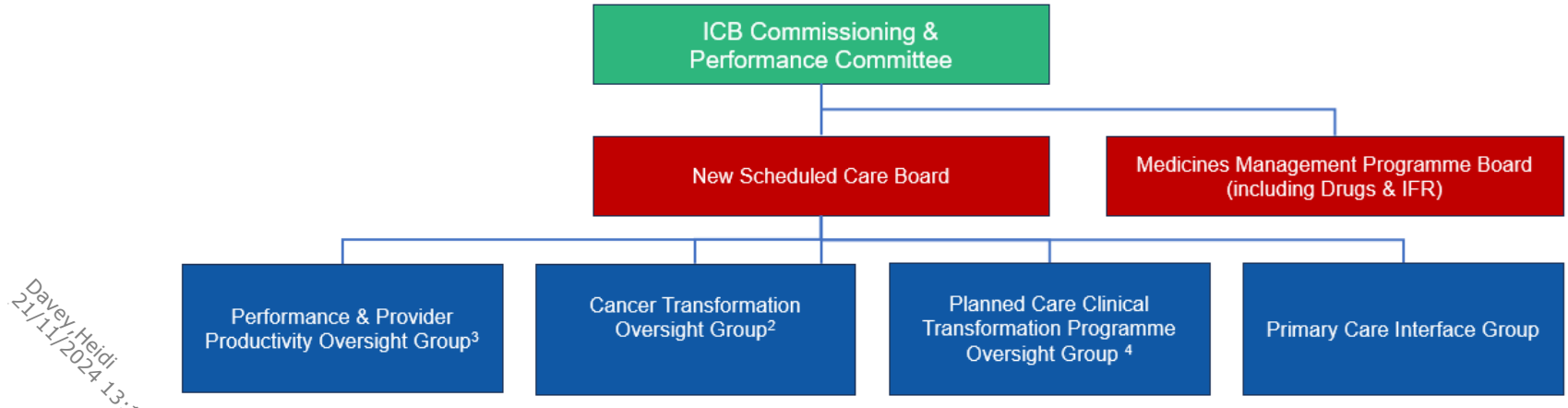
Norfolk and Waveney Integrated Care System







Norfolk and Waveney
Integrated Care Board

Agenda item: 13

Subject:	**Primary care access recovery plan and improving the issues across the primary-secondary care interface**
Presented by:	**Mark Burgis, Executive Director of Patients and Communities** **Sadie Parker, Director of Primary Care**
Prepared by:	**Amanda Sear, Senior Manager Primary Care Strategic Planning, supported by Community Commissioning, Digital, Planned Care and Primary Care Teams**
Submitted to:	**Norfolk and Waveney ICB Public Board**
Date:	**27 November 2024**

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 on-going work to support improvements across the primary-secondary care interface and overview of Pharmacy First.

The paper was prepared for review for the General Practice and Pharmacy Delivery Group meeting held on 8 October 2024, and updated where additional information has become available.

Background

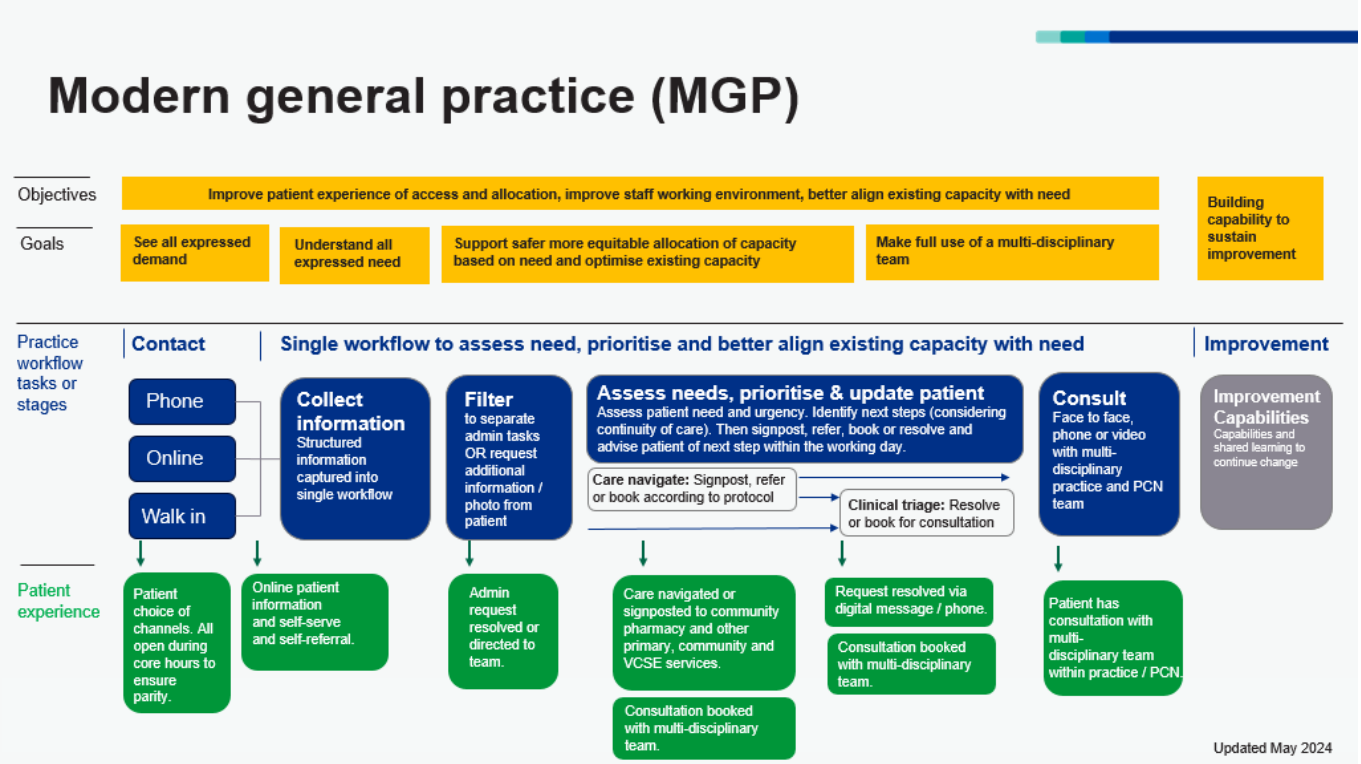
This paper sets out progress made against national requirements set out by NHS England (NHSE)

Primary Care Access Recovery Plan (PCARP)

Key outcomes expected for the first half of 2024/25 included:

- Development of our interface programme of work and delivery against key areas, including the roll-out of appropriate access to test requesting for allied health professional working in primary and community care settings
- Increased sign up to and usage of the NHS App and support for educational events for our population
- Installation of cloud-based telephony system across all GP surgeries to support managing the *"08:00 hours rush"*, so patients get a better experience of contacting their practice
- Utilise transition funding to enable more GP surgeries to manage workload and better respond to patient needs through the implementation of *Modern General Practice* (see picture below)

- Promote a culture of quality improvement across primary care, harnessing the power of technology where appropriate to support this



Progress Update

Progress against key deliverables under PCARP during the first half of 2024/25 can be found below:

Increase the use of NHS App and other digital channels to enable more patients access to their prospective medical records and manage repeat prescriptions.

The NHS App Roadmap is continuing to grow with proxy access (managing health services for another person via the App) being at the forefront. Proxy access is available to patients not registered at the same practice and child access available from birth, as well as being available across care settings such as hospitals. It is subject to ID checks to ensure appropriate use by those acting for someone else.

Digital Team work carried out:

- Promotion of the NHS app via practice events utilising GP Surgery Patient Participation Group members
- Screen messaging made available in GP surgery waiting areas
- Redmoor Social Managed Media Campaigns offer to GP surgeries to promote the NHS App and increase patient sign up
- Working with practices to optimise both their websites having the NHS App front and centre, and enabling the 4 core functionalities
- Created a toolkit with resources and guidance videos [NHS App Optimisation portal]

- Supported practices to ensure that when hosting an event, they take into consideration the digital exclusion and deprivation of their population page.

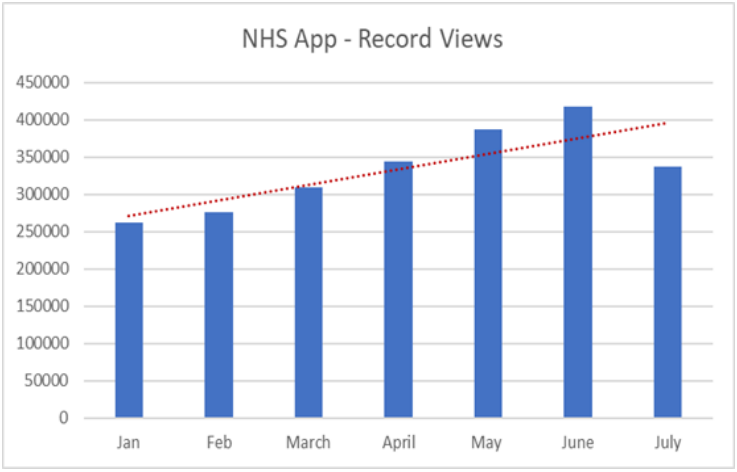
Next steps:

- Continued growth of NHS App usage, with proxy access
- To refresh the NHS App Toolkit
- Tailored approach for working with GP surgeries with lower than 50% uptake.
- Promotion of NHS App and Ambassador programme
- Gather feedback for further case studies

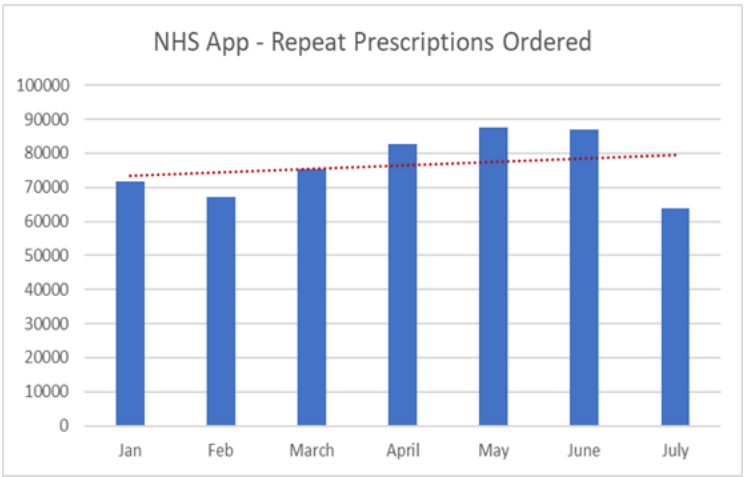
Targets include increasing NHS App record views from 9.9m to 15m per month by March 2025 and increasing repeat prescription numbers from 2.7m to 4.2m per month by March 2025

Engagement:

- 54 GP surgery staff are NHS App Ambassadors in Norfolk and Waveney (as at 30/08/24)
- 516,081 patients had the NHS App (54% of population age 13+)
- 12 GP surgeries had 60% of patients registered to use the NHS App
- 45 GP surgeries had all 4 core functionalities enabled
- 39 GP surgeries had offered appointment booking via the NHS App in the month of July



Record Views:
April 344,680
May 387,169
June 418,521



Repeat Prescriptions:
April 82,632
May 87,623
June 87,064

Make on-line registration available in all practices by October 2024

Target: more than 90% of practices using the on-line registration system by 31st October 2024

Background: NHS England co-developed a new registration solution with patients and practices to make registering with a GP surgery easier, simpler, and standardised. GP surgeries are contractually required to adopt and offer this online registration system along with the new paper form by 31st October 2024. Norfolk and Waveney GP surgeries already had an online offer which had previously been developed by our digital team., so in many cases they had to move across to the national offer.

Digital team work carried out:

- 1 to 1 support for all GP surgeries providing information and answering questions
- Promotion of weekly NHSE webinars through dedicated channels
- Working with the NHSE Registration Team, alongside the Local Medical Committee (LMC) to support GP surgeries
- Creation of a dedicated training portal page, including access to a demo environment for GP surgeries to test the service
- Resources are also available for:
    - How to enrol through profile manager
    - GP Registration Roadmap
    - Contact details for NHSE Team

Support continues to be available for the last GP surgery to enrol, but at the end of October the target had been achieved.

Work continues to support the delivery of the Primary Care Access Recovery Plan to move to a modern general practice model, including:

- Working with GP surgeries to assess their current digital tools suggesting how they might be used to underpin the development of triage models aligned to patient need and workforce model.
- Migrate online consultation providers where required
- Sharing best practice to enable processes to be streamlined without the need to increase digital “add-ons” by streamlining within one digital package
- Support offer and advice for GP Surgeries to ensure their websites meet NHS Website Accessibility Standards
- Create and update resources for GP surgeries to support informed decision making for digital tools
- Working with Primary Care Network (PCN) Digital Transformation Leads to support PCNs to access funding opportunities for, and increase their effective use of, digital tools

Continue to expand Self-Referrals to appropriate services

As part of the 2023/24 operational planning guidance, with a refresh of expectations in 2024/25, ICBs were asked to implement self-referral pathways in 7 named pathways. 5 of these are measured by Community Services Data Set (MSK, Audiology (Elderly hearing) Podiatry, Weight

Management and Wheelchair), the remaining 2 are Community Equipment Services and Falls Service.
Self-referral is in place across Norfolk and Waveney for all pathways except for community equipment. We are exploring opportunities for self-referral within community equipment with our commissioning partners.

National standardised rates are in place for MSK, audiology and podiatry, the latest regional data (for July 2024) showed locally we are exceeding these for MSK and audiology.

Community Pharmacy Update

The target for Pharmacy First appointments by March 2025 is 5,240 per month. Data for August 2024 recorded 3,179 consultations. Payment threshold for practices increased to 20 per month from September 2024. The total number of pharmacies is 172 and we have 160 community pharmacies signed up. Of those who are not signed up to deliver Pharmacy First:

- 1 is a DAC (Dispensing Appliance Contractor) and has not been signed up from the start.
- 3 are DSPs (Distance Selling Pharmacy)
- 7 are recent change of ownerships and this can sometimes mean it takes a little while to complete registration
- 1 has not been registered from the start due to not having a consultation room

The target for oral contraception prescriptions coming directly by March 2025 is 250 per month. Data for August 2024 recorded 179 consultations. The target for Community Pharmacy Blood Pressure check appointments by March 2025 is 3,500 per month. Data for August 2024 recorded 3,121 appointments.

We are currently on track to meet the targets set by NHSE, and alongside this we are looking to strengthen relationships on the ground with Community Pharmacies. We are planning to run a soft relaunch of Pharmacy First in November 2024 targeting GP surgeries, which will include the release of a GP toolkit to provide support with training on the service. The relaunch will also see the introduction of a 'Friends and Family' test to gain patient feedback on the service. We are also looking to introduce a pharmacy visit programme during November 2024 to those pharmacies who have not completed 30 consultations since the service launched to understand what the barriers are and how we may be able to help support. Arrangements are in place to increase engagement leads to support work with GP surgeries to upskill their teams on Pharmacy First to promote a positive experience for patient and providers.

Other noteworthy data available for Community Pharmacy shows:

- There have been 16,402 Pharmacy First Clinical Pathway consultations and 4470 minor illness consultations from 1 February to 31 August 2024
- There has also been a total of 7,180 urgent supplies of medicines over the same period
- There have 667 GP referrals into the clinical pathway, 264 referrals from NHS 111 and 13,471 self-referrals from the patient population, highlighting the need for further focus on our referral pathways to support GP resilience and out of hours provision

Implementing 'Modern General Practice' Access Update

Cloud-based telephony (CBT) is split into **3 Phases** across Norfolk and Waveney:

- **Phase 1** included 30 GP surgeries on sub-optimal phone systems, including 7 on pure analogue systems and is now complete

- **Phase 2**, introduced during December 2023, covered a further 20 GP surgeries with equipment which did not meet the Phase 1 criteria, or where they might have had some digital or cloud features, but lacked NHS England's updated (Phase 1) requirements for Cloud Telephony – 18 are complete with 2 remaining

- **Phase 3, The Migration Phase** targets 3 GP surgeries who were part of the 2021-23 NHS England Pilot scheme and will see the migration from the *Wavenet* to *GP Voice* platform, which is also being rolled out under Phases 1 and 2 from the National Framework and will align them with NHS England's updated requirements. 14 of the 35 surgeries are now live

All 3 Phases meet, or exceed NHS England's updated requirements for Cloud Telephony, supporting the Modern General Practice model under the National Framework for CBT suppliers.

The remaining surgeries have CBT but not all were part of the project and do not necessarily meet all the requirements (e.g. call back). Reasons for keeping with existing suppliers include recently agreed contracts which it was not practical to change; existing suppliers not being on the national framework; and contracts which can facilitate call back for an additional charge.

***General Practice Improvemen*t Programme (GPIP)**

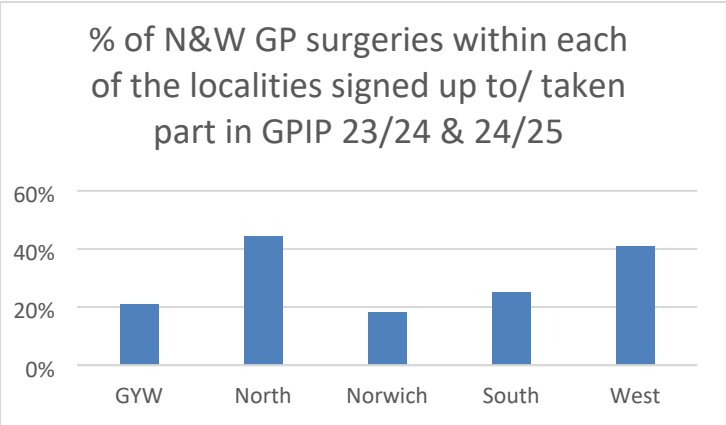
The General Practice Improvement Programme (GPIP) started in 2023/24 as part of *Capacity and Access Improvement* work and continues to evolve. During 2023/24 GPIP provided a suite of training and support offers, ranging from online resources to in-person facilitated workshops both for GP Surgeries and PCNs.

During 2024/25 the GPIP support offer was scaled back by NHSE, offering only GP surgeries a 13 week support programme delivered by new training facilitators, Royal College of General Practitioners. Uptake under the 2024/25 offer has decreased, with 6 GP surgeries undertaking the programme, compared to 25 under the 2023/24 programme. 2 GP surgeries have undertaken GPIP twice during both the 2023/24 & 2024/25 programmes. GP surgeries participating multiple times allowed them to utilise the data from cloud based telephony and online consultations (as well as other digital solutions) to further streamline internal processes and improve patient experience.

NHSE is currently undertaking a review of the GPIP offer to enable learning across ICBs and from April 2025, NHSE is planning to delegate responsibility for GPIP to ICBs to allow for localised training and support. Work is being undertaken to understand the resources and opportunities available to ensure GP surgeries can access support, where needed, to promote continuous improvements enabled through *modern general practice.*

GPIP summary:

- 31 GP surgeres had signed up or have taken part in the GP Improvement Programme during 2023/24 and 2024/25
- The North locality had the highest uptake in percentage terms, by GP surgeries (44%) whilst the West locality had the largest number of GP surgeries participating in the offer (9)
- 19 GP surgeries (61%) who participated in GPIP represent communities with an Index Multiple Deprivation (IMD) score of between 2-5. 10 had an IMD of 6-7, and 2 with an IMD of 8-9



Capacity & Access Improvement funding 2024/25

- As in 2023/24, 70% of the Capacity & Access Improvement funding is being paid to PCNs without any conditions via the Capacity and Access Support Payments (CASP) proportionate to their Adjusted Population, in 12 equal payments. PCNs have the discretion to use the funding according to local needs, for example, the supervision of ARRS staff or to increase the care home premium

- The remaining 30% of the Capacity and Access Payment (CAP) is being paid to PCNs via the Capacity and Access Improvement Payment (CAIP). To support cashflow, this is being paid to PCNs at any point in the year in monthly instalments once the PCN Clinical Director (CD) confirms to the ICB that all GP surgeries within the PCN have put in place one or more of the three individual domains of the Modern General Practice Access model, which each attract one third of the overall CAIP funding

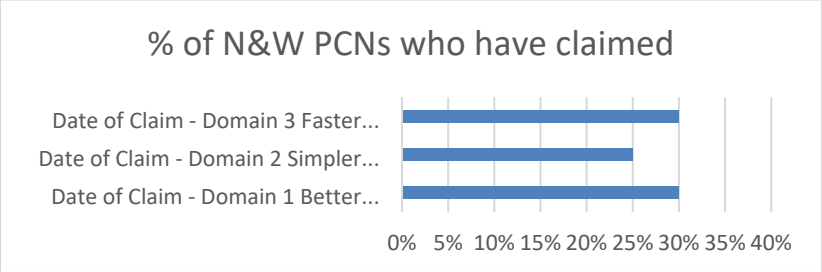
NHSE has set ICBs the target that over 90% of PCNs will meet CAIP payment criteria & claim for all three domains

- Currently 8 N&W PCNs have claimed for one or more domains, with only 4 PCNs having claimed for all three domains to date in 2024/25.

- The British Medical Association's (BMA) GP committee England (GPCE) released recommendations in June 2024 stating that *"Practices should defer sigining declarations of completion for 'better digital telephony' and 'simpler online requestes' until further GPC England guidance is issued in early 2025"*

Our understanding is that the main reasons for delaying claiming for domains is a concern from PCN Clinical Directors that they ensure all practices have the necessary components in place, as well as some PCNs expressing concerns about agreeing to share data (following the BMA recommendations). The delay in claiming will not affect the amount of funding the PCN can receive since once a claim is made, payment is pro-rated over the remaining months of the year. It does mean there are different levels of funding being accessed across N&W PCNs currently due to claims. N&W ICB continues to support PCNs with their queries regarding data sharing and the expectation is that with the August 2024 GP contract variation, which makes the sharing of CBT data metrics contractual, there will be an increase in claims for Domain 2.

Details of claims and the three domains can be found below:



• MGPA priority domain	• All PCN practices to have following components in place and these continue to remain in place
• 1) Better digital telephony	• Digital telephony solution implemented, including call back functionality; and each practice has agreed to comply with the Data Provision Notice so that data can be provided by the supplier to NHS England. • Digital telephony data is routinely used to support capacity/demand service planning and quality improvement discussions.
• 2) Simpler online requests	• Online consultation (OC) is available for patients to make administrative and clinical requests at least for the duration of core hours. • Practices have agreed to the relevant data provision notice (DPN) so that data can be provided by the supplier to NHS England as part of the 'submissions via online consultation systems in general practice' publication.
• 3) Faster care navigation, assessment, and response	• Consistent approach to care navigation and triage so there is parity between online, face to face and telephone access, including collection of structured information for walk-in and telephone requests. • Approach includes asking patients their preference to wait for a preferred clinician if appropriate, for continuity.

Complete implementation of highly usable and accessible online journeys for patients

- All N&W GP sugeries have accepted the CBT (Cloud based Telephony) DPN (Data Provision Notice) via CQRS (Calculating Quality Reporting Metrics Service)
- All N&W GP surgeries have also accepted the Online Consultation DPN.
- Prospective Records Access: As of 19th September 2024, Step 1 ("Organisational Settings to allow prospective Access") is now enabled across all except 1 surgery. There is still work to do to ensure all surgeries have undertaken Steps 2-4 for full contractual compliance (Step 2: practices undertake enhanced reviews for patients where necessary; Step 3: Practices set it as default that all new NHS App users have prospective access to their records on the app; Step 4: Patients have online accounts with full prospective access). Surgeries are being supported to ensure full compliance.

Build capacity

- The Primary Care Workforce Strategy and Operational Delivery Plan was approved by the Primary Care Commissioning Committee on 10th September 2024 supporting the themes of "Train, Retain and Reform". The plan includes 46 programmes, designed for delivery during 2024/25, all with key performance indicators (KPIs) to reflect both national and local targets

- Our Newly Qualified GP Incentive scheme received national recognition, and has been shortlisted for the HSJ (Health Service Journal) 2024 "Workforce Initiative of the Year". Winners will be announced 21st November 2024. To date, 17 newly qualified ST3 (Speciality Training Year 3) GP Trainees have received substantive primary care employment offers through the 2024/25 scheme

- 'Golden Hello' national and local incentive for dental professionals are in place, 26 dental professionals are being supported to secure substantive roles within primary care settings to date

- We have appointed our first Equality, Diversity, and Inclusion (EDI) Fellow for Primary Care to support the development and management of the EDI training programme which is paramount across all primary care settings

Cutting bureaucracy

Context

- Our Systems Interface Group, chaired by the ICB Executive Medical Director meets monthly, bringing together primary, secondary, community and mental health, to build on a collective understanding that when the interface between providers works well the patient experience is more positive

- As part of the ICB reorganisation a new post was created within the primary care team to focus on interface and ensure that key areas (e.g. self-assessment requirements) are built into system-led workplans

- To ensure interface processes remain 'fit for purpose' we held a workshop with system partners to share ideas on how interface can work better. This has given us the opportunity to reflect on how we can ensure ideas are shared and concerns are transparent

Progress update against the four National Primary Care Secondary Interface recommendations includes:

Self-Assessment

NHSE published a self-assessment toolkit under PCARP, for providers to evaluate their performance against five key areas in supporting the primary secondary care interface.

- The regional overview for initial assessments can be seen below, N&W data reflects a local request for all our main providers to complete these, rather than the national ask for acute providers to complete this. These initial responses were reviewed by the System Interface Group.

ICB name	No. Primary/Secondary Care Interface Assessment Tool Returns	Onward Referrals			Fit notes			Discharge Summaries And Outpatient Letters			Call and Recall			Clear Points of Contact		
		Level 0	Level 1	Level 2	Level 0	Level 1	Level 2	Level 0	Level 1	Level 2	Level 0	Level 1	Level 2	Level 0	Level 1	Level 2
East of England	14	0	4	10	10	2	2	4	8	2	1	9	4	5	5	4
NHS Norfolk and Waveney ICB	5	0	1	4	5	0	0	0	4	1	0	2	3	2	1	2
National	134	24	56	174	168	70	70	84	134	36	29	161	64	105	77	72

- Updated submissions (due in at the end of September 2024) have been received from the three Acute Trusts and will be discussed in detail at the December System Interface Group. Updates from other providers were being finalised at the time of writing this report.

- The annual self-assessment plans required under the terms of the national contract, also due at the end of September) from which actions plans can be developed will also be discussed at the December meeting. At the time of writing these have been received from the three Acute Trusts.

Cutting bureaucracy sits under our wider Interface workstream, key areas of focus during the first six months of 2024/25 include:

- Ensuring non-medical health professionals can appropriately 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

    - *The working group for the Norfolk & Norwich and James Paget Hospitals has now successfully agreed and started to implement their roll out plan for non-medical referrers with GP Surgeries to be able to request and receive their own pathology results. This has opened up the next steps to ensuring that those in the community are able to request the same. The size of the project and resource impact led to a collective decision to implement this as a phased project*

- Ensuring allied health professionals working in the community, can appropriately request imaging via the WebICE system after completing 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

    - *Now that the first phase of non-medical referrers access is being implemented in GP surgeries, we are able to open the next stage for radiology requesting. The identified Task & Finish Group, including representation from three acutes, community providers and the LMC, are committed to implementing this work to allow allied health professionals to refer appropriately according to their professional competency.*

- Enabling private consultants to refer patients directly into Trusts, rather than requesting the patient's registered GP makes the referral on their behalf

    - *Private consultants are now able to refer routine patients directly into secondary care without going via the patient's registered GP. Currently, urgent and suspected cancer patients still need to be referred by their registered GP to ensure these patients are upgraded and managed on the appropriate cancer pathway*

- Trusts offering complete care, for example making onward referrals as appropriate; providing urgent medications directly to patients; their own follow up phlebotomy, and checking and acting on results, as well as other necessary follow up care

    - *Whilst the trust self- assessments indicate processes are in place, incidents continue to be reported, albeit with no pattern for a particular organisation of department. A co-ordinated approach, including following up incidents raised; education*

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

back to GPs

  - *11 incidents were reported from Jan – Sept 2024. recognising there is likely to be under-reporting, and continue to engage with their workforce to ensure they are aware and adhere to this requirement. Next step for the Trusts is to enable electronic fit notes, however, there remain technical issues to overcome*

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

  - *This is currently one of the highest issues reported. during January – September 2024, 104 concerns were raised through our reporting system. A task & finish group set up under the System Interface Group to address improvements in common language, response times and template discharge letters to support effective and consistent communication has been established*

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

  - *Well established processes are in place to consider unintended consequences on primary care,reviewing pathways, all stakeholders, including the LMC continue to work together to ensure processes are well-understood and transparent*

Interface Challenges and Achievements

- All stakeholders remain positive and engaged, with effective engagement between Medical Directors across the system to effect positive change

- Increased opportunities for system partners understand the unintended consequences of processes/ways of working

- Following feedback from a stakeholder workshop, in the New Year our monthly System level meeting will become quarterly and focus on the overall clinical and operational management of interface, support Task & Finish groups and respond to resource queries

- Local groups will be developed, meeting more frequently with a wider membership and a focus on relationships, to support improvements around interface

- In order to gain a deeper understanding of where improvements could be made, an engagement exercise with general practice is being developed

- GP collective action, which started on 1 August 2024, has been noted as a positive in highlighting and working through areas which can cause high levels of frustration

- Positive feedback from those involved in the National Community of Practice for Interface

Recommendation

The ICB Board are asked to review and note the report and determine if they are assured the ICB will deliver on the progress against the ambitions of the *Delivery Plan for Recovering Access to Primary Care* and *General Practice and Secondary Care: Working Better Together.*

Key Risks	
Clinical and Quality:	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 GP Collective Action is ongoing as part of a national dispute between the British Medical Association (BMA) and NHS England The National Pharmacy Association (NPA) ran a six week ballot (from 23 September) for collective action, with member support. It is unclear at this time on the timelines or impact
Finance and Performance:	Capacity of care can be impacted due to inefficient working arrangements across the primary- secondary care interface GP Collective Action by general practice has the potential to 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 The ICB may have to consider commissioning enhanced services or developing alternative pathways to meet any service provision gaps.
Impact Assessment (environmental and equalities):	Reduced capacity could constrain the ability to address health inequalities.
Reputation:	Non-delivery of the ambitions outlined within the plan poses a significant system reputational risk due to the high profile of the plan nationally. Lack of perceived progress against primary secondary interface poses a reputational risk with primary care providers
Legal:	None identified
Information Governance:	System IG group established in response of challenges working across providers highlighted in previous report.
Resource Required:	Primary Care Workforce Transformation, Commissioning, Medical Directorate, Mental Health Directorate and Digital and Primary Care resource must be retained to support the delivery of this plan.

Reference document(s):	Delivery plan for recovering access to primary care (england.nhs.uk) Delivery Plan for Recovering Access – Update published 9th May 23 updated 3rd September 2024 https://www.england.nhs.uk/long-read/delivery-plan-for-recovering-access-to-primary-care-2/ Delivery Plan for Recovering Access – Update and Actions published April 2024 NHS England » Delivery plan for recovering access to primary care: update and actions for 2024/25 Cloud Based Telephony https://www.england.nhs.uk/long-read/funding-for-practices-moving-to-digital-telephony/ DPN Data Provision notice https://digital.nhs.uk/binaries/content/assets/website-assets/corporate-information/directions-and-data-provision-notices/data-provision-notices/cloud-based-telephony/20240816-cloudbasedtelephonydataprovisionnoticev1.0.pdf https://www.england.nhs.uk/gp/national-general-practice-improvement-programme/modern-general-practice-model/.
NHS Constitution:	NHS Standard Contract
Conflicts of Interest:	Declarations of interest for any GP and Trust partners are held on record
Reference to relevant risk on the Board Assurance Framework	Risk to resilience of primary care and transformation, on BAF and monitored through Primary Care Commissioning Committee, current score of 20
Governance	
Process/Committee approval with date(s) (as appropriate)	An update paper was presented to the General Practice and Pharmacy Delivery Group meeting held on 8 October 2024.

Norfolk and Waveney
Integrated Care Board

Agenda item: 14

Subject:	**Half 2 and Winter Planning**
Presented by:	**Marcus Bailey, System Resilience Director**
Prepared by:	**Marcus Bailey, System Resilience Director**
Submitted to:	**Norfolk and Waveney Integrated Care Board - Board Meeting**
Date:	**27 November 2024**

Purpose of paper:

To provide an overview of the approach to half 2 planning for urgent and emergency care.
To identify key workstreams to support half 2 delivery.
To draw the boards attention to system risks

Executive Summary:

As part of the NHS England guidance for Half 2 and Winter is for the Norfolk and Waveney System to review its annual operating plan submission, to identify any changes. This looks at anticipated delivery against key assumptions to enable performance in areas of patient flow within acute hospitals and in our communities through category 2 ambulance response times.

The assumptions within urgent and emergency care relate to acute bed occupancy are aimed at enabling patients to be seen and a decision within the emergency departments by 4hrs. This flow also supports handing over ambulances which enables them to respond to category 2 emergencies in our community.

Based around the demand for services and reviewing the planning assumptions there are focussed areas of activity and actions to support during this period. This builds upon the Urgency and Emergency Care (UEC) board for Norfolk and Waveney. There work incorporates the national guidance on top 10 high impact interventions which and the local UEC alliances.

The actions are summarised under the following headings:

- Enhancing Care
- Developing Services
- Connecting Care
- Prevention
- Reducing Length of Stay
- Alliance workstreams

These actions are part of the continuous improvement work, support collaboration between health and social care partners and build capacity for patient care. These focussed actions are essential to ensure that required capacity, against the modelling, is delivered.

The attached presentation provides further details on the framework, risks and areas of activity.

Recommendation to the Board:

To note the following:

- The framework for winter builds upon existing workstreams, increasing capacity through improvement or focussed areas to support specific flow opportunities.
- That mobilisation planned actions and activity continues to identify further mitigations to capacity based on the current modelling.

Key Risks	
Clinical and Quality:	Related to BAF and Operational risks in UEC
Finance and Performance:	Performance risk to ED 4hr performance, C2 ambulance response times. Impact potential to planned care to mitigate UEC activity
Impact Assessment (environmental and equalities):	N/A
Reputation:	The system is currently within Tier 2 oversight for UEC performance
Legal:	Ambulance delay related harm.
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	Number

Governance

Process/Committee approval with date(s) (as appropriate)	People and Communities Committee 25/11/24 UEC Board Workshop 11/11/24

Norfolk and Waveney ICB

H2 planning and winter 2024/25

Introduction

The NHS remains in a period of pressure around urgent and emergency care (UEC) and planned care provision. Alongside continued delivery of existing priorities, such as elective care including for those who have experienced a longer wait for treatment, the NHS is focussed on delivering year two of the UEC Care Recovery Plan (part of a submitted annual operating planning). As we enter the second half of the year the focus remains on:

- Delivering a 30min response for category 2 ambulance patients.
- Delivering an emergency department standard of 78% of patients being admitted, transferred or discharged within 4hrs of arrival, with a stretch to 80%.

Although H2 and winter is not an emergency or considered an unusual event, it is recognised as a period of increased pressure due to demand both in the complexity of people's needs and the capacity demands it places on resources within health, social care, and the wider Integrated Care System (ICS). Collaborative preparation and sharing of learning between partners is key to ensuring our population are best supported when pressures arise.

NHS England (NHSE) have also set national expectations for the winter period (16th September 2024) that will have ramifications for NHS organisations and wider ICS partners, in both the planning and delivery of support. These cover:

- Providing safe care over winter.
- Supporting people to stay well.
- Maintaining safety and patient experience.
- Using evidence based practice.

Social Care – Winter Overview

Publication of national expectations on social care during winter, by the Department of Health and Social Care (DHSC), was received on 17th September 2024. The letter outlines short-term priorities for the winter period, including:

- A 'home first' approach to support independence for as long as possible.
- A focus on ensuring high-quality care.
- Involvement of people receiving care and their families and carers.

The Association of Directors of Adult Social Services (ADASS) have emphasised the importance of care at home, intermediate care and information and advice this winter – with a focus on prevention of admission to hospital or residential care as a means of reducing pressures across health and social.

ASSD has developed a winter framework, building on previous years successful approaches. This framework reflects the following increasing priorities:

- Additional focus on intermediate care – given its vital importance to supporting people to remain at home, and return home after crisis, during winter.
- Managing demand and capacity within limited resource.
- Prioritising proactive intervention to support people to remain independent in winter.

With these refinements, the key strategic priorities for ASSD winter framework are:

- Meeting people's needs (to remain at, or return to, home).
- Resilient communities.
- Supporting our workforce, and
- Working together in winter conditions.

NWICB Context

For the NHS, and wider ICS partners involved in urgent and emergency care, delivery plans over the last 12 months have been developed to support this winter, leading to alternative access to healthcare, and alternatives to the emergency department if hospital care is required. Planning has also looked to increase capacity for patients on discharge pathways.

Three key areas of winter planning are in place

- 9 winter focus areas
- UEC Board Priorities
- 10 high impact interventions

For the NHS, the strategic focus is on responding to demand for UEC. Actions are designed to support safety and quality of patient care, with aim to get the right care, to the right patient at the right time, through various access points.

UEC Board priorities - Across Norfolk and Waveney, system partners have worked to meet national standards, to support patient care. The focus has enabled an improvement within our ambulance response times and our emergency department performance. It is recognised that these interim targets are still subject to variation with the focus on medium- and longer-term transformation to support sustainable change. The experience within 2024/25 to date has been one of fluctuation demand patterns on urgent and emergency care, especially at our emergency departments.

The areas of focus for the delivery of winter cover build upon existing workstreams and direction set by the Urgent and Emergency Care Board, across three domains:

- Deterioration/accident
- In-hospital
- Recovery and rehabilitation

Operational Delivery

- Review the annual operating planning – identify changes or differences within the assumptions.
- Continue with the UECRP (urgent and emergency care recovery plan) year 2;
  - ED 4hr performance
  - C2 performance including response to respond at 45mins
- Continue with the High Impact Interventions (Top 10) and the maturity matrices
- Support admissions avoidance and discharge activities being key
- SURGE and Demand approaches to support –revised Operating Pressure Escalation Level Framework.
- Delivery of the vaccination programmes
- Wide system engagement, awareness and involvement
- Risk identification and mitigations
- Focus on building and enhancing schemes.

Demand and Capacity - overview

- From annual operating plan submission our providers submitted data returns covering activity, capacity and assumptions.

Assumptions	Acute LOS	G&A Beds	Occupancy	Escalation Beds	NCTR
JPUH	7.1	470	95.10%	16	80
NNUH	6.9	973	99.30%	12	62
QEH	8.4	460	99.40%	0	73

- These were triangulated with workforce and finance returns.
- In reviewing half 2 compared to the submitted plan the following is noted:

  - There remains financial pressure within the system.
  - Workforce plans and triangulation require continued monitoring for delivery.
  - Activity is subject to variation in type at our emergency departments
  - The patients with no criteria to reside is higher at this point that originally planned
  - Occupancy is higher than the operating plan

Winter Plan

Enhancing care	Developing Services	Connecting Care
Prevention	Reducing Length of Stay	Continuous Improvement
Identifying Capacity	System Oversight and Resilience	UEC alliance workstreams

Davey Heidi
21/11/2024 13:10:42

Winter Plan – Outline Workstreams

- Enhancing Care
  - GP streaming
  - Pharmacy First
  - WIC
  - 111/OOH
- Developing Services
  - SDEC
  - UCCH
- UEC Alliance Workstream
  - D2A
  - Models of care
- Connecting Care
  - Care Homes
  - Older People and VW
  - Process improvement
- Reducing LOS
  - Increasing capacity
  - Process review
  - Improved outcomes
  - Pathway movement
- Prevention
  - Vaccinations – staff and community
- Improvement
  - Tier 2 regional support
  - Rapid Improvement Offer at JPUH
- Capacity
  - Waterfall chart linked to beds
  - Are there things we could stop doing to create capacity.
  - MH
- System oversight and escalation
  - Provider plans
  - System Control Centre
  - OPEL escalation
  - Ambulance 45min handover
  - Discharge focus event
  - Interprofessional standards
  - Temporary Escalation Space Oversight
- Risks
- Communication – public and professional

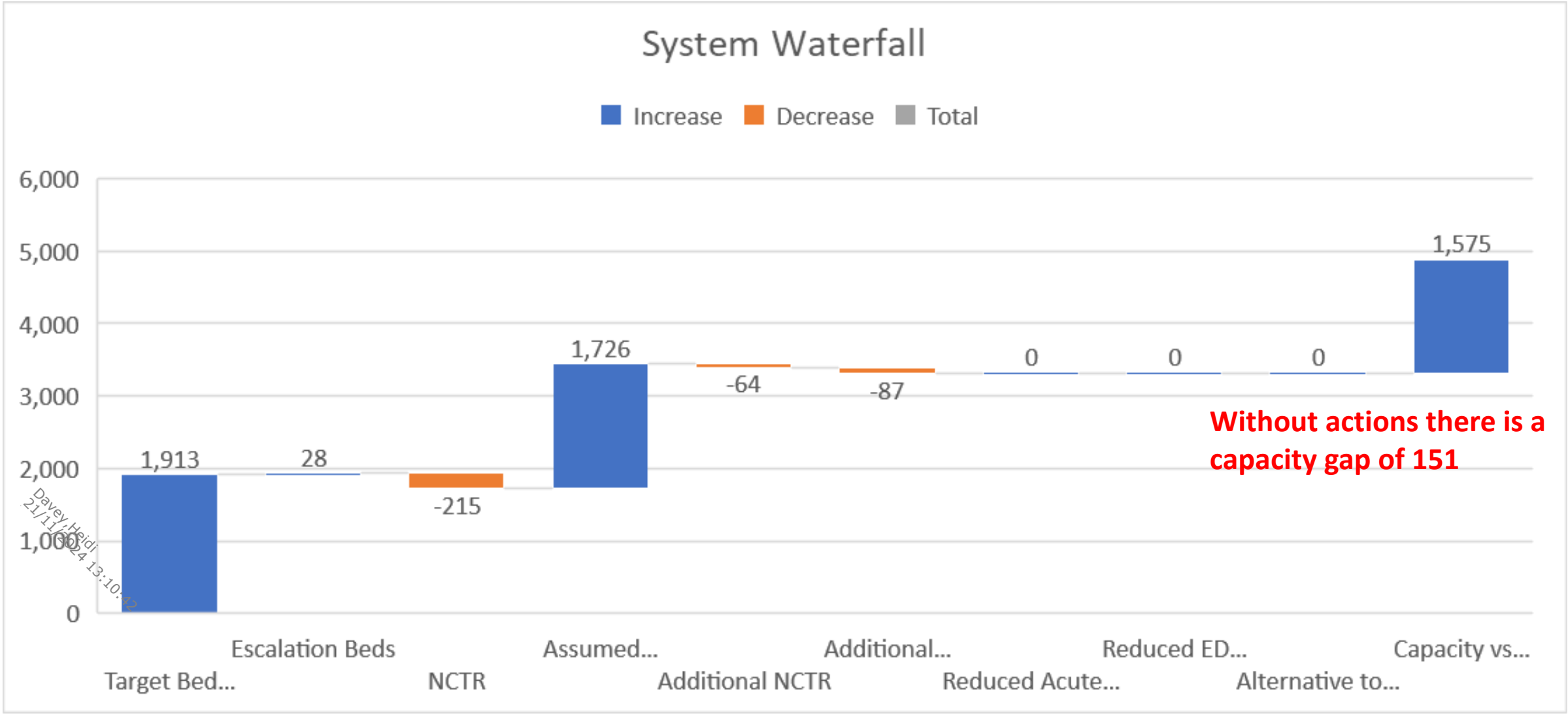
Key winter deliverables to support flow

The following areas are designed to support capacity:

- Internal provider actions aimed at front door, processes and discharge,
- Developing the frailty offer through integrating VW and care homes and 999 through the UCCH,
- Delivery of UCCH against MVP and enhancing further for winter with support of EEAST of extending hours and rapid triage,
- Maximise the opportunity within GP streaming across acute sites.
- Further development of Medical SDEC and frailty across our three acutes
- Reducing LOS in Acute across medical wards and where possible surgery,
- Reducing LOS in Community Intermediate care and delivery of the bed plan

System Capacity –'Waterfall'

Awaiting Final Mitigation Action and Provider Validation



System Actions

- Reducing length of stay across community and acute providers to support increased flow.
- Increase capacity through mobilisation of bed plan across community and mental health care Trusts.
- Focus support and care for people within care/residential homes using UCCH and VW to provide care closer to their home.
- Work with EEAST to effectively support alternative care to patients triaged as category two (segmentation).
- Expand UCCH hours of operation and facility to hold patients until services are available
- Support process and capacity improvement across D2A pathway 1 and 3

High Levels Risks

- In addition to system and provider strategic UEC risk the following have emerged:
  - There is no mobilisation of separate acute respiratory infection hub for this period, patients may present through existing care, increasing demand.
  - Occupancy levels remains high, resulting in over 96% occupancy through this period, resulting in further escalation mitigations being deployed.
  - Elements of the annual operating planning assumptions are not being met contributing to higher occupancy level and process challenges impacting flow.
  - Risk of impact through collective action remains during this period.
  - Operational pressure impacts sustainable improvement programmes across all providers, this increases further for providers who have additional support.

Escalation Space

- Throughout periods of pressure a range of actions, aligned to OPEL actions are consider for enactment based around risk balance.
- One of the immediate actions (within 60mins) to support patient flow and community risk is the use of full capacity or escalation policies.
- To create continued capacity full capacity principles are utilised.
- Under extremis, and within the guidance of NHSE, the use of temporary escalation space may be considered against the level of risk in the community and Urgent/Emergency Care Pathway.

Norfolk and Waveney
Integrated Care Board

Agenda item: 15

Subject:	**Norfolk and Waveney Integrated Care System Ageing Well Programme Progress Report**
Presented by:	**Frankie Swords, Medical Director James Allen, Clinical Programmes Senior Manager**
Prepared by:	**Frankie Swords, Medical Director Janice Shirley, Head of System Clinical Programmes James Allen, Clinical Programmes Senior Manager Lee Watson, Prevention Workstream Lead Paul Benton, Care Homes & Housing with Care Workstream Lead James Casson, Frailty Specialty Advisor Katie Honney, Dementia Specialty Advisor**
Submitted to:	**Norfolk and Waveney Integrated Care Board – Board Meeting**
Date:	**27 November 2024**

Purpose of paper:

To provide an update to the Norfolk and Waveney ICB Public Board on the work of the Norfolk and Waveney Ageing Well Programme.

Executive Summary:

In January 2023, the ICB Public Board supported a proposal to improve and better integrate health and care for older people in Norfolk and Waveney. Transforming Care in Later Life was then included as one of our eight ambitions in the ICB Joint Forward Plan published May 2023 with the initial objective to publish a strategy by April 2024.

A series of stakeholder workshops were then held, a review of published evidence and best practice was undertaken, and a new Ageing Well Programme Board was set up. The board led the development of a strategic framework for action, which was then published in February 2024.
The Ageing Well Programme is now overseeing the implementation of the strategic framework with four core priority workstreams:

1. Frailty Attuned Acute Care
2. Prevention
3. Care Homes & Housing with Care
4. Dementia

All workstreams have been established and transformation/improvement work has now commenced across these workstreams.

Regular assurance on the programme is reported through the ICB Patients and Communities Committee.

Background

Norfolk and Waveney have an older population compared to the rest of England. A quarter of the population is aged 65 and over and about 1 in 30 is aged 85 and over.
Across Norfolk and Waveney life expectancy is slightly longer than the average across England and is currently 80 years for males and 84 years for females. However, there are significant variations in life expectancy between the most deprived and least deprived areas of Norfolk and Waveney which is over 8 years for males and over 6 years for females. Furthermore, the healthy life expectancy across Norfolk is lower than the average for England at about 62.7 years for males and about 62.4 years for females and this figure has decreased over the last few years.

This means that the period that older people spend in ill health in Norfolk is getting longer. Older people are already more likely to be living with multiple health conditions. Common conditions that are more prevalent in older age include dementia, heart disease, hypertension (high blood pressure), respiratory disease, mental health conditions such as depression, cerebrovascular disease, joint problems, diabetes, and sensory impairment. These conditions can also interact, meaning that an older person who could have maintained independence and quality of life with any one of these diseases, might struggle to do so with the combination of conditions.

We must coordinate this care better, and make sure that the person and their family or carers are at the center of all that we do. As well as improving the care and support for older people already living with these conditions, we also need to try to prevent or delay them for as long as possible. Long term, that will enable older people to live more of their later life without disability and improve healthy life expectancy.

Becoming an Integrated Care System in 2022 means that the NHS across Norfolk and Waveney is working much more as a partnership with local government, local authorities, voluntary, community and social enterprise (VCSE) organisations. As a result of this, we have an opportunity to work together, to improve the planning, integration, and delivery of services for older people and those who care for them.

Introduction

The Ageing Well Programme Strategic Framework was published in February 2024 which you can access here.

This Strategic Framework was developed following engagement workshops throughout 2023, where 85 participants attended from partner organisations, voluntary organisations, charities, and members of the public including older people and their carers. This then followed to a desktop review and a steering group was established to review the findings of this engagement. The framework is underpinned by twelve recommendations identified in

the British Geriatric Society "Joining the Dots" (2023) report, alongside the Chief Medical Officer's Annual Report: Health in an Ageing Society (November 2023).

The strategic framework consists of:

a) a mission statement which describes the purpose of the ageing well programme.
b) a vision statement demonstrates what it will look like when we have delivered against this mission; and
c) a strategic framework of 9 goals to cover all of the work that we need to deliver against the 3 different phases of ageing.

Our Mission

To have health, carer and support services, that are fit for our ageing population - supporting people as they age, to lead longer, happier healthier lives.

Our Vision

Norfolk and Waveney will be a place where people in later life and their carers:

- Are helped to age well, living happier, healthier lives, living as independently as possible, for as long as possible
- Feel heard and respected, and know they will be treated as individual
- Experience services that ask, 'what matters most to you' and proactively act upon their answer

Our Nine Goals

1. Enabling independence and promoting wellbeing
2. Population based proactive anticipatory care
3. Integrated urgent community response, reablement, rehabilitation and intermediate care
4. Frailty Attuned Acute Care and integrated Dementia Care
5. System-wide awareness and understanding of frailty and the needs of the ageing population
6. Reimagining outpatient and ambulatory care
7. Enhanced health and care in care homes
8. Provision of coordinated and compassionate end of life care
9. Supporting the needs of families and informal carers

When reviewing and designing our services we will use the 3 phases of ageing to designate which phase of ageing the service is aiming to address:

1. Preparing for Later Life phase
2. Active Ageing Phase
3. Frail and more vulnerable older people phase

We have developed a matrix for organisations delivering services within the Norfolk and Waveney geography to complete that is split between these phases of ageing. This matrix is a means of beginning to consider the different levels of complexity and will support these organisations in targeting interventions and resources to where they will have most impact. It will support organisations to identify where they are currently working, where they will be able to support future service development and improvement and any omissions or duplications in current provision.

Ageing Well Programme - Progress Summary

The initial work of the programme was to undertake a service review and develop a service matrix, this has since allowed the programme team to identify gaps in service areas and potential areas for improvement.

Through this strategic framework, we have ensured the core elements of the framework feed into the Norfolk and Waveney Joint Forward Plan, specifically ambition 5: Transforming Care in Later Life. The Joint Forward Plan is our plan for the next five years and sets out how we are going to improve health and care services for our local population, their families and carers.

Each of our places have now used this framework to assess where there may be gaps in the services provided in that locality which need to be addressed, as well as to identify potential overlap or duplication.

The Ageing Well Programme consists of a selection of workstreams and projects with partners across the ICS working in a system wide, collaborative manner to make improvements for our Norfolk and Waveney population.

The programme has established a governance and reporting structure to support system wide improvement in four initial priority areas:

- Prevention
- Frailty Attuned Acute Care
- Dementia
- Care Homes & Housing with Care

Whilst this programme is continuing to develop, there is a significant drive to deliver this change and the projects which support these goals and ambitions are now in train.

Workstream Update - Frailty Attuned Acute Care

This is led by the Integrated Care of Older People consultant Dr James Casson, the ICB Speciality Advisor for Frailty.

The current focus of this workstream is to agree and implement a standardised frailty screening tool for use across the ICS. This aims to improve recognition of people with frailty. By ensuring that people with frailty are identified and coded in the same way wherever they receive care across our system, this will enable proactive targeted support to be put in place.

A clinical ageing network has been set up as part of this workstream, to allow clinicians from across the system to form a community of practise, and to give their views and assist with the identification and implementation of a standardised frailty screening tool. The network have agreed their intention to use of the Rockwood Clinical Frailty tool; and a three month pilot has commenced at Queen Elizabeth Hospital Kings Lynn, to assess the impact of the change. Core metrics are being identified for the development of a frailty dashboard.

Workstream objectives: *"1. Undertake a survey of frailty services and assessment tools across the three Trusts. 2. Agree upon a system wide definition of Frailty and single assessment tool. 3. Lead on frailty attuned acute care."*

Workstream Update - Prevention

This workstream is led by Lee Watson, Consultant in Public Health at Norfolk County Council (NCC). A key part of this workstream is to identify activities currently supporting those aged 50 an above to improve and maintain health and wellbeing including commissioned services, as well as to identify the needs of our residents. To this end, a Social Isolation and Loneliness Join Strategic Needs Assessment (JSNA) has been drafted for Norfolk and is nearing completion. A falls prevention JSNA working group has also been established to develop a needs assessment for Norfolk and Waveney. A 2024 winter communications plan has been collaboratively developed with both the Integrated Care Board (ICB) and NCC focusing on vaccinations, hardship, and winter wellness. In October, Norwich committed to becoming an age-friendly city, following in the footsteps of North Norfolk. This commitment will be followed by resident engagement to inform initial actions in the domains of transportation, housing, social participation, respect and social inclusion, civic participation and employment, communication and information, community support and health and outdoor spaces and buildings. Age-friendly communities aim to create more inclusive environments for people of all ages. The Suffolk County Council Public Health Team are currently working on their Annual Public Health Report which will focus on Ageing Well the Age Friendly domains mentioned above.

Workstream objectives: *"1. To define public health approach to healthy ageing in Norfolk. 2. To understand current position of preventative commissioned and non-commissioned services. 3. To make evidence-based recommendations for future preventative activity."*

Workstream Update - Care Homes & Housing with Care

Paul Benton, Director of Quality Assurance in Complex Care from the ICB is leading this workstream, focusing on supporting residents in care home and housing with care to live well. Specific areas of focus include the promotion of healthy living across the care market, supporting care providers to sign post residents to the most appropriate proactive clinical pathways, and supporting pathway redesign to provide more care at home for example using our virtual wards.

Currently the workstream is exploring an in/outreach model evaluation from Great Yarmouth with an intention to extend this model to other localities.

An in-person Champions Network Group has been scheduled with a focus on nutrition and building on a successful Quality improvement project "Enhancing Health Through Hydration".

The workstream also has a specific aim of reducing any inappropriate 999 call outs and ambulance conveyance of residents from care and nursing homes to acute hospitals, where better alternatives exist. Joint care home support with providers has now commenced targeting additional support to those care homes that are transferring larger numbers of residents to the acute hospitals. The ICB is looking to establish robust supporting measures for the care market during Winter. Successful pilots have also been undertaken with our out of hours primary care provider, 111 and virtual wards, which will be evaluated before any long term changes are made, in early 2025.

Workstream objectives: *"1. Reducing inappropriate conveyance from care market to the acute. 2. Support the promotion of healthy living across the care market. 3. Supporting providers/EEAST to sign post to clinical pathways. 4. Support development of pathway redesign to support care at home."*

Workstream Update - Dementia Attuned Acute Care

Work in this area was previously led by the Mental Health Programme, but this has now been realigned to the Ageing Well Programme. This workstream is now led by the Integrated Care of Older People consultant Dr Katie Honney, who is the ICB Speciality Advisor for Dementia. A Dementia Charter has been developed collaboratively with Suffolk colleagues and voluntary organisations such as the Alzheimer's Society with the intention to support organisations delivering services (or who see patients with Dementia as part of their role in health and social care) to support them in identifying the gaps in their organisations staff awareness and services delivered. This charter has now been signed by six out of seven statutory organisations across the system with self-assessment forms and action plans in the process of completion. This charter is now being shared with non-statutory providers, who are also encouraged to sign up to this. Dementia Awareness training has been delivered through the Alzheimer's Society for primary care staff between Jul-24 and Sep-24 with over 50 staff attending these sessions. An in-person Dementia Round Table Event took place in Sep-24 with representation from Acute, Community and Primary Care, Social Services and key VCSE partner organisations to share and learn from some specific patient stories, discuss the current pathway and identify potential improvements. This has led to a set of key priorities focused on education, a redesign of the current pathway for dementia and identifying those patients with suspected but undiagnosed Dementia. Whilst these key priorities have been identified, the core representatives are now considering further priorities that should be a focus in 2025/26 onwards. An Initial exploration of core Dementia metrics for the development of a dashboard to monitor the impact of this programme has commenced.

Workstream objectives: *"1. System Wide Leadership for the Dementia Programme. 2. Education & Upskilling in relation to patients living with Dementia, their families and carers. 3. Development of Dementia Data. 4. Review and redesign the Dementia Pathway across partner organisations, and the associated commissioning model."*

Next steps

Frailty Attuned Acute Care

The workstream recognise there is a clear interlinkage with the Community Falls programme within the ICB and the coming falls prevention Joint Strategic Needs Assessments (JSNA). As such, the workstream will be exploring the integration opportunities between the falls work currently taking place within the geography and any innovations and support the workstream can support in reducing, preventing and identifying patients that are at risk of a fall prior to this happening. The workstream also wishes to focus on expanding the current pilot around clinical frailty scoring to each acute hospital across the patch, as well as looking further into the education offers for frailty across the system and standardising the care offered to those frail patients.

Prevention

Finalising and publishing the Joint Strategic Needs Assessments (JSNA) for social isolation and loneliness, and Falls Prevention are current workstream priorities. These products will be available in the public domain to allow providers in the geography to consider opportunities for improvement and enable them to improve the care and experience received by both patients and their carers. These products will also be used to inform strategic conversations and informing pathways and interventions. The workstream will also be focusing on developing a healthy ageing communications plan for the public for 2025/26. The Suffolk Annual Director of Public Health report will be published in 2025.

Care Homes & Housing with Care

The workstream will be assessing digital technology and virtual assessments that could support the care market to reduce the need to convey patients from care homes to the acute

hospital setting. They will also be continuing to evaluate the use of Advanced Care Practitioner roles at NCHC that are expected to increase the uptake of virtual wards.

Dementia Attuned Acute Care

The workstream have agreed some significant priorities over the coming years, with a core focus on re-defining the dementia pathway model and standardising this where possible across the geography whilst working collaboratively with the Frailty workstream to ensure that the new pathway integrates with Frailty for the needs of the patient. The workstream also wishes to refine a number of opportunities into a deliverable two-year model, with a focus on identifying those patients with suspected dementia and early prevention.

Recommendation to ICB Public Board:

To note the contents of this report.

Key Risks	
Clinical and Quality:	• BAF05: There are increasing numbers of older people with complex health needs in Norfolk and Waveney
Finance and Performance:	• None identified
Impact Assessment (environmental and equalities):	• Age is a protected characteristic. The Integrated Care System will be able to demonstrate an appropriate and equitable response to the health needs of this population • There will need to be an appetite for change as this is about professionals working differently together, and in partnership with families and carers
Reputation:	• None identified
Legal:	• None identified
Information Governance:	• None identified
Resource Required:	• Programme and administrative support
Reference document(s):	• Norfolk and Waveney Integrated Care System Ageing Well Strategic Framework - Click Here • Norfolk and Waveney Integrated Care System Joint Forward Plan - Click Here | Ambition 5 - Click Here • Ageing Well Resources (KnowledgeNoW) - Click Here
NHS Constitution:	• None identified
Conflicts of Interest:	• None identified
Reference to relevant risk on the Board Assurance Framework	• No specific risk

NHS
Norfolk and Waveney

Ageing Well Programme

Janice Shirley, Head of System Clinical Transformation Programmes

Background

- Norfolk and Waveney has an older population compared to the rest of England. About 1 in 4 of the population is aged 65 and over and about 1 in 30 is aged 85 and over.
- Our population is older than in most systems, but a lot of our services have not been designed with older people in mind and may not be known to or easily accessed by the people who need them. Currently the available support from statutory, voluntary, and charitable services is often unknown to the person, confusing or complicated to access.
- This can mean that people don't always know what they can do to prevent ill health or get the help they need until far too late. So, we want to design and connect services to inform and support people as they age. With a focus upon prevention and ageing well, we want to make it easy for people as they age to access the right preventative intervention or support as soon as they need it. We want to simplify and join up the different types of services, social assets and amenities near to people, and delivered as close to home and as early as possible
- By making it easy to access support and by removing the barriers between the different types of support available, we will work together to enable people, as they age, to maintain their independence and preserve their quality of life for longer.

Developing the Ageing Well Strategy

How did we develop the strategy?

- ICB hosted an Ageing Well Workshop May 2023 where 85 participants from ICS partner organisations, voluntary organisations, charities and members of the public including older people and their carers attended. This was used to develop the overall aspiration, shared vision and strategy for older people.
- A desktop review (a high-level review to extract key themes, learnings, and best practices from a variety of sources) was then undertaken to sense check the outcomes of the workshop and updated national guidance
- A steering group reviewed the outcomes of both the workshop and desktop review. Seven key areas of focus were identified through this work.
- Key findings were fed back to multiple stakeholders in one-to-one interviews to sense check this.
- The steering group then combined the outcomes of that sense check to draft the strategic framework. This led to the refinement of the seven initial areas to give a new list of nine strategic goals.
- The draft strategic framework and proposed initial priorities were then shared, and ratified, at a follow-up workshop and published in Feb-24.
- This 5-year strategy has been agreed by the ICS partners

Ageing Well Vision and Mission

The Vision….

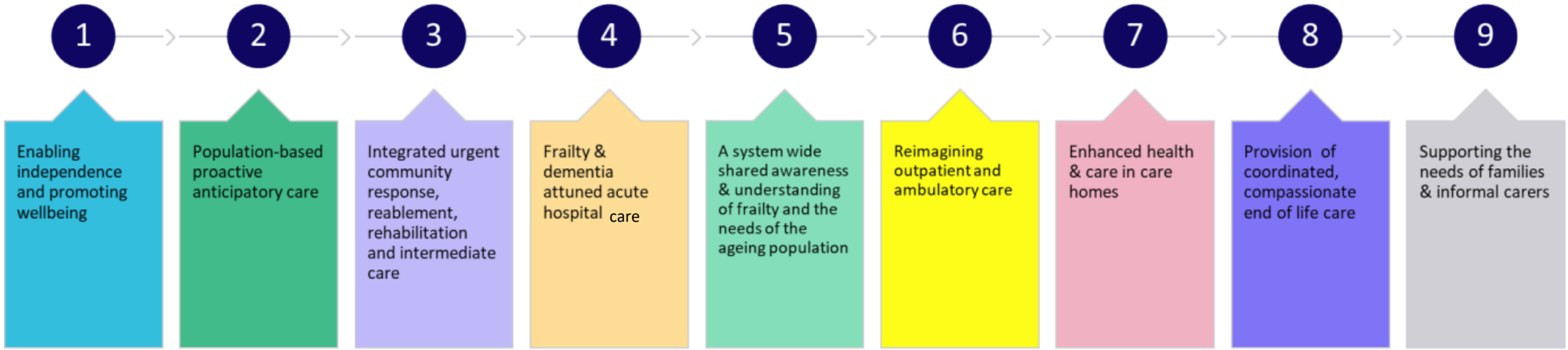
Norfolk and Waveney will be a place where people in later life, and their carers:

- Are helped to age well, living happier, healthier lives, living as independently as possible for as long as possible
- Feel heard and respected, and know they will be treated as individuals
- Experience services that ask, “what matters most to you” and proactively act upon their answer

The Mission..

is to have health, care and support services that are fit for our ageing population – supporting people as they age, to lead longer, happier, healthier lives.

The Ageing Well Strategic Framework



This framework should inform ICS partners' thinking, planning, commissioning and delivery of services for people as they age.

Older people, their carers' and loved ones' views are properly represented in decision making, design and evaluation of services

3 Stages of Ageing and Intervention

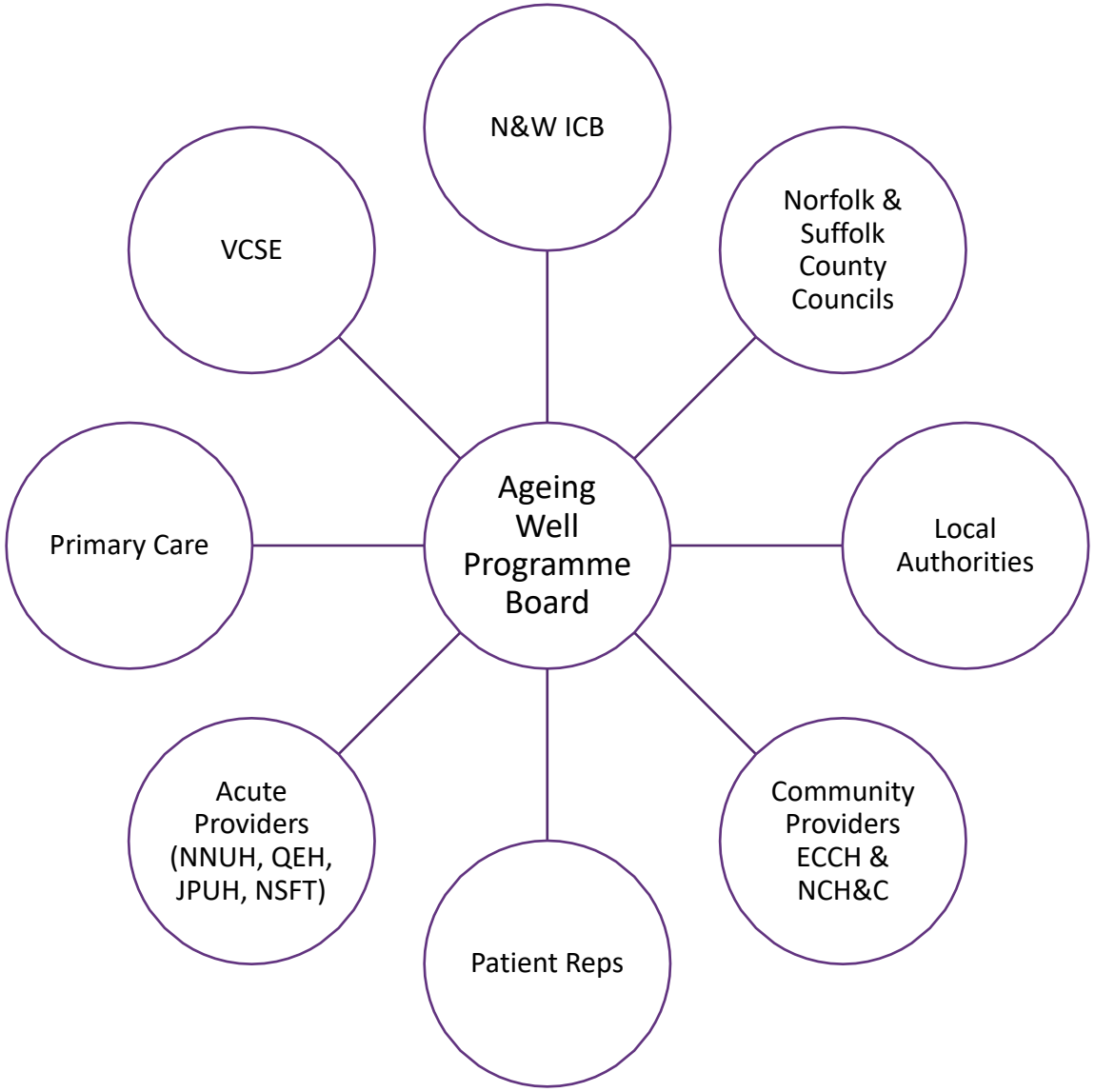
When reviewing and designing our services we will use the 3 phases of ageing to design and coordinate our services:

a) Entering old age: prevention of ill health, promote and extend healthy active life and compress morbidity (period of life before death spent in frailty and dependency)

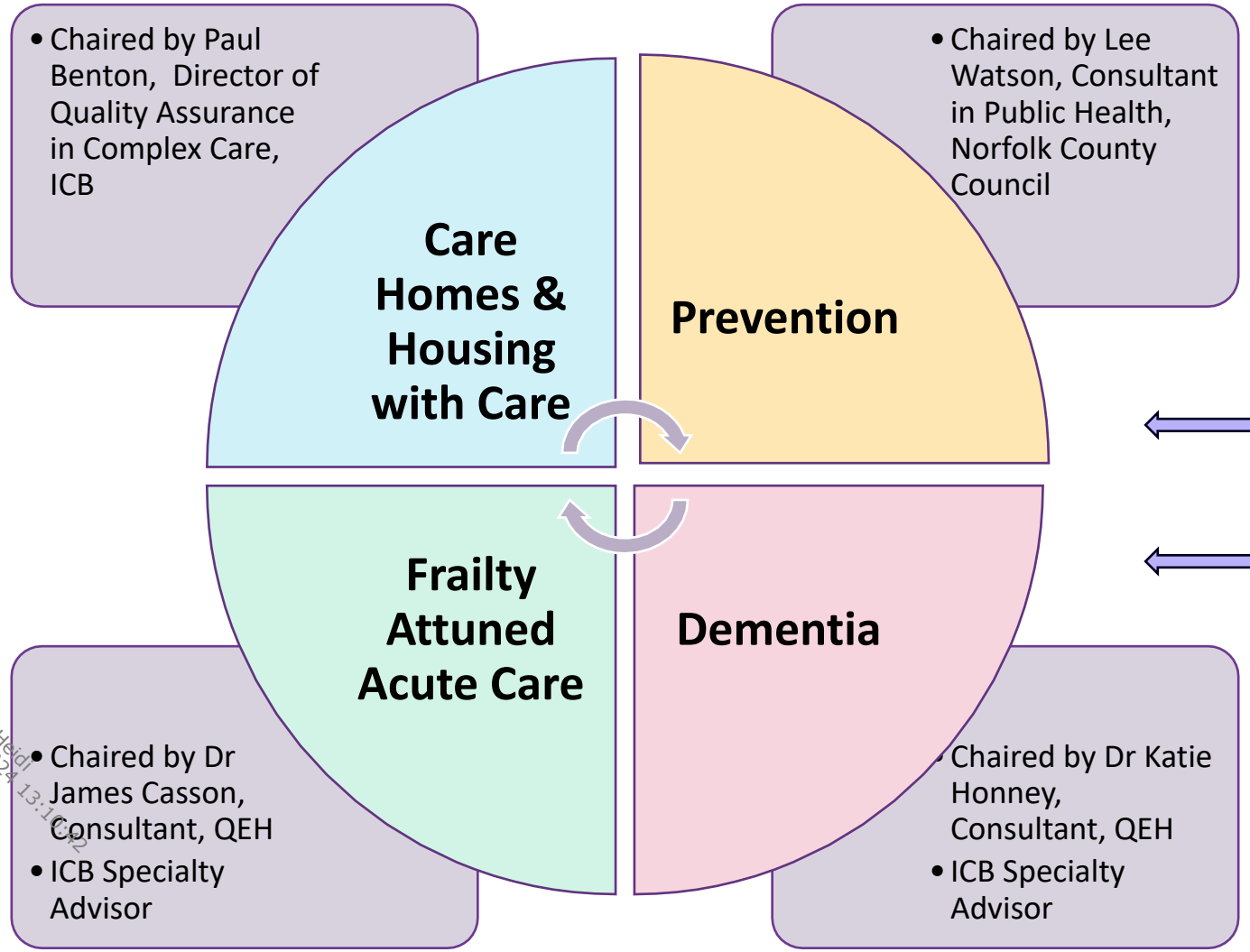
b) Transitional phase: (between healthy active life and frailty)

c) Frail and more vulnerable older people. Frailty is used to describe a state of health experienced by some people, most often older adults. It describes how some individuals lose their in-built reserves and become increasingly vulnerable to sudden changes in their health, which may be triggered by events such as an infection or change in medication or environment.

ICS Joint approach to Ageing Well



Programme Workstreams



Supporting workstreams

Palliative and End of Life Care

Medicines Optimisation

Senior Responsible Officer:
Ian Hutchison, CEO, ECCH

Senior Programme Manager:
James Allen

Workstream Objectives

Workstream High Level Summary - Frailty Attuned Acute Care

- We will undertake a survey of frailty services and assessment tools across the three local hospitals
- We will agree upon a system wide definition of Frailty and a single assessment tool
- We will lead on frailty attuned acute care and asses the current pathways requiring redesign

Workstream High Level Summary - Dementia

- We will develop education support packages for carers and patients and support upskilling of staff
- We will review and redesign the current pathway, so it is fit for purpose
- We will support earlier identification of patients with dementia and consider further opportunities based on the core stages such as identification, prevention, support for patients and carers, support for staff delivering care, post-diagnosis support and so on

Workstream Objectives

Workstream High Level Summary - Care Homes & Housing with Care

- We will reduce unnecessary transfer of patients from residential and nursing homes to the acute hospitals
- We will promote healthy living across residential and nursing homes
- We will support hospitals and ambulance services to signpost residential and nursing homes to the right clinical pathways
- We will redesign pathways to support care at home

Workstream High Level Summary - Prevention

- We will map the current position of preventative commissioned and non-commissioned services
- We will define the public health approach to healthy ageing in Norfolk
- We will make evidence-based recommendations for future preventative activity

Progress

This is a long term plan but we do have some short-to medium term objectives

Frailty Attuned Acute Care

- Set up a clinical ageing network across the three acute trusts
- Agreement to use a single tool to identify and code frail patients: The Rockwood Score
- 3-month pilot running at QEH to evaluate the tool

Workstream Update – Integrated Dementia Care

- Dementia Charter developed in collaboration with Alzheimer's Society. Signed and supported by 6/7 ICS statutory bodies
- Organisations working on self-assessment forms and action plans
- Dementia awareness training delivered to primary caer staff
- Round table event in September to share and learn from patient stories

Progress

Workstream High Level Summary - Care Homes & Housing with Care

- Promoting healthy living across the care market: Enhancing Health through Hydration
- Sign posting residents to most appropriate care pathways
- Targeting additional support to care homes to assist in reducing ambulance conveyances

Workstream High Level Summary - Prevention

- Identifying activities to improve and maintain health and wellbeing for residents over 50.
- Developing a Joint Strategic Needs Assessment on Social Isolation and Loneliness
- Established a Join Strategic Needs Assessment on Falls prevention
- Supporting drive to become Age-Friendly cities and communities

Next Steps

- Integrating community falls projects to reduce the risk, and prevent falls from happening
- Exploring education offers for frailty and standardising the care offer to frail patients
- Developing a healthy ageing communications plan
- Assessing digital technology and virtual assessments in the care home setting
- Support the increased uptake in virtual wards
- Redefining and standardising the dementia pathway
- Early identification and support for patients with suspected dementia

Improving lives together
Norfolk and Waveney Integrated Care System

Integrated Care Board Finance Report

September 2024

(Month 6 2024/25)

ICB Board – Part One: 27th November 2024

Contents

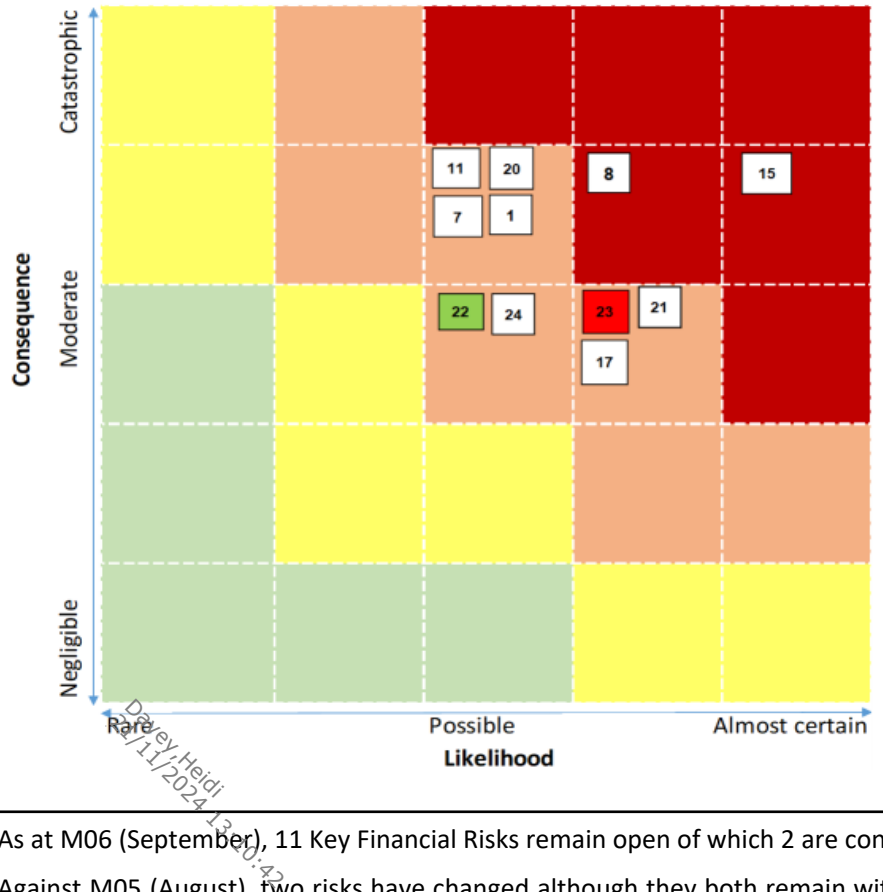
1. ICB Executive Highlights

- The following report is based on the financial plan submitted to NHSE on 12 June 2024, which included a planned £387k surplus position.
- This report represents the **M06** September **2024** year-to-date position of the ICB as part of the 2024/25 Financial Year.
- The ICB has reported an **on plan year-to-date position of £0.195m Surplus**,
- The ICB has reported a **on plan Forecast out-turn position of £0.39m Surplus**, but includes offsetting variances and other forecast assumptions, the major items being:
    - The assumed delivery of the Non-Recurrent Unidentified Efficiencies of £8.1m (this is a reduction of £6.8m due to the identification of new efficiency schemes in month). The ICB had identified potential mitigations which if delivered would cover the M06 year-to-date assumed Unidentified Efficiencies but would not, as at M06, cover the full year £8.1m risk.
    - The previously reported £(14.3)m of Continuing HealthCare (CHC) operational pressures has been funded in M06 as result of Executive Management Team discussions. The remaining forecast overspend of £0.6m is due to the utilisation of agency nurses to cover fast track nursing vacancies.
    - £(4.7)m of slippage on identified efficiency delivery within the Prescribing and Better Care Fund portfolios, and
    - £5.9m of Non-Recurrent mitigations arising from prior-year benefits, slowing of project expenditure and withholding of allocations.
- The **2024/25 Financial Plan included £51.3m of unmitigated risks** in-line with NHSE guidance relating to efficiency delivery, investment slippage, service demand, inflationary pressures beyond funding and corporate pay costs for the Re-Organisation.
- As at M06 £51.3m net planning risks were reassessed to £20.1m, which is excluded from the forecast. **Total net risks, including new risks in addition to planning risks, total £23.8m.**
- The M06 **underlying deficit is £122.3m**, a deterioration against the planned deficit of £101.8m. This arises from the full year effect of Recurrent CHC packages and the removal of the Non-Recurrent in-year savings being used to deliver the 2024/25 Financial Position. This figure is consistent with M05.

2. ICB Strategic Financial Risk Register

This risk dashboard categorises the key financial strategic risks by their impact and likelihood to help the strategic focus to be on those that will cause the ICB the greatest issues.

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



Financial Strategic Risks	Ref.	Details	Tolerated Risk appetite	Jul-24	Aug-24	Sep-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	12	12	9
	23	Debt and Working Capital Management (NCC)	6	9	9	12
Demand and Capacity	7	Continuing Health Care demand growth	9	16	12	12
	11	ERF: RTT backlog and Acute demand management	9	12	12	12
	24	Patient Choice (Learning Disabilities & Autism)	9	9	9	9
Efficiency	8	Efficiency, transformation development/delivery	8	16	16	16

Extreme	3	2	2
High	8	9	9
Moderate	0	0	0
Low	0	0	0
Total Risks	11	11	11

As at M06 (September), 11 Key Financial Risks remain open of which 2 are considered Extreme relating to the ICB Underlying Deficit and delivery against the Efficiency programme.

Against M05 (August), two risks have changed although they both remain within the High classification. Risk FINCOM22 recognises that whilst the delays to the new structure have resulted in an overspend against pay budgets, these costs have been almost fully mitigated by high vacancy volumes resulting in a reduced score of 9 from 12. FINCOM23 recognises that further discussions with NCC relating to legacy working capital continue which may cost the ICB £1.071m resulting in an increased score of 12 from 9.

3. ICB Statement of Financial Position (SOFP)

The Statement of Financial Position presents the aggregate closing position of the ICB as at 30th September 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.

Current assets
Total current assets have decreased since March 2024. The £18.1m balance is made up of aged debtors of £2m (including NHS Property Services £0.9m), net of a provision against this balance of £0.4m, prepayments & accrued income of £6m and dental under delivery of £10.5m. Trade debtors are subject to a quarterly review of bad debt for provision or write off, which are presented to the Audit Committee.

Current liabilities
Total current liabilities has decreased by £32m since March 2024, driven principally by ICB and system invoice accrual timing. The £153m balance is made up of trade creditors of £4m, Prescription Pricing Authority & dental accruals of £22m, payroll costs including GP pensions of £3m, deferred income of £3m, prior year accruals of £25m and ICB and system invoice accruals of £96m. Provisions include redundancy, legal claims, estates, standard staffing costs and elective recovery funding conditions. There has been an in-year part release against these provisions as costs are being incurred.

As part of the improvement in working capital with Norfolk County Council, outstanding non-PO transactions stand at £8.7m. All invoices raised outside of the contractual conditions against which the ICB made a full and final settlement on remain on-hold.

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 monthly. Any future commitments to balance the general fund shortfall will be supported by the next month's cash request from NHSE. This will however continue to remain negative as the NHSE principle is that cash should only be drawn based upon one month's commitment at a time

NHS NORFOLK & WAVENEY ICB STATEMENT OF FINANCIAL POSITION	Position as at 31/03/24	Position as at 31/08/24	Position as at 30/09/24
ASSETS EMPLOYED			
Non-Current assets			
Right-of-use Assets	1,005	1,005	1,005
Accumulated Depreciation	(332)	(412)	(428)
Total non-current assets	673	593	577
Current assets			
Trade and Other Receivables	23,673	23,623	18,117
Cash and Cash Equivalents	376	1,681	1,427
Total current assets	24,049	25,304	19,544
Current liabilities			
Trade and Other Payables	(174,924)	(154,136)	(153,353)
Lease Liabilities	(218)	(193)	(193)
Provisions for liabilities and charges (including non-current)	(12,786)	(10,717)	(1,957)
Total current liabilities	(187,928)	(165,046)	(155,503)
Long Term liabilities			
Non-Current Payables	(820)	(422)	(422)
Non-Current Lease Liabilities	(472)	(375)	(375)
Total non-current liabilities	(1,292)	(797)	(797)
Net assets employed	(164,498)	(139,946)	(136,179)
FINANCED BY TAXPAYERS EQUITY			
General fund	(164,498)	(139,946)	(136,179)
Total taxpayers equity	(164,498)	(139,946)	(136,179)

4. ICS Financial Summary: Revenue

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

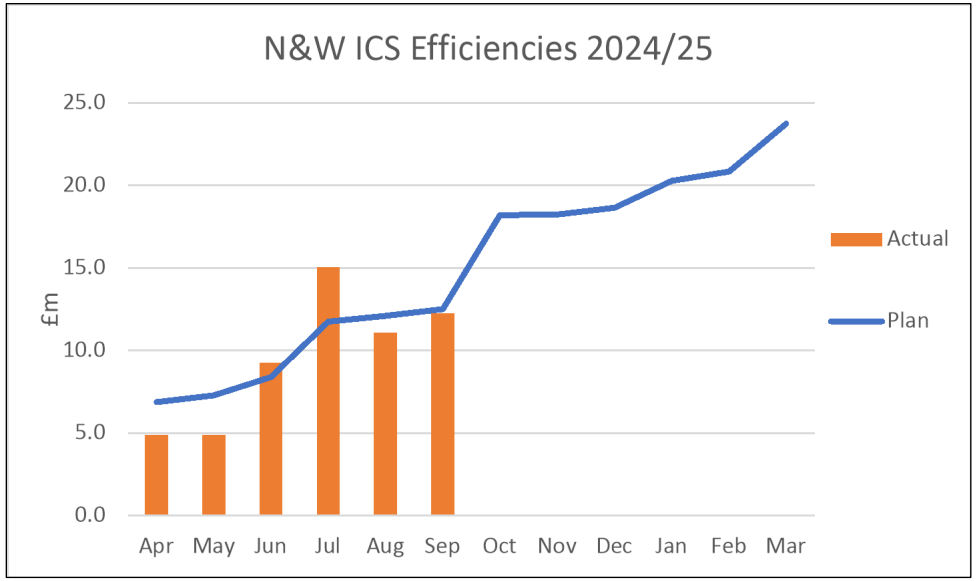
Revenue surplus/(deficit) £m	Month 6 YTD			Forecast Outturn		
Organisation	Plan	Actual	Variance	Plan	Actual	Variance
JPUH	2.6	0.1	(2.5)	(1.1)	(1.1)	0.0
NNUH	(3.5)	(13.1)	(9.5)	0.0	0.0	0.0
QEH	(6.1)	(18.9)	(12.8)	(0.8)	(0.8)	0.0
NSFT	0.6	(0.9)	(1.5)	0.0	0.0	0.0
NCH&C	(0.0)	(0.0)	0.0	1.5	1.5	0.0
Provider Subtotal	**(6.6)**	**(32.8)**	(26.2)	**(0.4)**	**(0.4)**	0.0
ICB	0.2	0.2	0.0	0.4	0.4	0.0
N&W System Total	**(6.4)**	**(32.6)**	(26.2)	**0.0**	**0.0**	0.0

- The position M6 YTD is a £32.6m deficit, which is £26.2m adverse against plan.
- Forecast outturn for the system is per plan, including the non-recurrent deficit funding of £21m allocated in M6.
- The following slides provide detail by organisation.

5. ICS Financial Summary: Efficiency and Transformation

- The N&W efficiency position is from the IFR/PFR's submitted to NHSE.

System Efficiencies £m	Month 6 YTD			Forecast Outturn			Forecast Outturn	
Organisation	Plan	Actual	Variance fav/(adv)	Plan	Actual	Variance fav/(adv)	Recurrent	Non-recurrent
JPUH	9.3	7.6	(1.7)	22.4	22.4	0.0	13.5	8.9
NNUH	18.4	11.9	(6.5)	50.1	50.1	0.0	23.1	27.0
QEH	6.9	2.8	(4.1)	29.5	29.5	0.0	25.1	4.4
NSFT	8.4	8.2	(0.3)	17.4	17.4	0.0	11.4	6.0
NCH&C	2.8	3.1	0.3	8.4	8.4	0.0	3.2	5.2
Provider Subtotal	**45.8**	**33.5**	(12.3)	**127.8**	**127.8**	0.0	**76.2**	**51.6**
ICB*	13.1	24.0	10.9	51.2	46.5	(4.7)	22.8	23.7
N&W System Total	**58.9**	**57.5**	(1.5)	**178.9**	**174.3**	(4.7)	**99.0**	**75.2**
ICB Budget Rephasing*	8.2	0.0	(8.2)	0.0	0.0	0.0	0.0	0.0
Reported ICB position	**21.3**	**24.0**	**2.7**	**51.2**	**46.5**	**(4.7)**	**22.8**	**23.7**
Revised system position	**67.1**	**57.5**	**(9.6)**	**178.9**	**174.3**	**(4.7)**	**99.0**	**75.2**



**ICB Internal reporting differs to the IFR submitted position due to a YTD efficiency plan rephasing of £8.2m. Therefore, the ICB are reporting a YTD favourable position of £2.7m against plan whereas the position against the submitted plan is a £10.9m overperformance.*

N&W ICS efficiency plan for 2024/25 is to deliver £178.9m of efficiencies.

Year-to-date:

- The efficiency position M6 YTD against plan is an adverse variance to plan of £1.5m. When including the ICB internal plan rephasing it is £9.6m adverse.
- Recurrent efficiency delivery is £27.4m against the plan of £36.7m, £9.3m under and NR delivery is £30.1m against the plan of £22.3m, £7.8m over, generating the net under delivery of efficiencies against plan of £1.5m.
- JPUH, NNUH, QEH and NSFT have various CIP schemes that are not meeting plan due to slippage. All are expected to recover during the year.
- The ICB is £2.7m favourable to budget mainly due to the 'closing the gap' exercise. NCHC has also been able to recognise some savings earlier than planned.

Full year forecast:

- Full year efficiency programme forecast is £174.3m, £4.7m adverse to plan. This variance is due to the ICB forecasting £4.7m lower than planned, mainly due to under delivery of Non-NHS procurement..

6. ICS Financial Summary: Capital

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

System CDEL £m	Forecast Outturn @ Mth 6											
	System CDEL					IFRS 16			Total System Performance			
Organisation	Plan	Plan Adj Inc./(Dec)	Total Plan	Actual	Variance (Under)/Over	Plan	Actual	Variance (Under)/Over	Tot. Plan	Actual	Variance (Under)/Over	
Excluding RAAC												
JPUH	9.1	0.0	9.1	9.1	(0.0)	0.2	0.1	(0.1)	9.3	9.2	(0.1)	
NNUH	15.8	0.0	15.8	15.8	0.0	15.5	14.4	(1.2)	31.3	30.2	(1.2)	
QEH	10.7	0.0	10.7	10.7	0.0	0.0	0.0	0.0	10.7	10.7	0.0	
NSFT	9.7	0.0	9.7	9.6	(0.0)	3.6	3.6	(0.0)	13.2	13.2	(0.0)	
NCH&C	4.6	0.0	4.6	4.6	0.0	2.0	2.0	0.0	6.7	6.7	0.0	
Subtotal excluding RAAC	**49.9**	**0.0**	**49.9**	**49.9**	**(0.0)**	**21.3**	**20.1**	**(1.3)**	**71.3**	**70.0**	**(1.3)**	
RAAC												
JPUH	7.2	1.7	8.9	8.9	(0.0)				8.9	8.9	(0.0)	
QEH	25.0	0.0	25.0	25.0	0.0				25.0	25.0	0.0	
Subtotal Including RAAC	**82.1**	**1.7**	**83.9**	**83.8**	**(0.0)**	**21.3**	**20.1**	**(1.3)**	**105.2**	**103.9**	**(1.3)**	
Adjustments												
Reduced IFRS 16 Allocation						(10.8)	0.0	10.8	(10.8)	0.0	10.8	
N&W System Total	**82.1**	**1.7**	**83.9**	**83.8**	**(0.0)**	**10.6**	**20.1**	**9.5**	**94.4**	**103.9**	**9.5**	

Central Programmes £m	Forecast Outturn @ Mth 6											
	CDEL					IFRS 16			Total System Performance			
	Plan	Plan Adj Inc./(Dec)	Total Plan	Actual	Variance (Under)/Over	Plan	Actual	Variance (Under)/Over	Tot. Plan	Actual	Variance (Under)/Over	
Total Central Programmes			131.0	105.6	(25.5)	0.0	0.0	0.0	131.0	105.6	(25.5)	
N&W Total Capital Programme			**214.9**	**189.4**		**10.6**	**20.1**		**225.5**	**209.5**		

- M6 combined system CDEL performance FOT is £9.5m above plan.
- The £9.5m forecast overspend is mainly due to the IFRS16 allocation being £10.8m lower than plan.
- The £1.3m underspend within IFRS16 schemes is mainly due to an underspend of £1.2m at NNUH.
- In addition to system CDEL, RAAC & IFRS 16 funds, there is £131.0m of central programme funding, making the total capital resource for N&W ICS £225.5m.

Glossary of terms (1)

Term	Description
BCF: Better Care Fund	A programme which supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers.
BPPC: Better Payment Practice Code	The NHS national payments code for good practice with associated mandated reporting. Sets a target of 95% compliance of paying suppliers within 30 days.
Cat M: Category M drugs	Part of the Drug Tariff which is used to set the reimbursement prices of over 500 medicines. It is the principal price adjustment mechanism to ensure delivery of the retained margin guaranteed as part of the contractual framework, using information gathered from manufacturers on volumes and prices of products sold plus information from the Pricing Authority on dispensing volumes to set prices each quarter.
CIP: Cost Improvement Programme	A provider measure of Efficiency and Productivity.
CHC: Continuing Health Care	A package of care for adults aged 18 or over which is arranged and funded solely by the NHS. In order to receive funding individuals have to be assessed according to a legally prescribed decision making process to determine whether the individual has a 'primary health need'.
GIRFT: Get It Right First Time	A national programme designed to improve the treatment and care of patients by reviewing health services. The programme undertakes clinically-led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.
GMS: General Medical Services	Contract which forms the basis of the relationship between the NHS and its GP contractors. The current contract came into force on 1 April 2004 and has been negotiated and updated annually between NHS Employers and the British Medical Association (BMA) since then. It is based upon a multi facetted formula which identifies spend and applies specific ratios resulting in an overall annual percentage pay award for each practice.
GPFV: General Practice Forward View	National development programme of investment in workforce, technology and estates designed to speed up transformation of General Practice services.
HDP: Hospital Discharge Programme	National funding stream to enable earlier discharge increasing flow in the system and release capacity in the acute hospitals.
LCS / LES: Locally Commissioned Services or Locally Enhanced Services	Services provided by GP practices that are either enhanced or additional to the core services offered. These are generally commissioned to meet a local need based on either deprivation or proximity to existing services. Includes services such as phlebotomy, anti-coagulation, atrial fibrillation and care homes. They can reduce onward referrals to Acute settings and funding is separate to practices core contracts.
Model Hospital	An NHS digital information service designed to help the NHS improve productivity, quality and efficiency. Enables health systems and trusts to compare their productivity and quality, and identify opportunities to improve.

Glossary of terms (2)

Term	Description
MHIS: Mental Health Investment Standard	The nationally set requirement for ICBs to increase investment in Mental Health services in line with their overall increase in allocation each year. This is subject to separate external audit on an annual basis to confirm compliance.
NCSO: No Cheaper Stock Obtainable	Items for which in the opinion of the Secretary of State for Health there is no product available to contractors at the price in Part VIII of the Drug Tariff, generally resulting in a higher priced product having to be used.
PHM: Population Health Management	An approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population by focusing on the wider determinants of health by using data to design new models of proactive care and deliver improvements in health and wellbeing which make best use of the collective resources.
PLICS: Patient Level Information and Costing Systems	Costing system which brings together healthcare activity information with financial information in one place. PLICS provides detailed information about how resources are used at patient-level, for example, staff, drugs, and diagnostic tests and combined with other data sources, provides trusts with a rich source of information to help understand their patients and their services.
PMS: Personal Medical Services	Voluntary option for GPs and other NHS staff to enter into locally negotiated contracts. PMS contracts offer local flexibility compared to the nationally negotiated GMS contracts by offering variation in the range of services which may be provided by the practice, the financial arrangements for those services and the provider structure (who can hold a contract).
QIPP: Quality, Innovation, Productivity and Prevention	The collective measure of system transformation efficiencies and productivity.
QOF: Quality and Outcomes Framework payments	This is a voluntary annual reward and incentive programme for all GP practices in England, detailing practice achievement results. It is not about performance management but resourcing and rewarding good practice.
Rightcare	Teams who work locally with systems to present a diagnosis of data and evidence across that population, working collaboratively with systems to look at the evidence to identify opportunities and potential threats. They use nationally collected robust data to complete delivery plans on a continuous basis, to evaluate the system and establish a base plan to maximise opportunities and turnaround issues.
Running costs / Programme costs	Running costs represent the costs of administering the ICB and the work it carries out / Programme costs represent the costs of services commissioned by the ICB.
s.117: Section 117 of Mental Health Act 1983	Entitlement to free after-care if a patient has been in hospital under specific sections of the Mental Health Act 1983. It meets the needs that a patient has because of the mental health condition that caused them to be detained and is designed to reduce the chance of the condition getting worse so avoiding a return to hospital.

Norfolk and Waveney
Integrated Care Board

Agenda item: 17

Subject:	**Finance Committee Report**
Presented by:	**Hein van den Wildenberg, Non-executive Member, Finance Committee Chair**
Prepared by:	**Emma Kriehn-Morris, Director of Commissioning Finance**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**27 November 2024**

Purpose of paper:

To provide the Board with an update on the work of the Finance Committee up to including the 29 October 2024.

A further Finance Committee is scheduled for 26 November, immediately preceding the ICB Board meeting. Any key points will be raised verbally in the Board meeting.

Committee:	Finance Committee
Committee Chair:	Hein van den Wildenberg
Meetings since the previous update	Last update provided: 25.09.2024 Subsequent Meetings: 29.10.2024 Meeting to be held at time of writing: 26.11.2024
Overall objectives of the committee:	The objective of the committee is to contribute to the overall delivery of the ICS objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan and strategy, consistent with the ICS Strategic Plan and its operational deliverables.
Main purpose of meeting:	To gain assurance on the financial position of the NHS entities in the ICS, and ICB respectively.
BAF and any significant risks relevant / aligned to this Committee:	BAF 8 – Achieve the 2024/25 financial plan. BORR08 – Underlying deficit position
Key items for assurance/noting:	*Please note that the information below is based on **Month 6** results and discussions held on October 29th. A Finance Committee meeting is taking place on November 26th, a day before the ICB Board meeting. A verbal update will be given during the Board meeting.* The main items discussed at the October 29th Finance Committee were as follows: - The Committee noted that £21m in extra funding had been received in the N&W system. Where the financial plan previously reflected a £21m deficit, the Plan is now to deliver a financially balanced plan. Whilst the extra funding is

	welcome, it has not changed the challenge in meeting the Plan. - At **Month 6 (September 2024)** the NHS entities in the N&W ICS show a deficit of £32.6m vs a Planned deficit of £6.4m, i.e. a shortfall of £26.2m. This is a further deterioration compared to previous months. The main drivers are under-delivery of efficiencies by most providers compared to Plan, premium pay cost expenditure, impacts of industrial action and service demand. Whilst the Forecast Outturn (FOT) for the year is reported as on Plan, the trajectory to get there looks particularly challenging. - At Month 6 the ICB shows a delivery on Plan, both years to date and for the financial year. The ICB has identified £6.8m in new efficiency schemes as a result of a 'closing the gap exercise', achieved by retaining non-recurrent underspend or delays to expenditure on Pay and Non-pay aspects. - Based on discussions during the October 29th committee meeting, there is presently **limited assurance** on the aggregate of NHS entities in N&W achieving their financial plan for the year. This assessment is based on the above-mentioned deteriorating trend, remaining levels of Unidentified Efficiencies, as well as lack of quantification on how the ICS Financial Recovery Board focus areas will help close the financial gap. - There is **reasonable assurance** for the ICB to achieve their financial plan, in view of the efficiency schemes identified in-month and potential mitigations from Elective Recovery Income in relation to high spend with independent providers. - In view of the deteriorating trend, NHSE moved N&W into category 4 in their Investigation & Improvement framework. Deloitte has been appointed to conduct a two-phase exercise. At the time of the meeting, Deloitte was in their first phase, being that of Investigation whereby a review of financial governance and saving opportunities are undertaken. This will inform Stage 2: Intervention to drive through changes. interviewing. Three staff from Deloitte's observed the Finance Committee meeting, as part of this exercise. Their manager shared the process being followed. - The CDEL (**Capital** Delegated Expenditure Limit) capital spend is assessed against an envelope, which now includes IFRS16 spend (essentially capitalised leases). Whilst year to date there is an underspend, due to slippage and delay in project roll-out, the Forecast Outturn presently points to a £ 9.5m overspend vs a Plan of £ 94.4m, largely driven by IFRS16 spend substantially higher than the allocation received. Work continues to happen through the **Strategic Capital Board** to assess trade-offs and manage within the financial envelope which is providing assurance to the deliverability of this position.

	- Separately there is a range of capital projects delivered under central programmes, such as Diagnostic Centres, Electronic Patient Record etc. Capital spends for these central projects this year is in line with a Plan of £ 131m. - The Committee received a report from the **Financial Recovery Board (FRB)**. The FRB, chaired by the NNUH CEO, has been reset, taking effect in September, and focussing on a select number of Sprints and work programmes to deliver near- and medium-term results. The 3 Sprint areas are: *) reduce Length of Stay; *) practical workforce actions; and *) clinical standardisation / biosimilars. Other work programmes for the medium term include the potential for a shared/single model for corporate services. Whilst the Committee was encouraged by the focus, there is a concern that no quantified impact was available. - The Committee received an update on the Medium-Term Financial Plan (MTFP), that has been submitted to the NHSE region. Whilst we are awaiting formal planning guidance for next year, the MTFP highlights a foreseen very tight financial envelope for 2025/26, not least for the ICB.
Items requiring approval:	None
Confirmation that the meeting was quorate:	Confirmed that meeting was quorate.

Key Risks (to extent applicable)	
Finance and Performance:	It is important that there is scrutiny of financial management of the ICB and the collective of NHS entities in the ICS, and this function is performed by the Finance Committee.
Reputation:	Ensuring effective committees and order of business essential for maintaining the financial reputation of the NHS entities in the ICS, including the ICB
Legal:	Finance Committee is a committee of the ICB.

NHS
Norfolk and Waveney
Integrated Care Board

Agenda item: 18

Subject:	**Deteriorating Quality Framework**
Presented by:	**Tricia D'Orsi, Executive Director of Nursing**
Prepared by:	**Evelyn Kelly, Senior Quality Governance & Delivery Manager**
Submitted to:	**Integrated Care Board**
Date:	**27 November 2024**

Purpose of paper:

To present the Board with a copy of the draft Deteriorating Quality Framework for ratification.

Executive Summary:

This document sets out the proposed ICB approach to identifying and responding to deterioration of quality across the ICS. We have based this work on a range of methodologies used to identify and respond to emerging quality concerns, across pathways, organisations and systems.

The proposed approach pulls in multiple different 'domains' that may provide insight into pathway, organisational and system performance and highlights the link between high quality care and robust and effective strategy, workforce engagement and financial management. This framework will provide a reference point for the continuous development of our shared system approach to quality oversight, assurance, and support across partners.

Additional work is taking place to develop standard operating procedures that support the algorithm and build in additional nuance and 'sector-specific' requirements for escalation and support, including pharmacy, optometry and dental.

Following Board approval, the tool will be circulated to provider partners with a request to endorse the approach through their Boards and socialise with their teams.

Recommendation to Board:

The Board is asked to:

1. To receive and respond to the content of the draft Deteriorating Quality Framework and approve for ICB implementation.

2. To receive and support the next steps in relation to sharing across the system for provider partner approval and implementation.

Key Risks	
Clinical and Quality:	The Deteriorating Quality Framework supports the collaboration approach to quality across the system.
Finance and Performance:	None
Impact Assessment (environmental and equalities):	None
Reputation:	The Deteriorating Quality Framework provides operational governance to support the ICS commitment to quality.
Legal:	None
Information Governance:	None
Resource Required:	None
Reference document(s):	None
NHS Constitution:	The Deteriorating Quality Framework provides operational governance to support the ICS commitment to quality.
Conflicts of Interest:	None
Reference to relevant risk on the Board Assurance Framework	This framework underpins and supports early identification quality and resilience risks at all levels; pathway, service, organisation, and system.

NHS
Norfolk and Waveney

Deteriorating Quality Framework

Final Draft v2.0 for Board Review

Tricia D'Orsi, Executive Director of Nursing

Introduction

This document sets out the ICB approach to identifying and responding to deterioration of quality across the ICS. We have based this work on a range of methodologies used to identify and respond to emerging quality concerns, across pathways, organisations and systems. It sets out our pathway of quality assurance and oversight, from identification of emerging issues and/or concerns, to risk assessment, support and escalation. **Key principles underpinning this approach are as follows:**

- That risk is shared across the system and that partners support each other on their improvement journeys.

- That the voice and experience of the people delivering care and support and the people, carers and families receiving care are listened to.

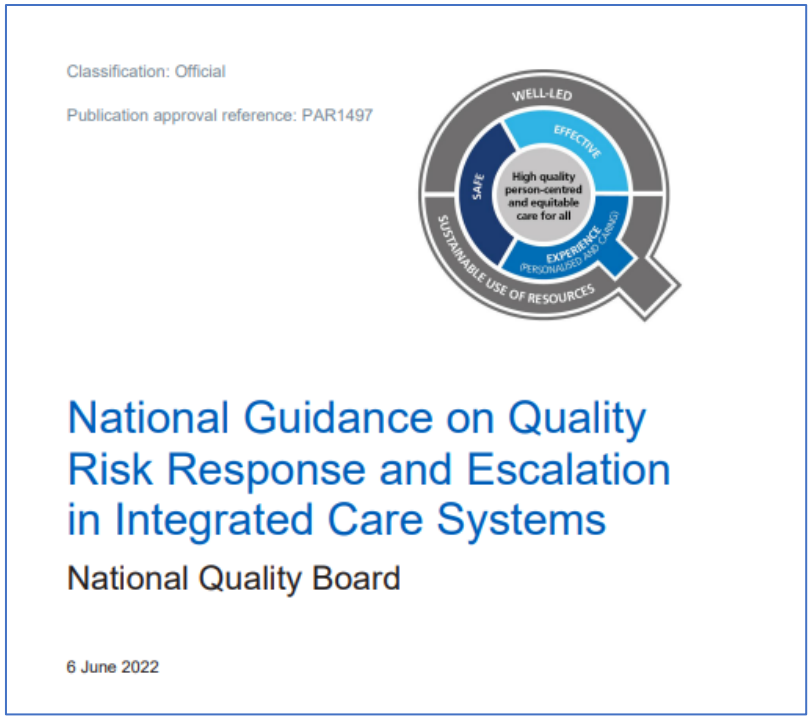
- That quality is a central consideration within efficiencies and financial decisions are made with a clear indication of how the quality and safety of care and support has been considered and maintained.

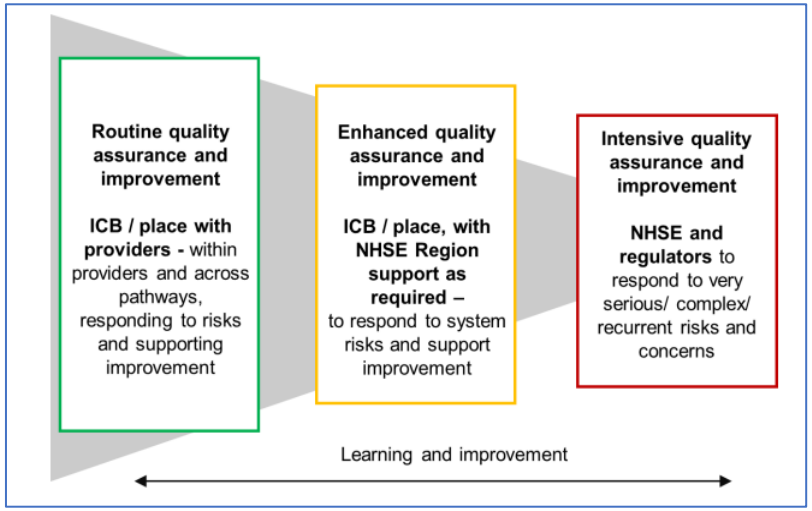
The ICB must ensure that our local population is our first priority, ensuring that within the available resources, people receive care from caring professionals; committed staff working in a common culture to protect them from avoidable harm and any deprivation of basic right.

Context

- NQB Guidance on Quality Risk Response and Escalation in ICSs sets out how quality risks should be managed in health and care systems.

- Explicit agreement that quality concerns/ risks should be managed as close to the point of care as possible, through systems, with NHS England supporting management of complex, significant and/or recurrent risks, which cannot be managed at system level.





Deteriorating Quality: Early Warning Signs (1/4)

Primary Cause	Early Warning Signs
1. Strategy	Lack of shared purpose and vision to improve quality and safety. Strategy and planning not aligned to wider system priorities and inequalities. No clear accountability framework. Lack of long-term workforce strategy. Lack of digital strategy. Inadequate strategic planning. A failure to learn and share lessons. No clear and effective quality management system. BAF not fit for purpose. Deterioration in CQC inspection ratings, including Well Led. Poor EPRR strategies.
2. Leadership	New/inexperienced leadership team. Inadequate focus on care quality demonstrated by senior leaders. Disconnect between senior leaders and staff at point of care. Limited clinical and care professional quality voice, including at Executive/Board meetings. Increasing turnover of senior managers. No leadership development strategy. Lack of Board knowledge and open discussions on finance and digital. Lack of challenge from NEDs. Failure to ensure sound system of internal controls e.g. risk/finance.
3. Culture	Culture of complacency. Closed culture and lack of transparency and candour. Defensive or unresponsive to external assurance. Fear/blame culture and bullying behaviours. Lack of professional curiosity and appreciative enquiry. Limited capacity/capability for quality improvement. Lack of learning from intelligence e.g. complaints/PALS/staff survey. Inadequate response to feedback from patient, carer and family concerns, complaints and surveys. Lack of continuous OD. Low staff morale. Lack of value and support for frontline staff. Limited value given to Patient Safety Specialists and other patient safety / clinical quality roles. Inadequate safety and QI training and support. Lack of evidence of CPD and appraisals. **Freedom to Speak Up**. Skill mix ratio of registered to support staff. Punitive approach to incident reporting.

Deteriorating Quality: Early Warning Signs (1/4)

Primary Cause	Early Warning Signs
4. Governance	**Corporate Governance:** very centralised decision making. Slow and unresponsive decision making. Regulatory breaches. Failure to address internal audit actions and/or re-audit. **Quality Governance:** Unclear roles and accountability at/below Board level in relation to quality governance. Insufficient resources, infrastructure and information systems for effective governance. Prioritisation on resolution of quality issues reported by external stakeholders over those raised internally by staff. Normalisation and tolerance of non-compliance; errors, lapses or mistakes which go unattended, unappreciated or unresolved for extended periods of time. Inadequate policies and procedures for dealing with poor clinical performance. Inadequate policies and procedures for implementing, embedding and monitoring evidence-based QI. Commissioner concerns around PSIRF implementation. Ineffective complaints management process / little evidence of complaints/claims driving improvement or as sources of learning. Ineffective systems and processes for seeking and responding to the views of staff and people using services, families and carers. Absence of proactive clinical audit programme and/or appropriate follow up action on results, absence of regular programme for clinical audit.
5. Risk Management	Lack of clearly defined risk appetite. Significant risks consistently unmitigated. Poor risk management processes, including processes and thresholds for escalation. Inadequate assessment and monitoring of efficacy of clinical risk management and digital clinical safety. Emerging risks not identified and dealt with promptly, in line with NQB guidance. Reliance on external organisations to identify compliance gaps. Poorly written action /improvement plans with a lack of SMART objectives.
6. Use of Information	Verbal assurance used in place of evidence. Limited use of quality and inequality impact assessments. Lack of triangulation of data to identify early concerns. Poor use of data to support quality improvement. Lack of holistic performance scorecard / lack of granular information to support care groups and clinical business unit.

Deteriorating Quality: Early Warning Signs (1/4)

Primary Cause	Early Warning Signs
7. Engagement & Wellbeing of Staff	Low/declining staff engagement. Multiple/persistent red flags on feedback surveys from staff and trainees. Failure to listen to / act on the views of staff, service users and stakeholders. Ineffective teamwork and poor working relationships (including between clinicians and managers). Lack of engagement / co-design with staff and people using services on service design and improvement (including Patient Safety Specialists/Partners and digital). Inadequate systems for record keeping and case management. Tensions with system partners / loss of relationships or immature relationships due to leadership behaviour or turnover. Limited communication, collaboration and data sharing with system partners. Lack of consideration or support for staff wellbeing e.g. unrealistic workloads. Geographical, professional or academic isolation. Lack of staff development (e.g. CPD, team days, joint MDT training), appraisal and reviews. Inadequate stakeholder engagement and collaboration.
8. Innovation and Improvement	Lack of improvement and change capability. Lack of co-production with staff and people using services, families and carers. Too many areas of focus / change in focus year on year. Change not sustained (but may be assumed to be so). Unwarranted variations in access, patient flow, outcomes and productivity. Non-compliance with standards, including clinical standards and quality. Lack of robust processes to ensure equitable and timely adoption of proven innovation or participation in research. Participation in NOF segments 3 or 4, and/or deteriorating performance.
9. Quality	Concerns / risks identified via system or regional quality intelligence, including via SQG/RQG and Emerging Concerns Protocol. Inadequate commissioning specifications and oversight arrangements. Contractual / legal action notifications. CQC Warning Notices, deterioration in ratings. **Safety:** significant under-reporting of incidents, infection rates. **Clinical effectiveness:** national / local clinical audits, CQC outliers, GIRFT, NCIP, SHMI and learning from deaths (e.g. LeDeR, Reg28 reports). **Experience:** patient, carer and family surveys, FFT, national surveys (e.g. GP Survey), PROMs, complaints, PALS. **Well Led:** staff surveys, staff turnover, NETS Survey. **Health inequalities:** CORE20PLUS5, health inclusion groups. **Sustainable.**

Deteriorating Quality: Early Warning Signs (1/4)

Primary Cause	Early Warning Signs
10. Operations	Deteriorating performance versus threshold of national targets or failure to improve (NOF): diagnostics, MSAB, cancer waiting times, RTT, excessive length of stay, use of s117 leave, over medication, access to talking therapies and recreational adult based activity, access to sport/diet/wellbeing/regular exercise, opportunity to access education and/or employment, OOA mental health placements. Participation in national Tiering Programme, Maternity Safety Support Programme and Recovery Support Programme.
11. Finance	Greater strategic focus on financial performance than quality. Efficiency savings made without adequate care pathway and demographic insights. Efficiency savings made without ongoing monitoring of impact on quality and outcomes. Lack of appropriate financial management and control. Increasing variance between trajectory and budget overspend. Reliance on non-recurrent savings. ICB pushing efficiency onto Providers.
12. Workforce	Inadequate processes for monitoring professional registration. Low appraisal and revalidation rates. Lack of action to address GMC/NMC standards for PG medical training / escalation to GMC/NMC enhanced monitoring. Inadequate quality control of medical training by Boards. System not using the unit for student placement. MAST completion rates not on trajectory / organisation not managing. Number and length of supervisions. Increasing sickness absence rates. Increasing use of temporary staff/increasing agency spend. Safer staffing numbers and skill mix e.g. RGN/RMN. High staff turnover / vacancy rates. Poor relationship with local trade unions / industrial action. Frontline healthcare worker vaccine uptake.
13. Outcomes	Outcomes reported by people receiving services and by staff delivering care and support. Link into Quality Strategy and Dashboard, and wider insights, including Community Voices, engagement and public health needs assessments.

ICB Nursing & Quality Team Role

The ICB Nursing & Quality Team leads on strategic quality assurance and patient safety improvement which are core functions of the ICB within the system. **The key values that underpin this work are as follows**:

- Partner relationships are key.
- The ICB approach is supportive and transparent, working with partners and providers.
- The experience and perspectives of the people delivering care and support and the people, carers and families receiving care are key to the oversight of quality.
- Early warnings have a robust and transparent route for escalation and management, with links into the ICB's risk registers, Quality Strategy and Dashboard.

The following algorithm sets out the escalation pathway for quality concerns, which may relate to a specific high-impact patient safety incident/event or cumulative concerns that have developed into a theme for concern, based on the early warning signs described in the earlier slides.

ICB Nursing & Quality Team – Routine Quality Monitoring

- ICB risk profiling
- Complaints/FFT/patient, family, carer and staff feedback, Martha's Rule
- Safeguarding
- Whistleblowing / FTSU
- PSII/Never events/NPSA
- Leadership /culture
- Safer Staffing
- Governance
- Mortality and LFD
- Delivery against contract; quality/performance
- Quality Dashboard and benchmarking e.g. Model Hospital
- NOF, Annual Quality Accounts and PSIRF plans
- Peer review / quality visit outcomes
- CQC & regulator insights
- Provider forums

Incident/insight requiring quality oversight support. **Initiate initial discussion with provider/s.**

1. Inform N&Q Senior Team. Complete SBAR* Escalation.

Further action required?

NO → **CORE BUSINESS Routine Quality & Safety Oversight and Assurance, reporting into SQG & QSC**

YES

Escalation of Risk – Working Across Teams

2. Assessment of risk. Matrix approach working with wider teams and Subject Matter Experts**.

3. Consider targeted Quality Assurance Visit in line with Protocol, with relevant Subject Matter Experts.

4. Joint working with Provider/s to address immediate concerns and form improvement plan.

5. If improvement plan actions not met, step up to Enhanced Assurance at SQG and escalate risk to ORR via Q&SC.

6. Ongoing support to Provider/s, monitoring of improvement plan and management of risk.

Was Assurance Gained?

NO → 7. Arrange Quality Review Meeting with Partners, Commissioners and Regulators to determine next steps. **Briefing for ICS EMT.**

YES

Evidence not gained that concerns would be resolved within an **agreed** timeframe.

8. Escalate to **Q&SC**. If the challenge is felt to be impacted by system financial position, escalate to **Financial Recovery Board**. Consider escalation of risk to **BORR**.

Increasing Assurance and Reducing Risk?

NO → **9. SQG Rapid Risk Review or Risk Summit. Ensure that risk is understood by all system leaders.**

*SBAR: Situation, Background, Assessment and Recommendation

** Subject Matter Experts might include Safeguarding, IP&C, Medicines Optimisation, Health Inclusion, BI etc.

Norfolk and Waveney
Integrated Care Board

Agenda item: 19

Subject:	**Quality and Safety Committee Report**
Presented by:	**Aliona Derrett, Quality and Safety Committee Chair**
Prepared by:	**Evelyn Kelly, Quality Governance & Delivery Manager**
Submitted to:	**Integrated Care Board - Board Meeting**
Date:	**27 November 2024**

Purpose of paper:

To provide the Board with an update on the work of the Quality and Safety Committee for the period of 25 September 2024 to 07 November 2024.

Committee:	**Quality and Safety**
Committee Chair:	Aliona Derrett
Meetings since the previous update on 25/09/24:	03 October 2024,14:00 – 17:00 07 November 2024,14:00 – 17:00

Overall objectives of the committee:

To seek assurance that the Norfolk and Waveney system has a unified approach to quality governance and internal controls that support it to effectively deliver its strategic objectives and provide sustainable, high-quality care and to have oversight of implementation of the ICS Quality Strategy and NHS National Patient Safety Strategy. To be assured that these structures operate effectively, that timely action is taken to address areas of concern, and to respond to lessons learned from all relevant sources including national standards, regulatory changes, and best practice.

To oversee and monitor delivery of the ICB key statutory requirements, including scrutiny of the robustness and effectiveness of its arrangements for safeguarding adults and children, infection prevention and control, medicines optimisation and safety, and equality and diversity. To ensure that patient outcomes from care are collected and measured, to inform outcomes-based commissioning for quality.

To review and monitor those risks on the BAF and Corporate Risk Register which relate to quality, and the delivery of safe, timely, effective, and equitable care. To consider the effectiveness of proposed mitigations and to escalate concerns to risk owners and operational leads/forums as agreed by Committee Members.

To approve ICB arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and secure continuous improvement in quality. To seek assurance that commissioning functions act with a view to supporting quality

improvement; developing local services that promote wellbeing and prevent adverse health outcomes, equitably, across all patients and communities in Norfolk and Waveney.	
Main purpose of meeting:	**03 October 2024** • ICS Quality Dashboard and Strategy Oversight • Mental Health LD&A Inpatient Transformation Plan • Adult Social Services System Learning Event • CYP Neurodevelopmental Service Provision • PSIRF, Lessons Learned and Complaints • Infection Prevention & Control and AMS • Terms of Reference **07 November 2024** • ICS Quality Dashboard and Strategy Oversight • Right Care Now Update • Medicines Optimisation Assurance Report • System Quality Group Assurance Report **Committee Approvals for this period:** • ICB Deteriorating Quality Framework • Policy for Children's Continuing Care • Norfolk Section 11 Safeguarding Self-Assessment • EHAI Impact Assessment Policy • ICB Pandemic Response Plan
BAF and any Board Operational risks relevant / aligned to this Committee:	**BORR02: Continuing Healthcare** Risk remains at 20, reflecting the challenges in sourcing appropriate care due to care market capacity, particularly in relation to specialised care for people with complex needs. This creates risk in relation to quality and experience of care, as well as increased financial cost of sourcing care. **BORR13: Community Nursing Unallocated Visits** Risk remains at 16, reflecting the current challenges in demand and capacity, which creates risk in relation to the quality and experience of care as well as moral injury to staff and resilience across the wider community services. **BORR14: CYP Mental Health Case Managers** Risk remains at 16, reflecting the challenges in meeting demand for case management allocation, which in turn creates risk in relation to quality and experience of care and the potential for poorer long-term outcomes. **BORR15: CYP Mental Health Waiting Lists** Risk remains at 16, reflecting the challenges in demand and capacity, which creates risk in relation to delayed treatment which impacts on the long-term outcomes for children and young people as they move into adulthood. This is also a potential area of moral injury to staff and resilience across the wider mental health pathways. **SRR54: CYP MH Approved/Responsible Clinicians**

	Risk was proposed to reduce from 16 to 12 in Month 07. NSFT is currently reviewing its crisis pathways, which will include consideration of an all-age psychiatric liaison that will cover these roles. In the interim, the Trust is using community resources to mitigate the gaps. Committee requested that the risk remain at the score of 16 with Committee oversight, to ensure that the mitigation is effective and sustainable, with a review next month. **BORR16: CYP Speech and Language Therapy** Risk remains at 16, reflecting the fact that NCC, as lead commissioner, are not currently assured of service delivery against some of the provider's key performance measures. This creates risk in relation to accessibility, quality and experience of care and outcomes for children and families. **BORR17: Euroking E3 Maternity Information** Risk remains at 16, reflecting the National Patient Safety Alert issued in relation to this information system. Concerns relate to the potential for unintended errors in pregnancy records, both within current pregnancy and those previous, which raises a patient safety risk. **BORR18: Children's Mental Health Team Skill Mix** Risk remains at 16, reflecting the Trust's challenge in accessing available trained staff to deliver its services for babies, children, young people, and families, which creates risk in relation to delayed treatment and long-term outcomes for children and young people. **BORR19: Lynch Syndrome Pathway** Risk remains at 16, reflecting the absence of a local pathway, which is opposed to NICE guidance. This creates a risk that potentially affected people will not be screened, identified, and offered risk reducing measures to protect against potentially preventable cancers. **BORR20: Care Provider Capacity System-Wide Impact** Risk remains at 15, reflecting local social care market capacity, and the risk of providers terminating care provision or closing due to failure to comply with statutory regulations. This has the potential to impact on hospital discharge activity as well as LD&A hospital admissions. **BORR21: CYP Podiatry Provision** Risk remains at 15, reflecting the inequity of paediatric podiatry services across Norfolk and Waveney. Children in Central Norfolk are unable to easily access podiatry services which creates a risk of poorer outcomes, across the short term and into adulthood. **BORR22: Adult Speech & Language Therapy Provision** Risk remains at 16, reflecting gaps in service provision emerging across the system, due to historical commissioning gaps, amendments to provider service criteria and staff skill mix. This creates a risk of some patients receiving a limited service, with poorer experiences of care and outcomes.

	BORR23: Tuberculosis Service Provision Risk remains at 16, reflecting the challenge for existing specialist TB Nurse capacity to meet increasing demand. This particularly an issue in Central Norfolk and there is inequity across the community pathway across the system. This creates risk around impact on patient safety, quality of care and public health protection. **BORR24: 12hr DTA Mental Health Breaches** Risk remains at 16, reflecting the impact of 'decision to admit' breaches where a specialist mental health bed cannot be found in a timely way. This causes extended waits for service users in busy A&E departments, that raises the risk of poor experience of care and exacerbation of symptoms in a clinically unsuitable environment. **BORR25: Surge Capacity to Support Acute Trusts** Risk was proposed to increase from 12 to 16 in Month 07 and added to the BORR. This reflects the seasonal pressures currently being experienced within the system and reflects the increased use of surge beds, which creates risk in relation to quality and experience of care. This is also a potential area of moral injury to staff. Committee supported this increase in risk rating.
Key items for Board to take note of:	**ICS Quality Dashboard and Strategy Oversight** Committee receive an update every month on the data provided by the Integrated Performance Report Quality Dashboard as well as oversight of delivery of the ICS Quality Strategy. The dashboard report highlighted headline items including urgent community response times, Cancer performance and mental health metrics relating to safety and quality of care. Committee discussed out of area mental health and noted that NSFT will be opening their River Centre in the new year, which will increase local capacity by 10 to 15 beds. Committee requested a deep dive on the number of patients and length of stays for out of area placements at the next meeting. *This item links to risk BORR24 around 12hr DTA Mental Health Breaches.* **Mental Health LD&A Inpatient Transformation Plan** Committee were briefed on the one-year plan, submitted in June 2024, setting out transformation intentions to meet national standards in years two and three. NHSE have provided feedback and offered support and to share collective learning across systems. This plan is a critical opportunity to address flow and quality needs, supporting equity of access, experience, and outcomes for those facing inequities. Committee discussed the resource within our system, focusing on quality in the care home market, and the importance of working together collaboratively. *This item links to BAF03 and BAF04 around mental health transformation.* **CYP Neurodevelopmental (NDD) Service Provision** An update was provided on the long-term system model and proposal for a business case to address the identified challenges.

	The presentation highlighted the high demand for Autism and ADHD assessments, and long waiting times. The proposed new model shifts the focus from assessments to meeting children's needs. This model aims to reduce the demand for assessments by 30% and improve current services. We currently have a waiting list of circa. 7000 with a wait time of around seven years for an assessment. If no action is taken, the waiting list could exceed 11,500 by 2027. Work around the new Provider Framework is progressing well, ensuring that private assessments meet NHS standards and reducing the backlog of reports needing NHS ratification. The quality assurance process for providers is ongoing, with clear expectations set for those choosing private assessments. The ICB Executive Director of Nursing emphasised the importance of a collaborative approach to address the crisis in neurodevelopmental services, highlighting the need for a system-wide commitment to support the proposed model and ensure quality and safety. *This item links to BORR10 around Paediatric NDD Provision.* **PSIRF, Lessons Learned and Complaints** An update was provided around the successful roll out of the national Patient Safety Incident Response Framework (PSIRF) across all Acute Trusts, with good engagement from provider partners. Independent Service Providers are now starting to adopt PSIRF and new guidance for Primary Care and Care Homes has been released. Committee received an overview of lessons learned from adverse incidents, complaints, and claims. *This item links to the Committee's delegated oversight and assurance responsibility.* **Infection Prevention & Control and AMS** Committee discussed headlines from the ICS Infection Prevention and Control and Antimicrobial Stewardship (AMS) Partnership meeting in September 2024 where the Respiratory Syncytial Virus (RSV) vaccination programme and the decline in antibiotic usage was discussed. It was noted that the local Health Protection Field Team funding ceases next April 2025, with other funding options being explored. JA emphasised the importance of collaboration and partnership in preventive measures. *This item links to the Committee's delegated oversight and assurance responsibility.* **Right Care NoW Update** Committee were updated on the current system position of patients with no criteria to reside, length of stay data and discharge activity pathway overview. Committee were also updated on the ICS Right Care NoW Transformation Programme, and ICB-led quality improvement case studies. Current priorities include further development and utilisation of the OPTICA tool and stabilisation of Pathway 2, which includes the delivery of a new modular build at NCH&C. Planning for Winter 2024/25 is underway and further priorities have been set to develop and improve Pathway 3 and develop shared system quality assurance and oversight processes. The ICB Head of Integrated Discharge is working with the Dementia Leads at NCH&C to

	integrate the new Dementia Intensive Support Specialist Nurse into existing services. *This item links to BORR 02 and BORR20 risks around NHS CHC and Care Market Capacity.* **Medicines Optimisation Assurance Report** Committee received an update on the current position for primary care prescribing with a quality and safety focus, particularly around local work to reduce the use of dependence forming medicines, emphasising the importance of patient education and engagement in reducing opiate prescriptions. The system broad-spectrum antibiotic prescribing rate has dropped below 10%, supported by a joined-up approach between the ICB Medicines Optimisation Team and ICB Infection Prevention and Control Team. The team is working with PCN Teams to communicate the importance of improvement and address misunderstandings about antibiotic prescribing. *This item links to the Committee's delegated oversight and assurance responsibility.* **Regulation, Standards and Best Practice** Committee were briefed on the national health protection response to the outbreak of Clade I Mpox in Eastern and Central Africa. *This item links to the Committee's delegated oversight and assurance responsibility.* **System Quality Group Assurance Report** Committee received an update on the work of the Norfolk and Waveney System Quality Group (SQG) for the period of 23/08/2024 to 25/10/2024. It highlighted ongoing work at JPUH to address Regulation 29a issues raised by CQC in their obstetrics and maternity department. A Rapid Quality Review Meeting has been held to address these concerns and work with key partners, including NNUH who have provided peer support. NNUH remain under enhanced GMC monitoring for its junior medical staff education and training programme and the Trust is working closely with the NHS England regional team. Committee noted the quality concerns that had been raised in respect of the outgoing non-emergency patient transport service (NEPTS) and reflected on the transparent and proactive approach of its new provider.
Items requiring formal approval of Board:	**ICB Deteriorating Quality Framework (Board Item)** The framework sets out the proposed ICB approach to identifying and responding to deterioration of quality across the ICS, based on a range of methodologies used to identify and respond to emerging quality concerns, across pathways, organisations and systems. The proposed approach pulls in multiple different 'domains' and highlights the link between high quality care and robust and effective strategy, workforce engagement and financial management. This framework will provide a reference point for the continuous development of our shared system approach to quality oversight, assurance, and support across partners. Following Board approval, the tool will be circulated to provider partners with a request to endorse the approach through their Boards and socialise with their teams.

Confirmation that the meeting was quorate:	The October and November 2024 meetings were quorate, as defined in the Governance Handbook.

Agenda item: 20

Norfolk and Waveney
Integrated Care Board

Subject:	**Risk Management**
Presented by:	**Karen Barker, Executive Director of Corporate Affairs and ICS Development**
Prepared by:	**Nikki Bartrum, Corporate Governance Senior Manager**
Submitted to:	**Norfolk and Waveney Integrated Care Board – Board Meeting**
Date:	**27 November 2024**

Purpose of paper:

This paper presents the Board with a copy of the updated Board Assurance Framework to assist in the facilitation of discussions around risks associated impacting the ICB's ability to deliver its 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 Board Assurance Framework (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.

The risk registers were last presented to the Board in public in September 2024. Since then, many teams have been reviewing and updating their risks.

Please find attached a copy of the following (as at 20 November 2024):

- Appendix 1: Board Assurance Framework (BAF)
- Appendix 2: Risk visual

Attention is directed towards the following notable changes:

Board Assurance Framework (BAF)

Risk	Changes
BAF03: Barriers to Full Delivery of the Mental Health Transformation Programme (CYP)	• Risk has transferred from the Quality and Safety Committee to the Commissioning and Performance Committee.
BAF04: Barriers to Full Delivery of the Mental Health Transformation Programme (Adult)	• Risk has transferred from the Quality and Safety Committee to the Commissioning and Performance Committee.
BAF06: System / Urgent & Emergency Care (UEC) Pressures	• Risk has transferred from the Patients and Communities Committee to the Commissioning and Performance Committee.

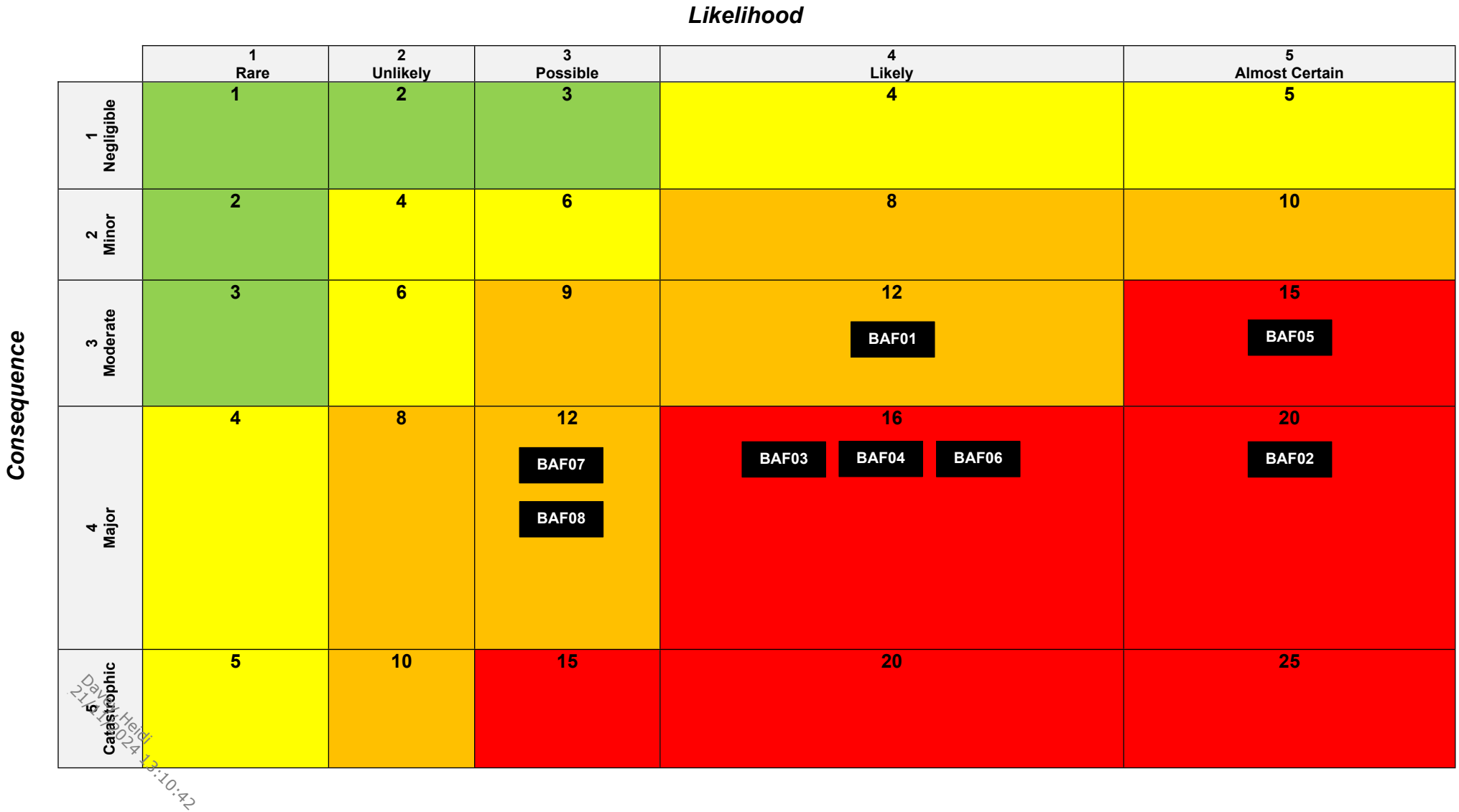
Recommendation to the Board:

The Board are asked to note the contents of this paper and approve the change in responsible committee for BAF03, BAF04 and BAF06.

Key Risks	
Clinical and Quality:	None
Finance and Performance:	None
Impact Assessment (environmental and equalities):	None
Reputation:	It is important the Board is apprised of the key risks in the organisation currently.
Legal:	N/A
Information Governance:	N/A
Resource Required:	Corporate Affairs risk management resource
Reference document(s):	None
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Appendix 2: Risk visual

Board Assurance Framework risks
Board Operational Risk Register risks



Norfolk and Waveney Integrated Care Board

NHS Norfolk and Waveney ICB – Board Assurance Framework

Version	V4	Date last updated:	

Board Assurance Framework – Summary Page

Ref	Risk title	Executive lead	Committee	Date risk identified	Target delivery date	Risk appetite	Score at target delivery	2024/25 monthly risk rating											
								1	2	3	4	5	6	7	8	9	10	11	12
Ambition 1: Population Health Management, Reducing Inequalities and Supporting Prevention																			
BAF01	Health Inequalities and Population Management	Mark Burgis / Frankie Swords	Patients & Communities	01/07/22	31/03/25		4	12	12	12	12	12	12	12					
Ambition 2: Primary Care Resilience and Transformation																			
BAF02	Primary Care Resilience and Transformation	Mark Burgis	Primary Care Commissioning	31/08/24	31/3/27		12					NEW	20	20					
Ambition 3: Improving Services for Babies, Children and Young People and Developing Our Local Maternity and Neonatal System (LMNS)																			
BAF03	Barriers to Full Delivery of the Mental Health Transformation Programme (CYP)	Tricia D'Orsi	Commissioning & Performance	01/07/22	30/11/24		8	16	16	16	16	16	16	16					
Ambition 4: Transforming Mental Health Services																			
BAF04	Barriers to Full Delivery of the Mental Health Transformation Programme (Adult)	Jocelyn Pike	Commissioning & Performance	01/07/22	31/03/25		8	16	16	16	16	16	16	16					
Ambition 5: Transforming Care in Later Life																			
BAF05	Increasing number of ageing population with complex health conditions	Frankie Swords	People and Communities	20/06/204	31/03/28		12			New 15	15	15	15	15					

Ref	Risk title	Executive lead	Committee	Date risk identified	Target delivery date	Risk Appetite	Score at target delivery	2024/25 monthly risk rating											
								1	2	3	4	5	6	7	8	9	10	11	12
Ambition 6: Improving Urgent and Emergency Care																			
BAF06	System / Urgent & Emergency Care (UEC) Pressures	Mark Burgis	Commissioning & Performance	01/07/22	31/03/25		**12**	**16**	**16**	**16**	**16**	**16**	**16**	**16**					
Ambition 7: Elective Recovery and Improvement																			
BAF07	Elective Recovery	Andrew Palmer	Commissioning & Performance	01/12/22	31/03/25		**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**					
Ambition 8: Improving Productivity and Efficiency																			
BAF08	Achieve the 2024/25 Financial Plan	Steven Course	Finance	10/05/22	31/03/25		**12**	**12**	**12**	**12**	**12**	**12**	**12**						

Ambition 1: Population Health Management, reducing inequalities and supporting prevention

BAF01 (Inphase ref 00000008)	
Risk Title	**Health inequalities and Population Health Management**
Risk Description Please include any collaboration and partnership aspects of the risk.	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.

Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Mark Burgis / Dr Frankie Swords	Patients and Communities	Suzanne Meredith/ Tracy Williams/ Shelley Ames	**01/07/2022**	**31/03/2025**

Risk Scores								
Unmitigated			**Mitigated**			**Target**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	**4**	**16**	**3**	**4**	**12**	**1**	**4**	**4**
Risk appetite:					**Risk tolerance:**			

Controls	**Assurances on controls**
• The HI Strategic Framework for action and the PHM strategy have been published. Implementation plans under development. • Specialty advisors are leading on HI, PHM.and the Core20Plus5 clinical areas. • ICP supported proposals for a strategic group and co-ordination group to formally oversee delivery of the Health Inequalities Framework for action. Co-ordinating multi-partner health inequalities group now in place. .SROs established for Lifestyle factors and Healthcare Inequalities • Health Inequalities & VCSE Partnering team appointed to lead health inequalities work programme development. • The Health Improvement Transformation Group (HITG) focusses on Primary Prevention: smoking, physical activity and Healthy weight, report to ICP. • Community Voices gathering insights into HI and connecting with local communities to help address. • ICS groups set up for Inclusion health groups, vaccines inequalities, Core20plus5 programme group, NHS Anchors group, access and support programme group, reporting to HIOG • Datahub Population Health dashboards in place to support reporting and health oversight. • 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	**Internal:** PHM and addressing HI has been identified as a priority in our JFP. Progress against key national delivery timelines reported and led by appropriate governance structures: Health Inequalities Oversight Group (HIOG), PHM Oversight Group (PHMOG) and PH and Inequalities Board with assurance reporting to Patients and Communities Committee. NHSE reporting of NHS Inequalities Improvement Frameworks and annual reporting against NHS statement on Information for health Inequalities. Elective Recovery Board receive regular reporting on waiting lists per decile of deprivation index **External**: Integrated Care Partnership Board Health Inequalities governance structure including a strategic steering group and co-ordination group.

receive) are raised by the HI team to be managed across the ICP. • Refresh of the VCSE Assembly and partnership working reporting into the PH&I Board	

Gaps in controls or assurances

- Embedding resources at Place level to co-ordinate the mechanisms needed to address HI and deliver PHM.
- Further work required to develop the data hub and dashboards.
- NHSE HI funding not ring-fenced to support emerging work programmes and respond to system priorities.
- Agreed governance for Equality health impact assessments but uniform process not yet established.
- Dashboard of indicators to monitor progress for PHM and HI under development as part of ICB datahub

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
28/10/24	ICS Health Inequalities commitments launched at ICP conference on 16th October. Working groups now established for NHS Anchors and Core20Plus5. The NHS Anchors Group will be overseeing completion of NHS Boards HI self-assessments. The ICBs own Board HI Self-assessment will be presented as part of the 12 November All-staff event. Re-procurement of specialist software to support PHM programme now completed.	**G**	**30/11/24**

Visual Risk Score Tracker – 2024/25

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

Ambition 2: Primary care resilience and transformation

BAF02 (Inphase ref 00000032)				
Risk Title	**Primary Care Resilience and Transformation**			
Risk Description Please include any collaboration and partnership aspects of the risk.	Under the Joint Forward Plan we have committed to integrating primary care services to deliver improved access (including digital tools and remote monitoring offers, etc.) to a wider range of services from multi-professional teams, focused on preventing illness and improving outcomes for our population within their communities. Our high-level outputs include: • Developing a vision for providing accessible enhanced primary care services • Improving patient outcomes and experience • Stabilise dental services and setting a strategic direction for the next five years Primary Care Services are the responsibility of the Integrated Care Board, including the recruitment and retention of healthcare professionals. There are particular risks to the resilience of general practice, access to NHS dentistry treatment and Level 2 dental services which are reflected in the risk scores. The community pharmacy and optometry landscape is less defined at the time of writing, but workforce and funding challenges are evident across community pharmacy which represent a risk, but could potentially be supported through greater integration and collaborative working with other primary care providers. Limitations of national contracts, collective action by General Practice, independent contractors 'handing back' NHS contracts, workload pressures, recruitment and retention and interface challenges are, together, impacting on access to high quality, sustainable primary medical, community pharmacy and dentistry services together with Level 2 dental services for our population. This may lead to delays in accessing care, unavailability of care (particularly dentistry), 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, and fragile services. • As the cornerstone of healthcare, primary care resilience risks system ability to deliver against key workstreams, including the overall aim of moving towards a more population-based proactive community model of care which addresses prevention, health inequalities and improves outcomes. Reduced access in primary care may also impact on the resilience of other system providers.			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Mark Burgis	Primary Care	Sadie Parker	**31/08/2024**	**31/03/2027**

Risk Scores								
Unmitigated			**Mitigated**			**Target**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**5**	**4**	**20**	**3**	**4**	**12**
Risk appetite:					**Risk tolerance:**			

Controls	Assurances on controls
• ICB organisational change programme has seen a reduction in vacancies within the Primary Care Commissioning and Strategic teams. • Operational readiness work is seeking to align the Primary Care Team with colleagues from Workforce, Estates, Digital, Place, Quality, Planned Care and Finance, etc. to support	**Internal:** ICB Executive Management Team, Primary Care Commissioning Committee, Dental Services and General Practice & Community Pharmacy Delivery Groups, Workforce Steering Group, Primary Care Strategic Planning Meetings, Primary Care Team **External:** NHS England via delegation agreement and assurance framework, Health Education England, Norfolk

joined up primary care; including access to sustainable dentistry and general practice services. • An overarching strategic vision and principles for primary care are being finalised to support the development long-term plans for general practice and community pharmacy during 2024/25, followed by optometry. • A long-term dental plan has been published, with delivery monitored through PCCC. • Performance/quality management and reporting in place. • Clinical expertise provided by Clinical and Care Professional and Clinical Fellow roles across primary care. • Ring-fenced budgets and commissioning targeted to simultaneously support population need and resilience. • Primary Care Access Recovery Plan delivery reported regularly to ICB Board and NHS assurance meetings. • System Interface Group and matrix working in place to support national requirements for self-assessment. • Local LMC General Practice Alert System established which informs improvement and support work monitored through the PCCC. • Strong relationships in place with local representative committees across all primary care services.	and Waveney Local Dentistry and Medical Committees, Health Overview and Scrutiny Committee meetings, Regional and Local Professional Network and Managed Clinical Networks, Healthwatch Norfolk/Suffolk, NHS Business Services Authority. Primary Care Commissioning Committee meetings held in public.

Gaps in controls or assurances
• Lack of in-depth knowledge about the resilience and stability of **all** primary care services across Norfolk and Waveney. • Lack of awareness and understanding across the system about the impact struggling primary care services will have in the longer term on other system partners and services. • Unknowns associated with the ongoing collective action associated with the BMA's 'Save General Practice' campaign in respect of pressure on primary medical care and other system partners and impact on access to healthcare for our population. • Significant gaps in ICB teams remain following restructure and reliance on wider teams (eg Quality and Workforce) to address the issues – there is a reduction in vacancies in the primary care team but building knowledge and relationships will take time, with operational readiness work in progress. • ICB's financial position is impacting on our ability to support resilience and transformation in primary care leading to temporary and more expensive solutions being put in place, particularly across dental and primary medical contractors. • Primary care dashboard/ delivery report remains in development, leading to a lack of integrated performance oversight. • Lack of access to NHS dentistry services is an area of quality and safeguarding concern - this impacts 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. • CQC activity is currently focused on private dental practice, rather than NHS practices. • General practice visit programme has been tested but not launched due to vacancies impacting capacity, CQC inspections focused on where there is a significant risk or concern. • Data to capture inappropriate transfers of workload and general practice pressures is incomplete - planning resources may be less effective if based on an incomplete picture. • Workforce and capacity shortages across general practice, community pharmacy and dental practices, together with the ongoing drug shortages, are having an impact on access to robust and effective primary care provision. • Resilience policy in development, which will link into any bids for section 96 support for general practice. • Five-year Primary Care Strategy has expired, new strategic framework/long term plans in development for integrated neighbourhood working, general practice and community pharmacy, however capacity and long term absence is affecting progress.

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**
28/08/24	Dental • ICB Clinical Advisor - Dental successful appointment made, going through recruitment checks. • Year-end reconciliation for 2023/2024 complete. • Review of urgent treatment pilot complete. • All Golden Hellos have been taken up for the year.	**B**	**Complete**
28/08/24	Medical • New ICB interface manager post, successful appointment. Beginning to review the work programme and Terms of Reference for the System Group. • Close monitoring of BMA collective action ongoing. • Triple lock approval for funding of MGUS monitoring, now going through governance.	**B**	**Complete**
28/08/24	Draft primary care vision and principles being presented to PCCC for discussion and approval.	**B**	**Complete**
31/09/24	Dental • ICB clinical advisor has commenced. • Expressions of interest received from existing providers to increase access with a focus on health inequalities. • New senior primary care commissioning manager has taken up post. • SNEE ICB has begun recruiting to the regional team for supporting development of specialist secondary care dental services Medical • Workshop held to review Terms of Reference and project infrastructure for system interface group. • Close monitoring of BMA collective action ongoing. • MGUS disease monitoring LES fully approved and being offered to practices. • Draft primary care vision and principles approved in principle, final amends being circulated to voting members. Community Pharmacy • National discussion about potential collective action for community pharmacy. • New risk for community pharmacy developed for approval. • Commissioning officer in the team remains vacant.	**A**	**31/12/24**
28 /10/24	The primary care workforce team has moved into the primary care directorate and is responsible for general practice, dentistry and optometry. 49 programmes are actively being delivered. Community pharmacy workforce development sits within the medical directorate. Primary care vision and principles has been shared with primary care commissioning committee members for final approval. Work is now starting to develop an overall strategic framework for primary care Dental • Expressions of interest to provide additional capacity targeting health inequalities reviewed and in the process of being confirmed with providers so capacity can come on stream this financial year. • Mid-year review process underway.	**A**	**31/12/24**

	• National workforce data received with analysis underway. A reduction in workforce is noted, and the staff groups collected are limited. Medical • Close monitoring of the impact of GP collective action continues, feeding into regional monitoring. • The team has started planning for a programme of work to develop a long-term plan for general practice. • The ICB is currently out to consultation on a proposal to close the Toftwood Medical practice in Dereham and transfer patients to neighbouring practices. Public drop-in sessions and a public meeting are due to take place in November, with the final decision at Primary Care Commissioning Committee in December. Community Pharmacy • Materials being developed to support general practice in referring to Pharmacy First. • Relaunch of Pharmacy First coming on line in early November. • NWICB performance on Pharmacy First is strong when compared to regional colleagues however there is more opportunity to increase referrals		

Visual Risk Score Tracker – 2024/25												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score					**20**	**20**	**20**	**20**				
Change					**NEW**	➡	➡	➡				

Ambition 3: Improving service for babies, children and young people and developing our Local Maternity and Neonatal System (LMNS)

BAF03 (Inphase ref 00000007)				
Risk Title	**Barriers to full delivery of the Mental health transformation programme (CYP)**			
Risk Description Please include any collaboration and partnership aspects of the risk.	There is a risk that during a period of unprecedented mental health demand and acuity of need, current system capacity and models of care are not sufficient to meet demand. If this happens individual need will not be met at the earliest opportunity, by the right service or by the most appropriate person and need will escalate. This may lead to worsening inequality and health outcomes, increased demand on other services and reputational risk			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Tricia D'Orsi	Commissioning & Performance	Rebecca Hulme	**01/07/2022**	**30/11/24**

Risk Scores								
Unmitigated			**Mitigated**			**Target**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	**4**	**16**	**4**	**4**	**16**	**2**	**4**	**8**
Risk appetite:				**Risk tolerance:**				

Controls	**Assurances on controls**
• Dedicated CYP strategic commissioning team in place • Effective System wide governance framework • Collaboration with system partners to understand demand and capacity has begun and the shared resource is better understood. • Development of robust understanding of the financial envelope available to drive the transformation, and investment necessary, including appropriate measures to reconcile these is still in process. • System approach to increasing knowledge skills and expertise across agencies and developing additional capacity through use of digital. Greatly assisted by digital appointing a digital lead. Digital workstream initiated. • Financial slippage is being mitigated against protecting our ability to maintain MHIS investment. • Implementation of system wide transformation programme • Commitment from system partners to adopting Thrive approach – mental health needs being considered and addressed in wider health and social care settings. • Additional partnership working with VCSE. • All age Eating Disorder Strategy • Established Children and Young Peoples System Collaboratives in Norfolk and Suffolk • Working in partnership with Norfolk and Suffolk Constabularies to implement a system wide collaborative approach to Right Care Right Person • Intensive day support unit now open for eating disorders and parent support offer in place. • Professional Therapeutic Pathway in place • Integrated Front Door phase one and two in place • Enhanced support offers for 18–25-year-olds in wellbeing hubs. • Gender Identity Service in place • Additional capacity within Professional Therapeutic Pathway in place	**Internal:** SMT, EMT, Integrated Care Board, Finance Committee, Quality Committee, Mental Health Oversight Board, Transformation Delivery Group **External**: CYPMH Executive Management Group, CYP Strategic Alliance Board, HWBs Norfolk and Suffolk, NW Health and Care partnership MH Board, NHSE/I Regional MH Board and subgroups, HOSC Norfolk and Suffolk, System Improvement and Assurance Group, Children and Young People's System Collaborative

Gaps in controls or assurances
• Capacity and commitment within main NHS provider to support transformation and collaboration impacted by historical backlog, ongoing quality concerns and frequent changes in leadership and care model. • Capacity within the substantive CYP integrated commissioning team to deliver on the scale of transformation required. • ICB's financial position is impacting on the ability to support resilience and transformation. • 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. • Lack of clarity about leadership for CYP within new structure. • Lack of alignment in age bands with model in Suffolk footprint.

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 Update 28.08.24 Workforce information outstanding. Further discussion has taken place regarding information format. Update 31.10.24 Meeting has taken place with NSFT staff to agree information needed, remains outstanding. Requested again through SPQRG.	**R**	**30/11/24**
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 19/06/24 referrals to NSFT reducing following introduction of Integrated Front Door. No corresponding reduction in waiting list to date. NSFT have developed a recovery plan for referral to assessment and are developing a similar plan for referral treatment. Exploring opportunities to utilise additional capacity. Update 28.08.24 significant work within main provider to reduce waits. All CYP waiting longer than 52 weeks for assessment have been addressed – plan now to look at those waiting >48 weeks. Corresponding work to reduce referral to treatment waits. Some concerns regarding sustainability raised at SPQRG Update 31.10.24 Delays to treatment still significant despite significant reduction in demand. Request to provider to review productivity. Some referrals still being rejected despite IFD in place and triage at referral.	**R**	**30/11/24**
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. Update 19/06/24 funding approved, next steps meeting with NCC to mobilise plan. Update 28.08.24 meeting with NCC taken place. Refinement of model to further develop integrated model and to ensure best use of capacity	**A**	**31/03/25**
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. Workshop completed 15/12/2023. Priorities for workstreams proposed and will be established within January 2024 Update 19/06/24 workstreams established and scoping vision for priority areas. Update 28.08.24 Case for change in development. For presentation to Executive team in October 2024 Update 31.10.2024 case for change agreed. Further work required to develop screening tools and develop business case to be taken through prioritisation process	**A**	**31/10/24**
02/01/24	Integrated Front Door further role out to include NSFT direct referrals scheduled to commence April 2024	**B**	**Complete**
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.	**B**	**Complete**

Visual Risk Score Tracker – 2024/25												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	**16**	**16**	**16**	**16**	**16**	**16**	**16**	**16**				
Change	→	→	→	→	→	→	→	→				

Ambition 4: Transforming Mental Health Services

BAF04 (Inphase ref 00000006)				
Risk Title	**Barriers to full delivery of the Mental health transformation programme (Adults)**			
Risk Description Please include any collaboration and partnership aspects of the risk.	There is a risk that during a period of unprecedented mental health demand and acuity of need current system capacity and models of care are not sufficient to meet the need. If this happens, individual need will not be met at the earliest opportunity, by the right service or by the most appropriate person and need will escalate. This may lead to worsening inequality and health outcomes, increased demand on other services and reputational risk			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Jocelyn Pike	Commissioning & Performance	Mark Payne	**01/07/2022**	**31/03/2025**

Risk Scores

Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	**4**	**16**	**4**	**4**	**16**	**2**	**4**	**8**

Risk appetite:		**Risk tolerance:**	

Controls	Assurances on controls
• System wide governance framework in situ • Finance & Planning working group meet monthly to drive robust financial arrangements and deliver planned MHIS investment. • Ongoing work with Population health management team to proactively contact and offer support/ physical health assessment and vaccination. • Working in partnership with Norfolk and Suffolk Constabularies to implement a system wide collaborative approach to Right Care Right Person	**Internal:** SPRG, SMT, EMT, Board **External**: N&W MH Strategic Oversight Board, HWBs Norfolk and Suffolk, NW Health and Care partnership MH Forum, HOSC, Norfolk and Suffolk NHSE/I Regional MH Board and subgroups, NHSEI System Improvement and Assurance Group,

Gaps in controls or assurances

- Impact of pandemic and cost of living crisis on mental health and well-being of population leading to increased need for support and adding to capacity pressures and resilience of providers
- Organisational development required to drive forward internal cultural change. Cultural shift required as a system to enable successful transformation and ensure mental health is better understood and regarded as 'everyone's business.'
- Cultural, digital and operational collaboration to enable access and easily navigable mental health services, is at an early stage of development.
- Conflicting priorities across complex system transformation agenda
- Intra-system Electronic Patient Record connectivity, especially at the interface of primary/secondary/social care and third sector provision, remains a challenge and priority to address.
- Ability to recruit, retain and train a viable number of staff to enable service expansion and meet the MH and well-being needs of the N&W population.
- Limited influence on alternative provision within a tightly prescribed talking therapies model – National NHSEI and HEE guidance is restrictive and does not allow local flexibility.
- The ICB restructure commenced July 2023 impacting on team capacity.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
29/04/22	Phase 1 of the N&W Long term Plan (LTP) funded MH Transformation Programme Plan completed 31/03/24. 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**

	Phase 2 of MH Transformation continues to be developed. Recent reviews of community and crisis teams within NSFT are providing the foundations of the next phase of transformation.		

29/04/22	Focus on MH Workforce and development of new roles central to success of LTP funded transformation funded programme. Several challenges to embedding localised integrated approach (as described in N&W MH workforce strategy published in 2021) including transition from Health Education England to Work, Training & Education at regional level, as well as local focus on ICB restructure. 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. Met with Workforce Lead lack of organisational capacity and operational readiness currently to progress this action. Plan to review with MH SRO support. No further update at 4/11/24	**A**	**31/10/24**
29/04/22	National MH KPI achievement; developed Oversight Plans with support from NHSEI to work towards recovery of trajectories for the following: Physical Health in Severe Mental Illness, improving Dementia Diagnosis and reducing Out of Area Placement OAP). Rated amber to reflect difficulties reducing use of OAP beds. Work continues to increase Physical Health checks for people with severe mental illness and dementia diagnosis, trajectory submitted to achieve over a longer 2 year period in recognition of primary care capacity and QOF challenges. The system is currently over trajectory in terms of meeting its OoAP trajectory locally, and also (slightly) under trajectory re. delivery of agreed local Dementia Diagnosis recovery.	**A**	**31/03/25**
20/10/22	Community Transformation: Stocktake of Community Transformation (3-year LTP funded transformation programme) 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. Effective primary care engagement and delayed CMHT diagnostic is a risk to delivery. We continue to support NSFT (who are leading this work) to coproduce a revised model with Primary Care, to ensure the model is sustainable and effective.	**A**	**31/03/25**
28/08/24	New update added to capture concerns raised by primary care concerning lack of clarity and responsiveness of NSFT crisis pathway; constructive meeting held 19 July (NSFT and ICB Exec Directors Medicine and Nursing) and clear communications to clarify crisis pathway shared by NSFT to primary care and LMC. Ongoing work to address wider challenges of referral management being supported by ICB mental health team. Concerns regarding timeline for CRHT and CMHT diagnostic being picked up through monthly NSFT SPRG (contractual) meeting. This and the action above regarding Community Transformation stocktake links with wider community pathway transformation work including national initiative 'Intensive & Assertive Outreach Review'. Contract Performance Notice issued against NSFT on 24/10/24, re. failure to effectively deliver Single Point of Access and Crisis Resolution Home Treatment Team services.	**A**	**31/03/25**
29/08/23	Right Care, Right Person (RCRP); ICB Leads working in partnership with Norfolk and Suffolk Constabularies. RCRP launched in Norfolk in early June. Suffolk Police went live October 2023. All workstreams have gone live with daily meetings to review any issues and learning. No significant issues reported to date.	**B**	**Complete**
22/03/24	Worked through contractual changes, will continue to monitor any adverse impact with VCSE organisations affected by requirement to pay increased Living and Minimal Wage increases	**B**	**Complete**

	VSCE continue to report significant cost pressures as consequence of below inflation uplifts in 24/25.	

Visual Risk Score Tracker – 2024/25												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score	**16**	**16**	**16**	**16**	**16**	**16**	**16**					
Change	→	→	→	→	→	→	→					

Objective 5: Transforming care in later life

BAF05 (Inphase re 00000031)				
Risk Title	**Increasing numbers of older people with complex health needs in Norfolk and Waveney**			
Risk Description Please include any collaboration and partnership aspects of the risk.	The period that older people spend in ***ill*** health in Norfolk is getting longer. Older people are already more likely to be living with multiple and complex health conditions. Common conditions that are more prevalent in older age include dementia, heart disease, hypertension (high blood pressure), respiratory disease, mental health conditions such as depression, cerebrovascular disease, joint problems, diabetes, and sensory impairment. The risks are that: a) services will be unable to continue to meet the increasing demand and needs of our ageing population with complex health needs. b) costs associated with care of this population will increase significantly adding to financial pressures. c) quality of care for older people may decline if a) and b) are not suitably mitigated.			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Dr Frankie Swords	People & Communities Committee	Janice Shirley	20/06/24	**31/03/28**

Risk Scores								
Unmitigated			**Mitigated**			**Target**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**5**	**3**	**15**	**4**	**3**	**12**
Risk appetite:					**Risk tolerance:**			

Controls	Assurances on controls
• Ageing Well Programme Board with substantive programme manager and specialty advisors in post. • Workstreams established across all programme areas: Dementia, Frailty Attuned Acute Care, Care Homes & Housing with Care and Prevention • Increased focus upon early intervention (identify and intervene) • Increased focus upon upstream prevention and remaining active	**Internal:** Transforming care in later life has been identified as a priority in our JFP. Progress against key national delivery timelines reported and led by appropriate governance structures: System Ageing Well Programme Board reporting to Patients and Communities Committee. **External**: Integrated Care Partnership Board

Gaps in controls or assurances

- Embedding resources at Place level to co-ordinate the mechanisms needed to deliver Ageing Well Strategic Framework
- Further work required to develop the data hub and dashboards to monitor medium / long term impacts.

No specific budget allocated to the Ageing Well Programme to support emerging work and respond to system priorities.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
01/07/24	Frailty Attuned Acute Care workstream agreed unified frailty scoring for use across system.	**B**	**19/07/24**
01/07/24	Dementia Awareness education sessions delivered for Primary Care staff.	**B**	**08/07/24**
01/07/24	Population data analysis complete; social isolation and loneliness and falls prevention Joint Strategic Needs Assessment (JSNA) groups established.	**B**	**19/07/24**
01/07/24	Frailty Attuned Acute Care workstream agreed unified scoring tool for use across the ICS in July 24 with pilot of Clinical Frailty Scoring tool to start Sept 2024.	**B**	**02/09/24**
01/07/24	Joint Care home support group established including wider stakeholders.	**B**	**06/09/24**
01/07/24	Facilitating an ICS Dementia Round Table event with findings to be shared with stakeholders to identify priority areas.	**B**	**25/09/24**

04/11/24	Dementia Charter to be signed by all organisations and self-assessments completed by all providers to understand gaps in service delivery and what organisations must improve.	**A**	**31/12/24**
04/11/24	Winter Communications Plan for 2025 developed and finalised ahead of implementation.	**A**	**31/11/24**
04/11/24	Joint Strategic Needs Assessment for Social Isolation and Loneliness completed to inform systemwide work and NCC commissioning for 2025.	**G**	**31/03/25**
04/11/24	Ageing Well Programme Blueprint developed to establish priorities and align workstreams	**A**	**31/01/25**
04/11/24	Develop appropriate system Dashboard with all core workstream metrics	**A**	**31/03/25**

Visual Risk Score Tracker – 2024/25												
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Score			**15**	**15**	**15**	**15**	**15**					
Change			**NEW**	→	→	→	→					

Objective 6: Improving urgent and emergency care

BAF06 (Inphase ref 00000003)				
Risk Title	**System / Urgent & Emergency Care (UEC) Pressures**			
Risk Description Please include any collaboration and partnership aspects of the risk.	There is a risk that the Norfolk and Waveney health and social care system does not have sufficient resilience or capacity in the right care setting to meet the urgent and emergency care needs of the population whenever a need arises. This can result in longer than acceptable response times to receive treatment, delays in being discharged from hospital and as a result potentially poorer outcomes for our patients with associated clinical harms. This could lead to worsening ambulance response times for patients with a life threatening and / or life changing condition and an increasing number of patients remaining in hospital when they no longer meet the nationally prescribed 'criteria to reside.' The associated increase in longer lengths of stay and higher occupancy levels in all acute and community hospitals results in delays in admitting patients from our emergency departments (EDs) into a bed. In turn, this congests the EDs slowing down ambulance handover leading to more crews outside hospital who are unable to be released to respond to 999 calls.			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Mark Burgis	Commissioning & Performance	Ross Collett	**01/07/2022**	**31/03/2025**

Risk Scores								
Unmitigated			**Mitigated**			**Target**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	**5**	**20**	**4**	**4**	**16**	**3**	**4**	**12**
Risk appetite:					**Risk tolerance:**			

Controls	Assurances on controls

• **Strategic Oversight:** UEC Programme Board oversees non-elective flow and monitors a system wide transformation programme to improve the responsiveness of our Urgent and Emergency Care pathways to ensure patients receive the right treatment in the right place at the right time; that timely discharge for non-elective patients from inpatient hospital and community beds takes place and that appropriate discharge capacity is available to meet the discharge demand from health settings.
• **Business Continuity:**
  ○ All Trusts, including community, 111 and primary care have business continuity plans in place to manage the operational response to in-year peaks in demand and periods where demand exceeds 'business as usual' levels.
  ○ A seven-day System Control Centre (SCC) and East of England Ambulance Service (EEAST) System Oversight Cell (SOC) are in place. The SCC and SOC work alongside Providers to coordinate operational responsiveness when individual or multiple providers are unable to meet demand in a timely and safe way and to escalate to appropriate levels of management when decisions to mobilise additional resources are needed.
Specific controls to appropriately manage urgent and emergency care demand ensuring patient's needs are met:
• **Hospital 'Admissions Avoidance':** A range of 'Admissions Avoidance' schemes are in place across N&W to ensure that patients who have an 'urgent' care need are seen in a timely way in the right care setting, the core services are:
  ○ **111 / GP led Clinical Advice Service (CAS):** This service provides advice to healthcare professionals and the public triaging and referring patients to the most appropriate service and setting that will best meet their needs.
	Internal: ICB Executive Management Team; Norfolk and Waveney UEC Programme Board; Three UEC Alliances aligned to each acute hospital system; System Control Centre (SCC)
	
	External: ICS Executive Management Team (CEOs Group); Trust Boards; NHSE Regional Strategic Oversight

○ **Unscheduled Care Coordination Hub (SPoA):** The UCCH has been established since October 2023 as a 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):** ○ There is a tactical work programme led by the UEC Programme Board Chair to increase flow by increasing	

speed of discharge and reducing length of stay ahead of winter. ○ Each of the three UEC Alliances have a programme of work focussed on increasing flow and rate of discharge. • Position continues to improve with a reduction in escalation beds at the Acute hospitals and improvement in C1 and C2 ambulance response times. Ambulance handover into ED is showing 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 which in turn will reduce latent demand on acute hospital EDs.
- A number of UEC initiatives including uplifts in community bed stock are associated with short term funding. This could result in an increased risk of reduced bed stock from January 2025 and an associated increase in hospital bed pressures. Without a long term funding solution this risk will remain with continuous short term extensions providing mitigation which is not sustainable.
- The ICB currently has an interim Director of Resilience who is responsible for the SCC. As this post is interim and there is no substantive funding attached to this role there is a risk that the SCC does not meet the regional Minimum Viable Product
- Short term sustainability of SCC is a risk as all three operational leads have resigned from post. The triple lock process means the process of recruitment is delayed and there will be a gap in SCC service provision because of this.
- 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**
29/8/24	The ICB has committed to recurrently supporting the Unscheduled Care Coordination Hub – this is a core deliverable in the Joint Forward Plan (JFP). The Unscheduled Care Coordination Hub will better coordinate admission avoidance activity and deliver right care, right place, first time which has demonstrated a reduction in in ambulance dispatch and unnecessary conveyance to hospital which in turn supports C2 improvements. As the UCCH becomes more established it will further improve hospital flow and outcomes for people with frailty.	**A**	**31/3/25**

Visual Risk Score Tracker – 2024/25

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

Objective 7: Elective recovery and improvement

BAF07 (Inphase ref 00000010)	
Risk Title	**Elective Recovery**
Risk Description Please include any collaboration and partnership aspects of the risk.	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, including waits for diagnostic tests and for cancer care.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Andrew Palmer	Commissioning & Performance	Andrew Palmer	**01/12/2022**	**31/03/2025**

Risk Scores								
Unmitigated			**Mitigated**			**Target**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**3**	**4**	**12**	**3**	**4**	**12**
Risk appetite:					**Risk tolerance:**			

Controls	**Assurances on controls**
• The Elective Recovery Board meets bi-weekly to oversee all workstreams to improve performance and reduce harm. • As of December 2024, the Elective Recovery Board is transitioning into the Provider Performance and Planning Oversight Group (PPPOG), which will report into the Scheduled Care Board (SCB). • Each Provider has completed waiting list validation, all patients clinically prioritised. Each Provider is expected undertake a cycle of waiting list validation every 12 weeks. • 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 January 2024 for Paediatrics. • Additional orthopaedic capacity at NNUH (NaNOC) opened in July 2024 and JPUH is due to open spring 2025. • Cancer: Local engagement to raise awareness of signs/ symptoms of cancer and to encourage early presentation to Primary Care/linking with health inclusion groups and areas of deprivation. Non-Specific symptoms (NSS) pathway is in place via the system cancer Rapid Diagnostic Service and the "C the Signs" Primary Care Clinical Decision support tool to improve	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 from Tier 2 to Tier 1 in November 2024. NNUH remains in Tier 1 Internal: Weekly and monthly performance metrics for each workstream monitored through the monthly Provider Performance and Planning Oversight Group from December 2024. External: Trust Board Governance processes and returns to NHSEI, National contract monitoring by NHSEI and Scheduled Care Board. Additional oversight and monitoring for impact on cancer pathways via the EOE Cancer Alliance Programme Board. Weekly Tiering KLOE return from Trusts to system, region, and national teams, monitored through fortnightly Tiering meetings.

quality and reduce variation in urgent suspected cancer referrals. • There is also insufficient oncology medical staffing across all providers to meet current demand. Additional transformation resource provided to support short-term locum capacity and mutual aid arrangements in place. Duty of candour letters sent where appropriate. Progression of non-medical multi-professional skill mix redesign projects, international recruitment and redesign of the system oncology services via the Speciality Oncology Network. Escalated to People Board. ICB Quality team supporting trusts to prioritise patients approaching the end of adjuvant treatment window to prevent harm occurring/provide appropriate support while waiting.	

Gaps in controls or assurances

- Cessation/ reduction of elective activity due to RAAC plank works at JPUH and QEH.
- Impact of industrial action in the acute and primary care sectors 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.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
19/11/24	• All trusts submitted zero 104-week waits for end of March 2024 • As of 11th November 2024: ○ NNUH have 146 65ww who will not be treated by 22nd Dec 2024. ○ JPUH have 37 65ww who will not be treated by 22nd Dec 2024. ○ QEH have 1 65ww who will not be treated by 22nd Dec 2024.	**A**	**31/03/25**
22/04/24	• New elective orthopaedic theatre capacity will come onstream at the JPUH in Spring 2025. • The NNUH orthopaedic centre (NaNOC) opened in July 2024 Recommend maintain risk rating due to steady decrease in number of 52-week breaches, clearance plans in place and opportunities for new capacity coming on stream over the summer.		**01/6/25**
22/04/24	• Trusts continuing to use ICB staff to contact patients and make arrangements to transfer patients to alternative providers including ISPs.		**31/03/25**
20/11/24	• Additional detail added re associated cancer risk and mitigations		

Visual Risk Score Tracker – 2024/25

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

Objective 8: Improving productivity and efficiency

BAF08 (Inphase ref 00000027)				
Risk Title	**Achieve the 2024/25 financial plan**			
Risk Description Please include any collaboration and partnership aspects of the risk.	IF the ICB does not deliver the 2024/25 Financial Plan of a break-even position, THEN the ICB may not be able to maintain spending on current levels of service, or to continue with plans for further investment. This may lead to a reduction in the levels of services available to patients.			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Steven Course	Finance	Emma Kriehn Morris	**10/05/2022**	**31/03/2025**

Risk Scores								
Unmitigated			**Mitigated**			**Target**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	**4**	**20**	**3**	**4**	**12**	**3**	**4**	**12**
Risk appetite:					**Risk tolerance:**			

Controls	Assurances on controls
• Monthly monitoring of risks and mitigations, reported to NHSE/I. • Detailed plan for 2024/25 approved by Board and submitted to NHSE/I as part of the wider ICS plan. • Monthly Finance Report presented to Finance Committee and Board. • Analysis and understanding of underlying recurrent position, including drivers of the deficit on a monthly basis. • ICS Medium Term Financial Model has been developed on consistent assumptions. • Key lines of Inquiries (KLOEs) have been reviewed and provide assurances as to strong financial governance and best practice adoption. The ICB is part of the Triple Lock process with self-imposed reduced limits of £25k.	**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

Financial Plan Delivery:

- No contingency reserve in plan;
- £51m of unmitigated risks against the plan at the point of final submission; As at M06 (September 2024) the £51m planning risks have been re-assessed to £21m (M05 £30.8m) on a probability basis.
- In addition to the revised £21m Planning Assumption Risks, a further £2.8m (M05 £1.9m) of Net Risks have been noted resulting in a Total net risk of £23.8m (M05 £32.6m).
- The financial position assumes full delivery of the unidentified Efficiencies equating to £8.1m (M05 £14.9m). This is a significant risk to the delivery of the in-year financial plan.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
01/04/24	Review of monthly and year to date performance and assess forecast out-turn evaluated risks and mitigations.	G	**Monthly to 31/03/25**
31/07/24	Review of all mitigations and recovery actions to support the financial delivery to plan.	A	**Monthly to 31/03/25**

Visual Risk Score Tracker – 2024/25

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

Norfolk and Waveney
Integrated Care Board

Agenda item: 21

Subject:	**Revised NHS Norfolk and Waveney ICB Constitution**
Presented by:	**Karen Barker, Executive Director of Corporate Affairs and ICS Development**
Prepared by:	**Amanda Brown, Associate Director of Corporate Governance**
Submitted to:	**Norfolk and Waveney Integrated Care Board – Board Meeting**
Date:	**27 November 2024**

Purpose of paper:

To present proposed revisions to the ICB's Constitution for approval and to approve leads as set out in the paper.

Executive Summary:

NHS England has published updated governance guidance for ICBs on their Constitutions to take account of wider legislative developments. This paper highlights proposed changes to the Constitution and asks for approval to submit the revised Constitution to NHSE for approval.

Report

NHS England have revised the template model Constitution to take account of legislative changes and have requested that ICBs update their Constitutions to ensure that they take account of these changes.

NHS England have produced an updated template model Constitution which has been used to make changes to the ICB's Constitution. These changes have been made in track to the attached draft Constitution. The proposed changes are detailed below:

- Ensuring one of the non-executive board members is identified as the Deputy Chair. This cannot be the audit and risk committee chair. (2.2.3 (f), 3.4, and 4.6.8 (a).)

- Ensuring one of the non-executive board members is identified as the Senior Non Executive member: to bring clarity which non-executive member should support the NHSE Regional Director on the appraisal and Fit and Proper Person compliance of the Chair, consistent with arrangements for NHS Trusts set out in the Code of Governance for providers (2.23 (f), and 3.4). It is proposed by the Chair that this role is fulfilled by Hein Van Den Wildenberg.

- Expressing the Chair's period of office as a maximum, rather than a fixed term: to ensure drafting is compatible with the appointment where necessary of interim Chairs by NHS England with Secretary of State approval (3.3.4).

- Confirming that a proposal for the Chair or a non-executive to serve on the board for longer than six years will be subject to rigorous review and they will not serve as a board member for longer than nine years in total: to ensure objectivity is maintained, aligned to the Code of Governance for providers.

- Updating references to procurement rules: to take account of the introduction of the Provider Selection Regime.

- Removing clauses related to ICB establishment and updating cross-references to legislation.

- Adding a clause to clarify that where deputies do join the Board where a member cannot attend that they do count towards the quorum for the Board at that meeting. We are able to amend this locally if we wish to say that they will not count towards the quorum. Similarly we are able to allow Partner Members to send deputies. We have previously not allowed this but now propose that this is amended to allow this in the same way as the Executive Directors may send deputies.

In addition, NHS England's '*Guidance on Integrated Care Board Constitutions and Governance'* has been updated to address the following areas:

- A ministerial commitment to Parliament that NHS England would issue guidance to ICBs meeting their statutory duty to keep under review the skills, knowledge and experience of their board.

- The section on managing conflicts of interest takes into account the introduction of the Provider Selection Regime.

- A section more clearly setting out the alternatives for ICBs to delegating their statutory functions to other bodies.

- Recognising the importance of executive leadership on supporting care leavers (not a new role but emphasising it is part of safeguarding leadership responsibilities). The ICB's Board Member for Safeguarding is the Executive Director of Nursing.

- The model constitution allows for the ICB to have use of a "Seal" for approving legal documents. It is proposed that these provisions are added to the Constitution.

Appendix A to the Model Constitution Guidance

Further to the work on the model Constitution itself, NHS England have also updated appendix A on Executive Lead roles to the ICB Board. This now includes care levers within the list of population groups that need to have an Executive Board member that has explicit responsibility for them. To remind the Board the list of these groups is set out below. It is proposed that the Chief Nurse becomes the lead for this group along with the other groups which has been previously agreed by the Board.

- Children and young people (aged 0 to 25)

- Children and young people with special educational needs and disabilities (SEND) Safeguarding (all-age), including looked after children **and care leavers.**
- Learning disability and autism (all-age).
- Down syndrome (all-age).

Recommendation to the Board:

To review proposed changes to Constitution and agree the changes. Further to agree submission of the draft document to NHS England for final approval.

To agree the Chair's proposal that Hein Van Den Wildenberg is the Senior Non-Executive Member.

To agree the Chief Nurse takes the Executive lead role for care levers in addition to the other population groups she is already responsible for.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	The ICB has to have a Constitution to be clear on the rules it follows as an organization.
Legal:	Ensuring that the Constitution is up to date and approved by the Board and NHS England.
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	*'Guidance on Integrated Care Board Constitutions and Governance'*
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	Presented to Board for agreement 27 November to 2024. Submission to NHS England for approval.

NHS
Norfolk and Waveney
Integrated Care Board

NHS Norfolk and Waveney Integrated Care Board

CONSTITUTION

Version	Date approved by the ICB	Date Approved by NHS England	Effective date
V1.0	N/A	1 June 2022	1 July 2022
V2.0	27 September 2022	4 October 2022	4 October 2022
V3.0	TBC	TBC	TBC

CONTENTS

1. Introduction

1.1 Foreword

NHS England has set out the following as the four core purposes of ICSs:

a) improve outcomes in population health and healthcare
b) tackle inequalities in outcomes, experience and access
c) enhance productivity and value for money
d) help the NHS support broader social and economic development.

The ICB will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

Our Integrated Care System

The Norfolk and Waveney Integrated Care System ("the ICS") is made up of a wide range of partner organisations, working together to help people lead longer, healthier and happier lives. The ICS is comprised of an NHS Integrated Care Board working with an Integrated Care Partnership committee formed jointly with local authority partners.

Over and above everything else we want to achieve, we've set ourselves three goals:

1. To make sure that people can live as healthy a life as possible.

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

2. To make sure that you only have to tell your story once.

Too often people have to explain to different health and care professionals what has happened in their lives, why they need help, the health conditions they have and which medication they are on. Services have to work better together.

3. To make Norfolk and Waveney the best place to work in health and care.

Having the best staff, and supporting them to work well together, will improve the working lives of our staff, and mean people get high quality, personalised and compassionate care.

The partners in our ICS work together at 'system' level across Norfolk and Waveney, more locally at 'place' and 'neighbourhood' levels, and through our primary care networks and provider collaboratives.

Our Integrated Care Board

NHS Norfolk and Waveney ICB ("the ICB") was formed on 1 July 2022 and covers the same area as the former Norfolk and Waveney CCG previously did. The ICB brings the local NHS together to improve population health and care. The responsibilities of the ICB include developing a plan to meet the population's health needs and arranging for the provision of health services.

As with all NHS bodies that plan and commission services in England, NHS Norfolk and Waveney ICB and our local NHS trusts and foundation trusts are subject to the triple aim duty, and as such consider the effects of their decisions on:

- the health and wellbeing of the people of England
- the quality of services provided or arranged by both themselves and other relevant bodies
- the sustainable and efficient use of resources by both themselves and other relevant bodies

Our Integrated Care Partnership

Our Integrated Care Partnership ("the ICP") brings together the local NHS, local authorities, the voluntary, community and social enterprise sector and other partners that have an impact on the wider determinants of health. The ICP is responsible for agreeing an integrated care strategy for improving the health care, social care and public health across the whole population. The ICB is required to have regard to the ICP's Integrated Care Strategy when making decisions, commissioning and delivering services. The ICP is a statutory committee of the ICB, Norfolk and Suffolk County Councils.

The membership of the ICP is the same as the Norfolk Health and Wellbeing Board and includes representatives from Suffolk County Council and Waveney. The partners involved are the ICB, providers of health and care services, our county, district, borough and city councils, voluntary, community and social enterprise sector organisations, Healthwatch, the Constabulary and the Office of the Police and Crime Commissioner.

This Constitution for the ICB and the terms of reference for the ICP are aligned to ensure that our governance arrangements are clear, and more importantly, that all partner organisations are working toward the same aim and goals.

1.2 Name

1.2.1 The name of this Integrated Care Board is NHS Norfolk and Waveney Integrated Care Board ("the ICB").

1.3 Area Covered by the Integrated Care Board

1.3.1 The area covered by the ICB is set out in the map below. The ICB covers the whole of the area covered by Norfolk County Council. The ICB also covers part of Suffolk but not all of the area covered by Suffolk County Council. The area covered by the ICB also includes the following local government areas: the District of Breckland, District of Broadland, Borough of Great Yarmouth, Borough of King's Lynn and West Norfolk, District of North Norfolk, City of Norwich, District of South Norfolk and also part of the District of East Suffolk.

1.3.2 All of the Lower Super Output Areas in the District of East Suffolk which are covered by the ICB are set out in Appendix 1.

1.4 Statutory Framework

1.4.1 The ICB is established by order made by NHS England under powers in the 2006 Act.

1.4.2 The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.

1.4.3 The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).

1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a Constitution, which must comply with the requirements set out in that Schedule. The ICB is required to publish its Constitution (section 14Z29). This Constitution is published at www.improvinglivesnw.org.uk.

1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the

statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act);
b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);
c) Duties in relation to children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014)
d) Adult safeguarding and carers (the Care Act 2014)
e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35);
f) Information law, (for instance, data protection laws, such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000); and
g) Provisions of the Civil Contingencies Act 2004

1.4.6 The ICB is subject to an annual assessment of its performance by NHS England, which is also required to publish a report containing a summary of the results of its assessment.

1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under:
a) section 14Z34 (improvement in quality of services),
b) section 14Z35 (reducing inequalities),
c) section 14Z38 (obtaining appropriate advice),
d) section 14Z40 (duty in respect of research)
e) section 14Z43 (duty to have regard to effect of decisions)
f) section 14Z45 (public involvement and consultation),
g) sections 223GB to 223N (financial duties), and
h) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

1.4.8 NHS England has powers to obtain information from the ICB (section 14Z60 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z61).

1.5 Status of this Constitution

1.5.1 The ICB was established on 1 July 2022 by The Integrated Care Boards (Establishment) Order 2022, which made provision for its Constitution by reference to this document.

~~1.5.2 This Constitution must be reviewed and maintained in line with any agreements with, and requirements of, NHS England set out in writing at establishment.~~

~~1.5.3~~1.5.2 Changes to this Constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

1.6 Variation of this Constitution

1.6.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act this Constitution may be varied in accordance with the procedure set out in this paragraph. The Constitution can only be varied in two circumstances:

a) where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved;or
b) where NHS England varies the Constitution of its own initiative, (other than on application by the ICB).

1.6.2 The procedure for proposal and agreement of variations to the Constitution is as follows:

a) The Chief Executive of the ICB can propose a change to the Constitution by notifying the board in writing with at least 7 days' notice.
b) The Chair of the ICB will be consulted on any proposed changes.
c) The board of the ICB must approve any changes to the Constitution in accordance with its standing orders.
d) Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related documents

1.7.1 This Constitution is also supported by a number of documents which provide further details on how governance arrangements in the ICB will operate.

1.7.2 The following are appended to the Constitution and form part of it for the purpose of clause 1.6 and the ICB's legal duty to have a Constitution:

a) Standing Orders – which set out the arrangements and procedures to be used for meetings and the processes to appoint the ICB committees.

1.7.3 The following do not form part of the Constitution but are required to be published.

a) The Scheme of Reservation and Delegation (SoRD) – sets out those decisions that are reserved to the board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated to.

b) Functions and Decision map – a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the

system. The Functions and Decision map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England).

c) **Standing Financial Instructions** – which set out the arrangements for managing the ICB's financial affairs.

d) **The ICB Governance Handbook** – this brings together all the ICB's governance documents so it is easy for interested people to navigate. It includes:
   - The above documents a) – c)
   - Terms of reference for all committees and sub-committees of the board that exercise ICB functions.
   - Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.
   - Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.
   - The up-to-date list of eligible providers of primary medical services under clause 3.~~6~~7.2

e) **Key policy documents -** which should also be included in the Governance Handbook or linked to it:
   - Standards of business conduct policy
   - Conflicts of interest policy and procedures
   - Policy for public involvement and engagement

2 Composition of the Board of the ICB

2.1 Background

2.1.1 This part of the Constitution describes the membership of the Integrated Care Board. Further information about the criteria for the roles and how they are appointed is in section 3.

2.1.2 Further information about the individuals who fulfil these roles can be found on our website at www.improvinglivesnw.org.uk.

2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this Constitution as "the board" and members of the ICB are referred to as "board members") consists of:

a) a Chair
b) a Chief Executive
c) at least three Ordinary Members.

2.1.4 The membership of the ICB (the board) shall meet as a unitary board and shall be collectively accountable for the performance of the ICB's functions.

~~2.1.4~~2.1.5 NHS England Policy~~,~~ requires the ICB to appoint the following additional Ordinary Members:

a) three Executive Members, namely:
   - Director of Finance
   - Medical Director
   - Director of Nursing
b) At least two non-executive members.

~~2.1.5~~2.1.6 The Ordinary Members include at least three members who will bring knowledge and a perspective from their sectors. These members (known as Partner Members) are nominated by the following and appointed in accordance with the procedures set out in Section 3 below**:**

- NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description
- the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description
- the local authorities which are responsible for providing social care and whose area coincides with or includes the whole or any part of the ICB's area.

While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board, they are not to act as delegates of those sectors.

2.2 Board Membership

2.2.1 The ICB has 5 Partner Members:

a) 2 Partner members: NHS trusts and foundation trusts
b) 1 Partner Member: primary medical services

c) 2 Partner Members: local authorities

2.2.2 The ICB has also appointed the following further Ordinary Members to the board:
a) 2 Non-executive Members
b) Member from the VCSE Assembly Board
c) Member from the Integrated Care Partnership

2.2.3 The board is therefore composed of the following members:
a) Chair
b) Chief Executive
c) 2 Partner members NHS trusts and foundation trusts
d) 1 Partner member primary medical services
e) 2 Partner members local authorities
f) 4 Non-executive Members (one of which, but not the Audit and Risk Committee Chair, will be appointed Deputy Chair and one of which, who may be the Deputy Chair or the Audit and Risk Committee Chair, will be appointed the Senior Non-executive Member
g) Director of Finance
h) Medical Director
i) Director of Nursing
j) Member from the VCSE Assembly Board
k) Member from the Integrated Care Partnership.

2.2.4 The Chair will exercise their function to approve the appointment of the Ordinary Members with a view to ensuring that at least one of the Ordinary Members will have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

2.2.5 The board will keep under review the skills, knowledge, and experience that it considers necessary for members of the board to possess (when taken together) in order for the board effectively to carry out its functions and will take such steps as it considers necessary to address or mitigate any shortcoming.

2.3 Regular Participants and Observers at board meetings

2.3.1 The board may invite specified individuals to be Participants or Observers at its meetings in order to inform its decision-making and the discharge of its functions as it sees fit.

2.3.2 Participants will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair to ask questions and address the meeting but may not vote.

a) Director of Performance, Transformation and Strategy
b) Director of People
c) Patients and Communities Director
d) Director of Corporate Affairs and ICS Development
e) Director of Population Health Management
f) Director of Place Development and System Support
g) Director of Digital and Data

h) Director of Public Health for Norfolk County Council (unless they are one of the local authority Partner Members)
i) Director of Public Health for Suffolk County Council (unless they are of the local authority Partner Members)

Further system Directors may be invited to participate as relevant by the Chair.

2.3.3 Observers will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may not address the meeting and may not vote.

a) Healthwatch Norfolk
b) Healthwatch Suffolk
c) Norfolk and Waveney Local Medical Committee

2.3.4 Participants and / or observers may be asked to leave the meeting by the Chair in the event that the board passes a resolution to exclude the public as per the Standing Orders

3 Appointments process for the board

3.1 Eligibility Criteria for Board Membership:

3.1.1 Each member of the ICB must:
a) Comply with the criteria of the "fit and proper person test"
b) Be ~~willing~~ committed to upholding the Seven Principles of Public Life (known as the Nolan Principles)
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.2 Disqualification criteria for board membership

3.2.1 A Member of Parliament.

3.2.2 A person whose appointment as a board member ("the candidate") is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

3.2.3 A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted—
a) in the United Kingdom of any offence, or
b) outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

3.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, Part 13 of the Bankruptcy (Scotland) Act 2016 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

3.2.5 A person who, has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any Health Service Body.

3.2.6 A person whose term of appointment as the chair, a member, a director or a governor of a health service body, has been terminated on the grounds:

a) that it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office
b) that the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings,
c) that the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest, or
d) of misbehaviour, misconduct or failure to carry out the person's duties;

3.2.7 A Health Care Professional, meaning an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002, or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was:

a) the person's suspension from a register held by the regulatory body, where that suspension has not been terminated
b) the person's erasure from such a register, where the person has not been restored to the register
c) a decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded, or
d) a decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to:

a) a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or
b) an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

3.2.9 A person who has at any time been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England and Wales, the Charity Commission, the Charity Commission for Northern Ireland or the High Court, on the grounds of misconduct or mismanagement in the

administration of the charity for which the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated.

3.2.10 A person who has at any time been removed, or is suspended, from the management or control of any body under:

a) section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities), or

b) section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 Chair

3.3.1 The ICB Chair is to be appointed by NHS England, with the approval of the Secretary of State for Health and Social Care.

3.3.2 In addition to criteria specified at 3.1, this member must fulfil the following additional eligibility criteria:

a) The Chair will be independent.

3.3.3 Individuals will not be eligible if:

a) They hold a role in another health and care organisation within the ICB area.

b) Any of the disqualification criteria set out in 3.2 apply

3.3.4 The term of office for the Chair will be a maximum of 3 years and the total number of terms a Chair may serve is 3 terms.

3.4 Deputy Chair and ~~Deputy Chair and~~ Senior Non-executive Member ~~Non-executive Member~~

3.4.1 The Deputy Chair is to be appointed from amongst the non-executive members by the board subject to the approval of the Chair.

3.4.2 No individual shall hold the position of Chair of the Audit and Risk Committee and Deputy Chair at the same time.

3.4.3 The Senior Non-executive Member is to be appointed from amongst the Non-executive Members by the board subject to the approval of the Chair.

~~3.4~~3.5 Chief Executive

~~3.4.1~~3.5.1 The Chief Executive will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England.

~~3.4.2~~3.5.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England

~~3.4.3~~3.5.3 The Chief Executive must fulfil the following additional eligibility criteria

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act

3.4.43.5.4 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) Subject to clause 3.45.3(a), they hold any other employment or executive role

3.53.6 Partner Member(s) - NHS trusts and foundation trusts

3.5.13.6.1 These Partner Members are jointly nominated by the NHS trusts and/or FTs which provide services for the purposes of the health service within the ICB's area and meet the Fforward pPlan Ccondition or (if the fForward pPlan cCondition is not met) the Llevel of sServices pProvided cCondition.

- James Paget University Hospitals NHS Foundation Trust
- Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
- Norfolk and Norwich University Hospitals NHS Foundation Trust
- East of England Ambulance Service NHS Trust
- Norfolk and Suffolk NHS Foundation Trust
- Norfolk Community Health and Care NHS Trust

3.5.23.6.2 These members must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an Executive Director of one of the NHS Trusts or FTs; or
b) Be an Executive Director of East Coast Community Healthcare CIC within the ICB's area; and
c) Any criteria set out in NHS England's guidance from time to time; and
d) One member is to have particular knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness, and of community services
e) One member ~~bringing~~ is to bring particular knowledge and experience in acute hospital services; and
f) Senior level operational expertise.

3.5.33.6.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply; and
b) Any exclusion criteria as set out in NHS England guidance applies

3.5.43.6.4 These members will be appointed by a panel subject to the approval of the Chair.

3.5.53.6.5 The appointment process will be as follows:

a) Joint Nomination:
   - When a vacancy arises, each eligible organisation listed at 3.56.1.a will be invited to make nominations.
   - The nomination of an individual must be seconded by one other eligible organisation.
   - Eligible organisations may nominate individuals from their own organisation or another organisation
   - All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement.

This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c):

- The full list of nominees will be considered by a panel convened by the Chief Executive.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.~~6~~5.2 and 3.~~5~~6.3
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.
- A fit and proper person test will also be undertaken on the preferred candidate before appointment.

c) Chair's approval:

- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

~~3.5.6~~3.6.6 The term of office for these Partner Members will be 3 or 4 years, as agreed with the Chair at the start of the term, and the total number of terms they may serve is 2 terms, in the case of a 3 year term, and 1 term in the case of a 4 year term.

~~3.6~~3.7 Partner Member - providers of primary medical services

~~3.6.1~~3.7.1 This Partner Member is jointly nominated by providers of primary medical services for the purposes of the health service within the ICB's area, and that are primary medical services contract holders responsible for the provision of essential services, within core hours to a list of registered persons for whom the ICB has core responsibility.

~~3.6.2~~3.7.2 The list of relevant providers of primary medical services for this purpose is published as part of the Governance Handbook. The list will be kept up to date but does not form part of this Constitution.

~~3.6.3~~3.7.3 This member must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Any criteria set out in NHS England's guidance from time to time;
b) This member must be a Health Care Professional, either a partner or employee, actively working within a practice in the Norfolk and Waveney ICB area; or
c) A locum that is active for the majority of their time within a practice in Norfolk and Waveney ICB area.
d) Fulfil the requirements relating to the relevant experience, knowledge, skills and attributes set out in a role and person specification.

~~3.6.4~~3.7.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply; and
b) Any criteria as set out in NHS England guidance applies.

3.6.53.7.5 This member will be appointed by a panel subject to the approval of the Chair.

3.6.63.7.6 The appointment process will be as follows:

a) Joint Nomination:
- When a vacancy arises, each eligible organisation described at 3.76.1 and listed in the Governance Handbook will be invited to make nominations.
- The nomination of an individual must be seconded by three other eligible organisations.
- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 10 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c):
- The full list of nominees will be considered by a panel convened by the Chief Executive.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.67.3 and 3.67.4
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.
- A fit and proper person test will also be undertaken on the preferred candidate before appointment

c) Chair's approval:
- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.6.73.7.7 The term of office for this Partner Member will be 3 or 4 years as agreed with the Chair at the start of the term, and the total number of terms they may serve is 2 terms in the case of a 3 year term, and 1 term in the case of a 4 year term.

3.73.8 Partner Member(s) - local authorities

3.7.13.8.1 These Partner Members are jointly nominated by the local authorities responsible for the provision of social care whose areas coincide with, or include the whole or any part of, the ICB's area. Those local authorities are:

a) Norfolk County Council
b) Suffolk County Council

3.7.23.8.2 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be the Chief Executive or hold a relevant Executive level role of one of the bodies listed at 3.78.1; and
b) Any criteria set out in NHS England's guidance from time to time.

3.7.33.8.3 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in 3.2 apply; and
b) any criteria as set out in NHS England guidance applies.

3.7.43.8.4 This member will be appointed by the panel subject to the approval of the Chair.

3.7.53.8.5 The appointment process will be as follows:
a) Joint Nomination:
- When a vacancy arises, each eligible organisation listed at 3.78.1.a will be invited to make nominations.
- Eligible organisations may nominate individuals from their own organisation or another organisation
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until a consensus is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c):
- The full list of nominees will be considered by a panel convened by the Chief Executive.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.78.2 and 3.78.3
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.
- A fit and proper person test will also be undertaken on the preferred candidate before appointment.

c) Chair's approval:
The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.7.63.8.6 The term of office for these Partner Members will be 3 or 4 years as agreed with the Chair at the start of the term, and the total number of terms they may serve is 2 terms, in the case of a 3 year term, and 1 term in the case of a 4 year term.

3.83.9 Medical Director

3.8.13.9.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Be a registered Medical Practitioner;
c) Any further criteria as set by NHS England from time to time; and
d) Meet the criteria as set out in the person specification for the role.

~~3.8.2~~3.9.2 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in 3.2 apply; and
b) any criteria set out in NHS England guidance applies.

3.8.3 This member will be appointed by the Chief Executive subject to the approval of the Chair. This will be after a recruitment process is undertaken which includes the Chief Executive and Chair on the selection panel.

~~3.9~~3.10 Director of Nursing

~~3.9.1~~3.10.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:
a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Be a registered Nurse
c) Any further criteria as set by NHS England from time to time; and
d) Meet the criteria as set out in the person specification for the role.

~~3.9.2~~3.10.2 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in 3.2 apply; and
b) any criteria as set out in NHS England guidance applies.

~~3.9.3~~3.10.3 This member will be appointed by the Chief Executive subject to the approval of the Chair. This will be after a recruitment process is undertaken which includes the Chief Executive and Chair on the selection panel.

~~3.10~~3.11 Director of Finance

~~3.10.1~~3.11.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:
a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Any further criteria as set by NHS England from time to time; and
c) Meet the criteria as set out in the person specification for the role.

~~3.10.2~~3.11.2 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in 3.2 apply; and
b) any criteria as set out in NHS England guidance applies.

~~3.10.3~~3.11.3 This member will be appointed by the Chief Executive subject to the approval of the Chair. This will be after a recruitment process is undertaken which includes the Chief Executive and Chair on the selection panel.

~~3.11~~3.12 Four Non-executive Members

~~3.11.1~~3.12.1 The ICB will appoint four Non-executive Members.

~~3.11.2~~3.12.2 These members will be appointed by a panel subject to the approval of the Chair.

~~3.11.3~~3.12.3 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Not be an employee of the ICB or a person seconded to the ICB
b) Not hold a role in another health and care organisation in the ICS area
c) One shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit and Risk Committee
d) Another shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration, People and Culture Committee
e) Another shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Finance Committee.
f) Another shall have specific knowledge, skills and experience with regard to the people and the community of Norfolk and Waveney.
g) Any other criteria as set out by NHS England's guidance.

~~3.11.4~~3.12.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) They hold a role in another health and care organisation within the ICB area; and
c) any criteria as set out in NHS England's guidance applies.

~~3.11.5~~3.12.5 The term of office for a Non-executive Member will be 3 years and the total number of terms an individual may serve is 3 terms, after which they will no longer be eligible for re-appointment.

~~3.11.6~~3.12.6 Initial appointments may be for a shorter period in order to avoid all Non-executive Members retiring at once. Thereafter, new appointees will ordinarily retire on the date that the individual they replaced was due to retire in order to provide continuity.

~~3.11.7~~3.12.7 Subject to satisfactory appraisal the Chair may approve the re-appointment of a Non-executive Member up to the maximum number of terms permitted for their role.

~~3.12~~3.13 Other Board Members

VCSE Assembly Board member

~~3.12.1~~3.13.1 This member is nominated by the Norfolk and Waveney Voluntary, Community and Social Enterprise (VCSE) Assembly Board.

~~3.12.2~~3.13.2 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be the Chief Executive or hold a relevant Executive level role in one of the VCSE sector legal entities in Norfolk and Waveney; and
b) Any criteria set out in NHS England's guidance from time to time

3.12.33.13.3 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in 3.2 apply; and
b) any criteria as set out in NHS England guidance applies.

3.12.43.13.4 This member will be appointed by a panel subject to the approval of the Chair.

3.12.53.13.5 The appointment process will be as follows:
a) Joint Nomination:
- When a vacancy arises, each member of the Norfolk and Waveney VCSE Assembly Board will be invited to make nominations.
- The nomination of an individual must be seconded by one other eligible member of the Norfolk and Waveney VCSE Assembly Board.
- Eligible members may nominate individuals from their own organisation or another organisation
- All eligible members of the Norfolk and Waveney VCSE Assembly Board will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c):
- The full list of nominees will be considered by a panel convened by the Chief Executive.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.1~~2~~3.2 and 3.1~~2~~3.3
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.
- A fit and proper person test will also be undertaken on the preferred candidate before appointment

c) Chair's approval:
- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

Integrated Care Partnership Board Member

3.12.63.13.6 This member is nominated by the Norfolk and Waveney Integrated Care Partnership.

3.12.73.13.7 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be a member of the Integrated Care Partnership Committee; and
b) Any criteria set out in NHS England's guidance from time to time

~~3.12.8~~3.13.8 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply; and
b) any criteria as set out in NHS England guidance applies.

~~3.12.9~~3.13.9 This member will be appointed by a panel subject to the approval of the Chair.

3.1~~3~~2.10 The appointment process will be as follows:

a) Joint Nomination:
   - When a vacancy arises, each individual member of the Integrated Care Partnership Committee will be invited to make nominations.
   - The nomination of an individual must be seconded by one other member of the Integrated Care Partnership Committee.
   - Eligible members may nominate individuals from their own organisation or another organisation
   - All members will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c):
   - The full list of nominees will be considered by a panel convened by the Chief Executive.
   - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.1~~2~~3.7 and 3.1~~2~~3.8
   - In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.
   - A fit and proper person test will also be undertaken on the preferred candidate before appointment.

c) Chair's approval:
   - The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

~~3.13~~3.14 Board Members: Removal from Office

~~3.13.1~~3.14.1 Arrangements for the removal from office of board members is subject to the term of appointment, and application of the relevant ICB policies and procedures.

~~3.13.2~~3.14.2 With the exception of the Chair, board members shall be removed from office if any of the following occurs:

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance.
b) If they fail to attend a minimum of 90% of the meetings to which they are invited, including ICB Board and Committee meetings, unless agreed with the Chair in extenuating circumstances
c) If they are deemed to not meet the expected standards of performance at their annual appraisal
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to dishonesty; misrepresentation (either knowingly or fraudulently); defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise
e) Are deemed to have failed to uphold the Nolan Principles of Public Life
f) Are subject to disciplinary proceedings by a regulator or professional body

~~3.13.3~~3.14.3 Members may be suspended pending the outcome of an investigation into whether any of the matters in 3.1~~3~~4.2 apply.

~~3.13.4~~3.14.4 Executive Directors (including the Chief Executive) will cease to be ~~Board~~ board members if their employment in their specified role ceases, regardless of the reason for termination of the employment.

~~3.13.5~~3.14.5 The Chair of the ICB may be removed by NHS England, subject to the approval of the Secretary of State for Health and Social Care.

~~3.13.6~~3.14.6 If NHS England is satisfied that the ICB is failing or has failed to discharge any of its functions or that there is a significant risk that the ICB will fail to do so, it may:

a) terminate the appointment of the ICB's Chief Executive; and
b) direct the Chair of the ICB as to which individual to appoint as a replacement and on what terms.

~~3.14~~3.15 Terms of appointment of Board Members

~~3.14.1~~3.15.1 With the exception of the Chair and Non-executive ~~m~~Members, arrangements for remuneration and any allowances will be agreed by the Remuneration, People and Culture Committee in line with the ICB remuneration policy and any other relevant policies published at www.improvinglivesnw.org.uk.and any guidance issued by NHS England or other relevant body. Remuneration for Chairs will be set by NHS England. Remuneration for Non-executive Members will be set by the Board. Any discussions about remuneration for the Non-executive Members will be held without the Non-executive Members present.

~~3.14.2~~3.15.2 Other terms of appointment will be determined by the Remuneration, People and Culture Committee.

~~3.14.3~~ Terms of appointment of the Chair will be determined by NHS England.

~~3.15 Specific arrangements for appointment of Ordinary Members made at establishment~~

~~3.15.1 Individuals may be identified as "designate Ordinary Members" prior to the ICB being established.~~

~~3.15.2 Relevant nomination procedures for Partner Members in advance of establishment are deemed to be valid so long as they are undertaken in full and in accordance with the provisions of 3.5 to 3.7.~~

~~3.15.3 Any appointment and assessment processes undertaken in advance of establishment to identify designate ordinary members should follow, as far as possible, the processes set out in section 3.5-3.12 of this Constitution. However, a modified process, agreed by the Chair, will be considered valid.~~

~~3.15.4 On the day of establishment, a committee consisting of the Chair, Chief Executive and one other will appoint the ordinary members who are expected to be all individuals who have been identified as designate appointees pre ICB establishment and the Chair will approve those appointments.~~

~~3.15.5~~3.15.3 ~~For the avoidance of doubt, this clause is valid only in relation to the appointments of the initial ordinary members and all appointments post establishment will be made in accordance with clauses 3.5 to 3.12.~~

4 Arrangements for the exercise of our functions

4.1 Good governance

4.1.1 The ICB will, at all times, observe generally accepted principles of good governance. This includes the Seven Principles of Public Life (the Nolan Principles) and any governance guidance issued by NHS England.

4.1.2 The ICB has agreed a standards of business conduct policy which sets out the expected behaviours that members of the board and its committees will uphold whilst undertaking ICB business. It also includes a set of principles that will guide decision making in the ICB. The ICB standards of business conduct policy can be found on our website at www.improvinglivesnw.org.uk.

4.2 General

4.2.1 The ICB will:

a) comply with all relevant laws including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations;
b) comply with directions issued by the Secretary of State for Health and Social Care
c) comply with directions issued by NHS England;
d) have regard to statutory guidance including that issued by NHS England; and
e) take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England.
f) respond to reports and recommendations made by local Healthwatch organisations within the ICB area

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with (a)-(f) above, documenting them as necessary in this Constitution, its Governance Handbook and other relevant policies and procedures as appropriate.

4.3 Authority to Act

4.3.1 The ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to:

a) any of its members or employees
b) a committee or sub-committee of the ICB

4.3.2 Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB. Where the ICB and other body enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund.

4.3.3 Where arrangements are made under section 65Z5 or section 75 of the 2006 Act the board must authorise the arrangement, which must be described as appropriate in the SoRD.

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a scheme of reservation and delegation (SoRD) which is published in full at www.improvinglivesnw.org.uk

4.4.2 Only the board may agree the SoRD and amendments to the SoRD may only be approved by the board.

4.4.3 The SoRD sets out:

a) those functions that are reserved to the board;
b) those functions that have been delegated to an individual or to committees and sub committees;
c) those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act

4.4.4 The ICB remains accountable for all of its functions, including those that it has delegated. All those with delegated authority are accountable to the board for the exercise of their delegated functions.

4.5 Functions and Decision Map

4.5.1 The ICB has prepared a Functions and Decision Map which sets out at a high level its key functions and how it exercises them in accordance with the SoRD.

4.5.2 The Functions and Decision Map is published at www.improvinglivesnw.org.uk.

4.5.3 The map includes:

a) Key functions reserved to the board of the ICB
b) Commissioning functions delegated to committees and individuals.
c) Commissioning functions delegated under section 65Z5 and 65Z6 of the 2006 Act to be exercised by, or with, another ICB, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body;
d) functions delegated to the ICB (for example, from NHS England).

4.6 Committees and sub-committees

4.6.1 The ICB may appoint committees and arrange for its functions to be exercised by such committees. Each committee may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees.

4.6.2 All committees and sub-committees are listed in the SoRD.

4.6.3 Each committee and sub-committee established by the ICB operates under terms of reference agreed by the board. All terms of reference are published in the Governance Handbook.

4.6.4 The board remains accountable for all functions, including those that it has delegated to committees and sub-committees and therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub-committees that fulfil delegated functions of the ICB, will be required to:

a) Submit regular decision or assurance reports to the board
b) Comply with any internal audit findings of the ICB
c) Conduct annual committee effectiveness reviews
d) Submit their term of reference for board approval.

4.6.5 Any committee or sub-committee established in accordance with clause 4.6 may consist of, or include, persons who are not ICB members or employees.

4.6.6 All members of committees and sub-committees that exercise the ICB commissioning functions will be approved by the Chair. The Chair will not approve an individual to such a committee or sub-committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

4.6.7 All members of committees and sub-committees are required to act in accordance with this Constitution, including the standing orders as well as the Standing Financial Instructions and any other relevant ICB policy.

4.6.8 The following committees will be maintained:

a) **Audit and Risk Committee:** This committee is accountable to the Board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit.

The Audit and Risk Committee will be chaired by a ~~non~~Non-executive ~~member~~ Member (other than the Chair and Deputy Chair of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters.

b) **Remuneration, People and Culture Committee:** This committee is accountable to the Board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB.

The Remuneration, People and Culture Committee will be chaired by a ~~non~~Non-executive ~~member~~ Member other than the Chair or the Chair of the Audit and Risk Committee.

4.6.9 The terms of reference for each of the above committees are published in the Governance Handbook.

4.6.10 The board has also established a number of other committees to assist it with the discharge of its functions. These committees are set out in the SoRD and further

information about these committees, including terms of reference, are published in the Governance Handbook.

4.7 Delegations made under section 65Z5 of the 2006 Act

4.7.1 As per 4.3.2 the ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

4.7.2 All delegations made under these arrangements are set out in the ICB Scheme of Reservation and Delegation and included in the Functions and Decision Map.

4.7.3 Each delegation made under section 65Z5 of the Act will be set out in a delegation arrangement which sets out the terms of the delegation. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation arrangements made under this provision will be reserved to the board.

4.7.4 The board remains accountable for all the ICB's functions, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation and these are detailed in the delegation arrangements, summaries of which will be published in the ICB's Governance Handbook.

4.7.5 In addition to any formal joint working mechanisms, the ICB may enter into strategic or other transformation discussions with its partner organisations on an informal basis.

5 Procedures for Making Decisions

5.1 Standing Orders

5.1.1 The ICB has agreed a set of standing orders which describe the processes that are employed to undertake its business. They include procedures for:

- conducting the business of the ICB
- the procedures to be followed during meetings; and
- the process to delegate functions.

5.1.2 The Standing Orders apply to all committees and sub-committees of the ICB unless specified otherwise in terms of reference which have been agreed by the board.

5.1.3 A full copy of the Standing Orders is included in Appendix 2 and form part of this Constitution.

5.2 Standing Financial Instructions (SFIs)

5.2.1 The ICB has agreed a set of Standing Financial Instructions (SFIs) which include the delegated limits of financial authority set out in the SoRD.

5.2.2 A copy of the SFIs is published in the Governance Handbook.

6 Arrangements for conflict of interest management and standards of business conduct

6.1 Conflicts of Interest

6.1.1 As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

6.1.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published on the website at www.improvinglivesnw.org.uk

6.1.3 All board, committee and sub-committee members, and employees of the ICB, will comply with the ICB policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

6.1.4 All delegation arrangements made by the ICB under section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

6.1.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Constitution, the Conflicts of Interest Policy and the Standards of Business Conduct Policy.

6.1.6 The ICB has appointed the Audit and Risk Committee Chair to be the Conflicts of Interest Guardian. In collaboration with the ICB's governance lead, their role is to:

a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest;
b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest;
c) Support the rigorous application of conflict of interest principles and policies;
d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation;
e) Provide advice on minimising the risks of conflicts of interest.

6.2 Principles

6.2.1 In discharging its functions the ICB will abide by the following principles:

a) The ICB acts in the public interest at all times
b) Avoiding undue influence
c) Transparency and Accountability.

6.3 Declaring and registering interests

6.3.1 The ICB maintains registers of the interests of:
a) Members of the ICB
b) Members of the board's committees and sub-committees
c) Its employees.

6.3.2 In accordance with section 14Z30(2) of the 2006 Act registers of interest are published on the ICB website at www.improvinglivesnw.org.uk.

6.3.3 All relevant persons as per 6.1.3 and 6.1.5 must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

6.3.5 All declarations will be entered in the registers as per 6.3.1

6.3.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed, or updated at least annually.

6.3.7 Interests (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this information.

6.3.8 Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be managed in accordance with the ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.4 Standards of business conduct

6.4.1 Board members, employees, committee and sub-committee members of the ICB will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:
a) act in good faith and in the interests of the ICB;
b) follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles);
c) comply with the ICB's Standards of Business Conduct Policy, and any requirements set out in the policy for managing conflicts of interest.

6.4.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct policy.

7 Arrangements for ensuring accountability and transparency

7.1.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 12(2) of Schedule 1B to the 2006 Act.

7.2 Meetings and publications

7.2.1 Board meetings, and committees composed entirely of board members or which include all board members, will be held in public except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.

7.2.2 Papers and minutes of all meetings held in public will be published.

7.2.3 Annual accounts will be externally audited and published.

7.2.4 A clear complaints process will be published.

7.2.5 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.

7.2.6 Information will be provided to NHS England as required.

7.2.7 The Constitution and Governance Handbook will be published as well as other key documents including but not limited to:

- Conflicts of interest policy and procedures
- Registers of interests
- Key policies

The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years (the "Joint Forward Plan"). The plan will, in particular:

a) describe the health services for which the ICB proposes to make arrangements in the exercise of its functions

~~7.2.8~~ explain how the ICB proposes to discharge its duties under :

- ~~sections 14Z34 to 14Z45 (general duties of integrated care boards), and~~
- ~~a) sections 223GB and 223N (financial duties).~~
- b)

~~and~~

~~a) proposed steps to implement the Norfolk and Waveney joint local health and wellbeing strategies~~

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c) set out any steps that the ICB proposes to take ~~proposed steps~~ to implement the Norfolk and Waveney joint local health and wellbeing strategies~~.~~

d) set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25.

e) set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic abuse and sexual abuse, whether of children or adults).

~~1.5~~7.5 Scrutiny and decision making

~~1.1.1~~7.1.1 At least three Non-executive ~~members~~ Members will be appointed to the board including the Chair; and all of the board and committee members will comply with the ~~Seven Principles~~Seven Principles of Public Life (the Nolan Principles) and meet the criteria described in the fit and proper person test.

~~1.1.2~~7.1.2 Healthcare services will be arranged in a transparent way, and decisions around who provides services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime.

~~1.1.3~~7.1.3 The ICB will comply with the requirements of the NHS Provider Selection Regime including:

a) Complying with existing procurement rules until the provider selection regime comes into effect.
b) evidencing that it has properly exercised the responsibilities conferred on it by the regime, once this is published, by:
   - publishing the intended selection approach in advance.
   - publishing the outcome of decisions made and the details of contracts awarded.
   - keeping a record of decisions made under the regime, including evidence that all relevant issues and criteria have been considered and that the reasons for any decision are clearly justified.
   - recording how conflicts of interest were managed.
c) monitoring compliance with this regime via an annual internal audit process, the results of which will be published.
d) including in the annual report a summary of contracting activity as specified by the regime.
e) ensuring that appropriate internal governance mechanisms are in place to deal with representations made against provider selection decisions and that any such representations are considered fairly and impartially within the timescales prescribed.

~~1.1.4~~7.1.4 The ICB will comply with local authority health overview and scrutiny requirements.

~~1.6~~7.6 Annual Report

1.1.17.1.1 The ICB will publish an Annual Report in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year. An annual report must in particular:

a) explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards)
b) review the extent to which the ICB has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan)
c) review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised), and
d) review any steps that the ICB has taken to implement any joint local health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

28 Arrangements for Determining the Terms and Conditions of Employees

2.1.18.1.1 The ICB may appoint employees, pay them remuneration and allowances as it determines and appoint staff on such terms and conditions as it determines.

2.1.28.1.2 The board has established a Remuneration, People and Culture Committee which is chaired by a Non-executive Member other than the Chair or Audit and Risk Committee Chair.

2.1.38.1.3 The membership of the Remuneration, People and Culture Committee is determined by the board. No employees may be a member of the Remuneration People and Culture Committee, but the board ensures that the Remuneration People and Culture Committee has access to appropriate advice by:

a) The Chair may invite relevant staff to the meeting as necessary in accordance with the business of the committee
b) Meetings may also be attended by the following individuals, who are not members of the committee, for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:
   - The ICB's most senior HR Advisor or their nominated deputy
   - The Director of Finance or their nominated deputy
   - The Chief Executive or their nominated deputy, and
   - Director of Corporate Affairs and ICS Development or their nominated deputy

2.1.48.1.4 The board may appoint independent members or advisers to the Remuneration People and Culture Committee who are not members of the board.

2.1.58.1.5 The main purpose of the Remuneration People and Culture Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18

to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the board are published in the ICB's Governance Handbook.

~~2.1.6~~8.1.6 The duties of the Remuneration People and Culture Committee include for the Chief Executive, Members of the Board and other Very Senior Managers:

a) Determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, pensions and cars;
b) Determine arrangements for termination of employment and other contractual terms and non-contractual terms.

For all staff:

a) Determine the ICB pay policy, including the adoption of pay frameworks such as Agenda for Change;
b) Oversee contractual arrangements;
c) Determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.

For Clinical Advisors:

a) Determine ICB pay policy
b) Oversee contractual arrangements

~~7.2.9~~8.1.7 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

~~8~~9 Arrangements for Public Involvement

~~8.1.1~~9.1.1 In line with section 14Z45(2) of the 2006 Act, the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

~~a)~~ the planning of the commissioning arrangements by the ICB
a)
~~a)~~ the development and consideration of proposals by the ICB for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them, and

b) decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

~~8.1.2~~9.1.2 In line with section 14Z54 of the 2006 Act the ICB has made the following arrangements to consult its population on its system plan:

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a) All consultation proposals will be formally agreed by the ICB and will be shared with a range of key stakeholder prior to the start of any consultation process to ensure that the proposals are robust and representative.

b) Work with Healthwatch Norfolk and Healthwatch Suffolk to ensure patient and public voice is embedded into the work of the Norfolk and Waveney Integrated Care Board, embracing co-production and co-design wherever possible.

~~8.1.3~~9.1.3 The ICB has adopted the ten principles set out by NHS England for working with people and communities:

a) Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.

b) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions.

c) Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.

d) Build relationships with excluded groups – especially those affected by inequalities.

e) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners.

f) Provide clear and accessible public information about vision, plans and progress to build understanding and trust.

g) Use community development approaches that empower people and communities, making connections to social action.

h) Use co-production, insight and engagement to achieve accountable health and care services.

i) Co-produce and redesign services and tackle system priorities in partnership with people and communities.

j) Learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

~~2.1.7~~9.1.4 These principles will be used when developing and maintaining arrangements for engaging with people and communities.

~~2.1.8~~9.1.5 These arrangements, include:

a) Working with patients and members of the public across the ICS to ensure patients and members of the public are involved in helping to shape services at a local level.
b) Strengthening Patient Participation Groups, supporting them to embrace new ways of reaching out to local communities and feeding these views into local alliances.
c) Working with the Norfolk and Waveney Communications and Engagement Group (including NHS, local authorities, both Norfolk and Suffolk Heathwatch, and VCSE) to consider as part of Norfolk and Waveney wide campaigns, communication and engagement activities.
d) Working with the Integrated Care Board to include patient stories at their meetings, linked to and focussed on highlighting the importance of patient and public views and voices to help inform decision making.

Appendix 1: Definitions of Terms Used in This Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022
ICB board	Members of the ICB
Area	The geographical area that the ICB has responsibility for, as defined in ~~part 2~~clause 1.3 of this Constitution
Committee	A committee created and appointed by the ICB board.
Sub-committee	A committee created and appointed by and reporting to a committee.
Forward Plan Condition	The 'Forward Plan Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Level of Services Provided Condition	The 'Level of Services Provided Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
Health Care Professional	An individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002
Place-based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders.
Ordinary Member	The board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the board are referred to as Ordinary Members.
Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in accordance with the procedures set out in Section 3 having been nominated by the following: • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description

	• the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description • the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.
Health Service Body	Health Service Body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.

Appendix 2: Standing Orders

1. Introduction

1.1. These Standing Orders have been drawn up to regulate the proceedings of the Norfolk and Waveney Integrated Care Board so that the ICB can fulfil its obligations as set out largely in the 2006 Act (as amended). They form part of the ICB's Constitution.

2. Amendment and review

2.1. The Standing Orders are effective from 1 July 2022

2.2. Standing Orders will be reviewed on an annual basis or sooner if required.

2.3. Amendments to these Standing Orders will be made as per clause 1.6.

2.4. All changes to these Standing Orders will require an application to NHS England for variation to the ICB Constitution and will not be implemented until the Constitution has been approved.

3. Interpretation, application and compliance

3.1. Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB Constitution and as per the definitions in Appendix 1.

3.2. These Standing Orders apply to all meetings of the board, including its committees and sub-committees unless otherwise stated. All references to board are inclusive of committees and sub-committees unless otherwise stated.

3.3. All members of the board, members of committees and sub-committees and all employees, should be aware of the Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.

3.4. In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the Executive Director, Corporate Affairs and ICS Development, will provide a settled view which shall be final.

3.5. All members of the board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

3.6. If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the board for action or ratification and the Audit Committee for review.

4. Meetings of the Integrated Care Board

4.1. Calling Board Meetings

4.1.1. Meetings of the board of the ICB shall be held at regular intervals at such times and places as the ICB may determine.

4.1.2. In normal circumstances, each member of the board will be given not less than one month's notice in writing of any meeting to be held. However:

a) The Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.

b) One third of the members of the board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the board specifying the matters to be considered at the meeting.

c) In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

4.1.3. A public notice of the time and place of meetings to be held in public and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

4.1.4. The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.

4.2. Chair of a meeting

4.2.1. The Chair of the ICB shall preside over meetings of the board.

4.2.2. If the Chair is absent, or is disqualified from participating by a conflict of interest, then the Deputy Chair of the ICB shall preside over the meeting of the board. The Deputy Chair shall be appointed by the board.

~~4.2.2.~~4.2.3. If both the Chair and the Deputy Chair are absent, or are disqualified from participating by a conflict of interest, then the board may appoint a temporary deputy to preside over meetings of the board.

~~4.2.3.~~4.2.4. The board shall appoint a Chair to all committees and sub-committees that it has established. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.3. Agenda, supporting papers and business to be transacted

4.3.1. The agenda for each meeting will be drawn up and agreed by the Chair of the meeting.

4.3.2. Except where the emergency provisions apply, supporting papers for all items must be submitted at least seven calendar days before the meeting takes place. The agenda and supporting papers will be circulated to all members of the board at least five calendar days before the meeting.

4.3.3. Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website at www.improvinglivesnw.org.uk.

4.4. Petitions

4.4.1. Where a valid petition has been received by the ICB it shall be included as an item for the agenda of the next meeting of the Board in accordance with the ICB policy as published in the Governance Handbook.

4.5. Nominated Deputies

4.5.1. With the permission of the person presiding over the meeting, the Executive Directors and the Partner Members of the board may nominate a deputy to attend a meeting of the Board that they are unable to attend. ~~For the avoidance of doubt, the~~The deputy may speak but may not vote on their behalf.

~~4.5.2. Partner Members will not be permitted to send deputies.~~

~~4.5.3.~~4.5.2. The decision of the person presiding over the meeting regarding authorisation of nominated deputies is final.

4.6. Virtual attendance at meetings

4.6.1. The board of the ICB and its committees and sub-committees may meet virtually using telephone, video and other electronic means when necessary, unless the terms of reference prohibit this.

4.7. Quorum

4.7.1. The quorum for meetings of the board will be 10 members, including:

a) Either the Chief Executive or the Director of Finance
b) Either the Medical Director or the Director of Nursing
c) At least one Independent member (which can include the Chair)
d) At least one Partner Member.

4.7.2. For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum.
b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.
~~b)~~c) A nominated deputy permitted in accordance with standing order 4.5 will count towards quorum for meetings of the board.

4.7.3. For all committees and sub-committees, the details of the quorum for these meetings and status of deputies are set out in the appropriate terms of reference.

4.8. Vacancies and defects in appointments

4.8.1. The validity of any act of the ICB is not affected by any vacancy among members or by any defect in the appointment of any member.

4.8.2. In the event of vacancy or defect in appointment the following temporary arrangement for quorum will apply:

- For a limited period the quorum will be reduced by one per vacancy.

4.9. Decision making

4.9.1. The ICB has agreed to use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

4.9.2. Generally it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required. The process for voting, which should be considered a last resort, is set out below:

a) All members of the board who are present at the meeting will be eligible to cast one vote each.
b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.
c) For the sake of clarity, any additional Participants and Observers (as detailed within paragraph 5.6. of the Constitution) will not have voting rights.
d) A resolution will be passed if more votes are cast for the resolution than against it.
e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.
f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Disputes

4.9.3. Where necessary or helpful, the board may draw on third party support such as peer review or support from NHS England.

Urgent decisions

4.9.4. In the case urgent decisions and extraordinary circumstances, every attempt will be made for the board to meet virtually. Where this is not possible the following will apply.

4.9.5. The powers which are reserved or delegated to the board, may for an urgent decision be exercised by the Chair and Chief Executive (or relevant lead director in the case of committees) subject to every effort having made to consult with as many members as possible in the given circumstances.

4.9.6. The exercise of such powers shall be reported to the next formal meeting of the board for formal ratification and the Audit and Risk Committee for oversight.

4.10. Minutes

4.10.1. The names and roles of all members present shall be recorded in the minutes of the meetings.

4.10.2. The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it.

4.10.3. No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

4.10.4. Where providing a record of a meeting held in public, the minutes shall be made available to the public.

4.11. Admission of public and the press

4.11.1. In accordance with Public Bodies (Admission to Meetings) Act 1960 All meetings of the board and all meetings of committees which are comprised of entirely board members or all board members at which public functions are exercised will be open to the public.

4.11.2. The board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.11.3. The person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the board's business shall be conducted without interruption and disruption.

4.11.4. As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time) the public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour.

4.11.5. Matters to be dealt with by a meeting following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the board.

5. Suspension of Standing Orders

5.1. In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended by the Chair in discussion with at least two other members,

5.2. A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

5.3. A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit Committee for review of the reasonableness of the decision to suspend Standing Orders.

6. Use of seal and authorisation of documents

6.1. The common seal of the ICB shall be kept by the Executive Director of Corporate Affairs or a nominated manager by them in a secure place.

6.2. Register of Sealing

6.3. The Executive Director of Corporate Affairs shall keep a register in which they, or another manager of the ICB authorised by them, shall enter a record of the sealing of every document.

6.4. Use of the Seal

7. Please refer to the Governance Handbook for who may authorise its use, and when use of the Seal will be triggered.

Appendix 3: Lower Super Output Areas covered by Norfolk and Waveney ICB

District of East Suffolk

Lower Super Output Areas covered by Norfolk and Waveney ICB in the District of East Suffolk
East Suffolk (PARTIAL) including LSOAs: E01030240, E01030241, E01030242, E01030259, E01030260, E01030261, E01030262, E01030277, E01030279, E01030281, E01030266, E01030267, E01030271, E01030278, E01030280, E01030246, E01030248, E01030249, E01030250, E01030264, E01030265, E01030255, E01030263, E01030270, E01030289, E01030290, E01030233, E01030235, E01030268, E01030269, E01030288, E01030247, E01030254, E01030256, E01030258, E01030276, E01030257, E01030274, E01030275, E01030287, E01030291, E01030234, E01030236, E01030237, E01030238, E01030223, E01030224, E01030225, E01030227, E01030228, E01030226, E01030286, E01030292, E01030293, E01030294, E01030239, E01030251, E01030252, E01030253, E01030272, E01030273, E01030230, E01030231, E01030232, E01030285, E01030282, E01030283, E01030284, E01030295, E01030229, E01030243, E01030244, E01030245

Norfolk and Waveney
Integrated Care Board

Agenda item: 22

Subject:	**Audit and Risk Committee Report**
Presented by:	**David Holt, Audit and Risk Committee Chair**
Prepared by:	**Amanda Brown, Associate Director of Corporate Governance**
Submitted to:	**Norfolk and Waveney Integrated Care Board – Board Meeting**
Date:	**27 November 2024**

Purpose of paper:

To provide the Board with an update on the work of the Audit and Risk Committee for the period July 2024 to November 2024.

To inform Board that following the appointment of the Deputy Medical Director, Mike Smith he will be taking on the role of Deputy Caldicott Guardian.

Committee:	Audit and Risk Committee
Committee Chair:	David Holt, Non-executive Member
Meetings since the previous update on 17 July 2024:	*Bullet pointed details of each committee meeting held since the last report to Board, including dates and times.* • ***18 September 2024***
Overall objectives of the committee:	This Committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.
Main purpose of meeting:	Main purpose of this meeting was to report on key areas to the Committee providing information and assurance. The main items covered were: **Briefing by Executive Director of Finance** This item highlighted the significant financial challenge faced by the ICB. The ICS system was currently showing an overspend and needed to get back to the planned position. The ICB is reporting on plan but there are significant risks attached to this. The financial recovery board is being used

	to look at the actions from the Investigation and Improvement framework to take forward to recover the position. **Internal Audit Plan** The meeting took the opportunity to review the internal audit plan to ensure it continued to meet organisational needs. It was agreed that the overall timing of audits was appropriate in the plan but considered that the continuing health care and workforce audits be brought forward to reflect risks to the organisation. **Internal Audit** Internal audit confirmed that good progress had been made against the internal audit plan and there were no overdue recommendations. **Counter Fraud Service Progress Report** The work on the counter fraud functional standards shows that there are currently 8 green and 4 amber rated components with no components rated red. It is anticipated that some of the current amber rated components will be rated green by 31 March 2025 to reflect the work completed by the ICB and Grant Thornton (GT). **External Auditor's Annual Report** External audit presented their annual report for 2023/24 which included commentary on the Value for Money arrangements (the report is available on the ICB website). The report provides an unqualified finding for the ICBs financial statements and that they provided a true and fair view of the financial position as at 31 March 2024 and that there were no matters to report by exception on the ICB's value for money arrangements. **Year End Debrief and Lessons Learned** Each year following the conclusion of the Annual Report and Accounts the Committee reviews the success of the process to identify any actions for the next year. This discussion confirmed that the draft and final submissions of the papers were made on time with no further inquiries or revisions requested. **Losses & Special Payments** This is a standing agenda item for the meeting. There were no write offs presented to this meeting, but an update on the working group of senior and operational levels with Norfolk County Council was discussed. **Information Governance Senior Information Risk Officer Report** The previous SIRO report was presented to the Committee in May 2024 and the updates to this meeting reflected the level of work that had been undertaken since then.

	Annual Review of Risk Management Framework The Risk Management Framework has been refreshed and sessions are taking place with risk owners on the outline process for identifying the risks. The executive team have met to discuss BAF risks and are looking at risk appetite and organization risks. **Gifts and Hospitality Register Annual Report** The annual report and register were presented to the meeting and discussed. o **Items for information** The Committee also received updates on the following matters: o Conflicts of Interest Committee Update o Internal Audit Reports with reasonable assurance or above and advisory reports o Procurement update and Tender Waiver Briefing o Audit and Risk Committee Policies Report o Audit and Risk Committee Annual Plan o Report on any urgent Board decisions and non-compliance with the Standing Orders o Review other reports and policies as appropriate
BAF and any Board Operational risks relevant / aligned to this Committee:	BAF reference numbers and detail of any Board Operational Risks (BORR) set out here. [Notes on this to assist drafting: Committees have to receive clear assurances on controls on the effectiveness of the action to address the identified gaps in controls which is included in the Committee chairs report to Board. Board Committees to receive assurance that controls over BAF risks are operating as expected and that action to address identified gaps in controls are on track and working as expected. These to be supported by evidence and metrics. Where gaps are identified in BAF controls, action is in place to address it. Review of the controls, assurance and gaps is undertaken to ensure that they are correctly stated on the BAF. Dates to achieve the targeted risk score for each BAF are challenged at Committee and any issues set out here. Evidence of committee consideration and support for changes to BAF risks are included in Committee chair reports to board.

	Are the Committee requesting that there are any changes to the BAF to the ratings? If so add this here]
Key items for assurance/noting:	To inform Board that following the appointment of the Deputy Medical Director, Mike Smith he will be taking on the role of Deputy Caldicott Guardian.
Items for escalation to Board:	N/A
Items requiring approval:	N/A
Confirmation that the meeting was quorate:	The meeting was quorate