



**Improving lives together**

Norfolk and Waveney Integrated Care System

# Estates Infrastructure Strategy

## 2024-2034

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**Produced by: ICB Estates Team**

**Approved by: ICB Board**

## Foreword

The Norfolk and Waveney Integrated Care System is a partnership of organisations that have come together to plan and deliver joined-up health and care services. Our mission is clear: *to help the people of Norfolk and Waveney to live longer, healthier and happier lives.*

There's no doubt our buildings and estate play a vital role in this. They shape how we care for people, the treatments we can provide and the way in which different services work together.

We are making significant investments in our primary care, acute, mental health, and community health estate. Coupled with our investment in new technology, this will help us to improve the quality and safety of people's care, the services we provide and the working lives of the thousands of people who work in health and care.

At the same time, we are making our estate more efficient and ensuring we get the best value for the public money we spend. This is not just good for the health of our finances, but also the health of our planet as we work towards our goal of net zero.

There is much we want to achieve over the next decade. This ten-year strategy sets-out how we will deliver our vision of *providing estate that allows delivery of the right care in the right place, enables better patient outcomes, and empowers health, social care and third sector staff to provide the best possible care.*

**Tracey Bleakley**  
Chief Executive Officer  
NHS Norfolk and Waveney



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Norfolk and Waveney Integrated Care System

# Executive Summary

This section provides an overview and summary of our Estates Infrastructure Strategy, 'our strategy on a page', and timelines showing recent achievements as well future infrastructure development plans for the next 10 years.

# Executive Summary

## 1.1 Our Estates Infrastructure Strategy

This new Estates Infrastructure Strategy, the third iteration for NHS Norfolk and Waveney, builds on our first strategy published in 2018, and its updated version from 2023. The strategy has been developed to incorporate the latest NHS England guidance for System Estates Infrastructure Strategies.

The system's estate infrastructure has a significant part to play in supporting and enabling the delivery of system priorities and ambitions. This strategy has been developed through extensive engagement, and the vision and goals within have been developed to meet the requirements of the Integrated Care Strategy, the ICS Clinical Strategy, the Joint Forward Plan, both national and local policy and guidance, and other service delivery priorities.

This strategy highlights the current state of our estate infrastructure, and the challenges faced; it provides strategic direction and priorities for estate infrastructure improvement and transformation; and it illustrates how we will deliver our goals and adapt our estate to reflect and support national and local direction and new models of care.

Our vision and overarching aim is to provide estate infrastructure that allows delivery of the right care in the right place, enables better patient outcomes, and empowers health, social care and third sector staff to provide the best possible care.

Our Estates Infrastructure Strategy is framed around four key goals: to improve access; to improve quality and condition; to improve environmental sustainability; and to improve efficiency.

The strategy has been developed by the ICB Estates Team, with input from colleagues from across the Integrated Care System. It will be a live document, and it is to be updated within the first 12 months to reflect the new 10-year Health Plan for the NHS and emerging commissioning and clinical strategies. Development and delivery will be reported and managed via the Estates Programme Board.

# Executive Summary

## 1.2 Our strategy on a page

Figure 1: Our Estate Infrastructure Strategy on a page

### Where are we now?

- 300+ sites used by our GP, acute, mental health, community and ambulance service providers
- 2 acute hospitals constructed using RAAC and in need of replacement
- Over £185 million cost to eradicate backlog maintenance, with almost 70% reported as Critical Infrastructure Risk, plus a growing backlog at our PFI hospital due to capacity and decant issues
- Over £230 million spent on estates and facilities annual running costs, with unwarranted variation and above peer benchmark costs in certain areas
- Over 160 million kWh of energy consumed, and over 36 thousand tonnes of CO2 emissions produced

### Where do we want to be?

- **To improve access** - Provide smarter and better health and care infrastructure that supports the delivery of transformational models of care, ensures that the right services can be delivered in the right place, and enables multi-disciplinary collaboration and joined-up care at every level.
- **To improve quality and condition** - Design, build and operate safe, flexible, modern, fit-for-purpose and well-maintained estate infrastructure that offers an improved working environment for our workforce, enhances positive experience and serves the needs of all its users.
- **To improve environmental sustainability** - Develop stronger, greener buildings that support our journey to net zero by implementing interventions to adapt and decarbonise our existing buildings as well ensuring all new estate infrastructure meets the NHS Net Zero Building Standards.
- **To improve efficiency** - Increase collaborative approaches to demand and capacity, prioritised capital investment, procurement frameworks and policy, and workforce planning and recruitment that ensures efficient use of our resources, offers greater value for money and financial sustainability.

### How do we get there?

- Enabling delivery through our workforce, data and intelligence, investment, leadership and governance
- Categorising our estate into core, flex, or tail to inform decision making
- Improving access by providing care closer home, transforming our hospital estate, and embedding the 'building for health' principles
- Improving quality and condition by eradicating RAAC and tackling backlog maintenance
- Improving environmental sustainability through our green plan and investing in low carbon technologies and reducing the carbon footprint of our estate infrastructure
- Improving efficiency by disposing of tail estate, assessing further co-location opportunities, and working with procurement and workforce colleagues to assess collaborative procurement and recruitment opportunities
- Ensuring health estate infrastructure is considered as our population grows, working with our local planning authorities and utilising developer contributions to expand our capacity

# Executive Summary

## 1.3 Our achievements since 2018

In the summer of 2018, our ICS (formerly the STP) submitted its first system 'Estates Workbook' to NHS England. Figure 2 below shows the 'Estate Strategy Journey' from our 2018 workbook, providing a high-level roadmap of what we wanted achieve throughout the strategy period.

The roadmap below has been annotated to highlight our achievements against our plans.

Figure 2: Our 2018 Estate Strategy Journey



Although a number of challenges in recent years have caused delays and impacted our timelines, in 2025 we will have delivered everything we set out to.

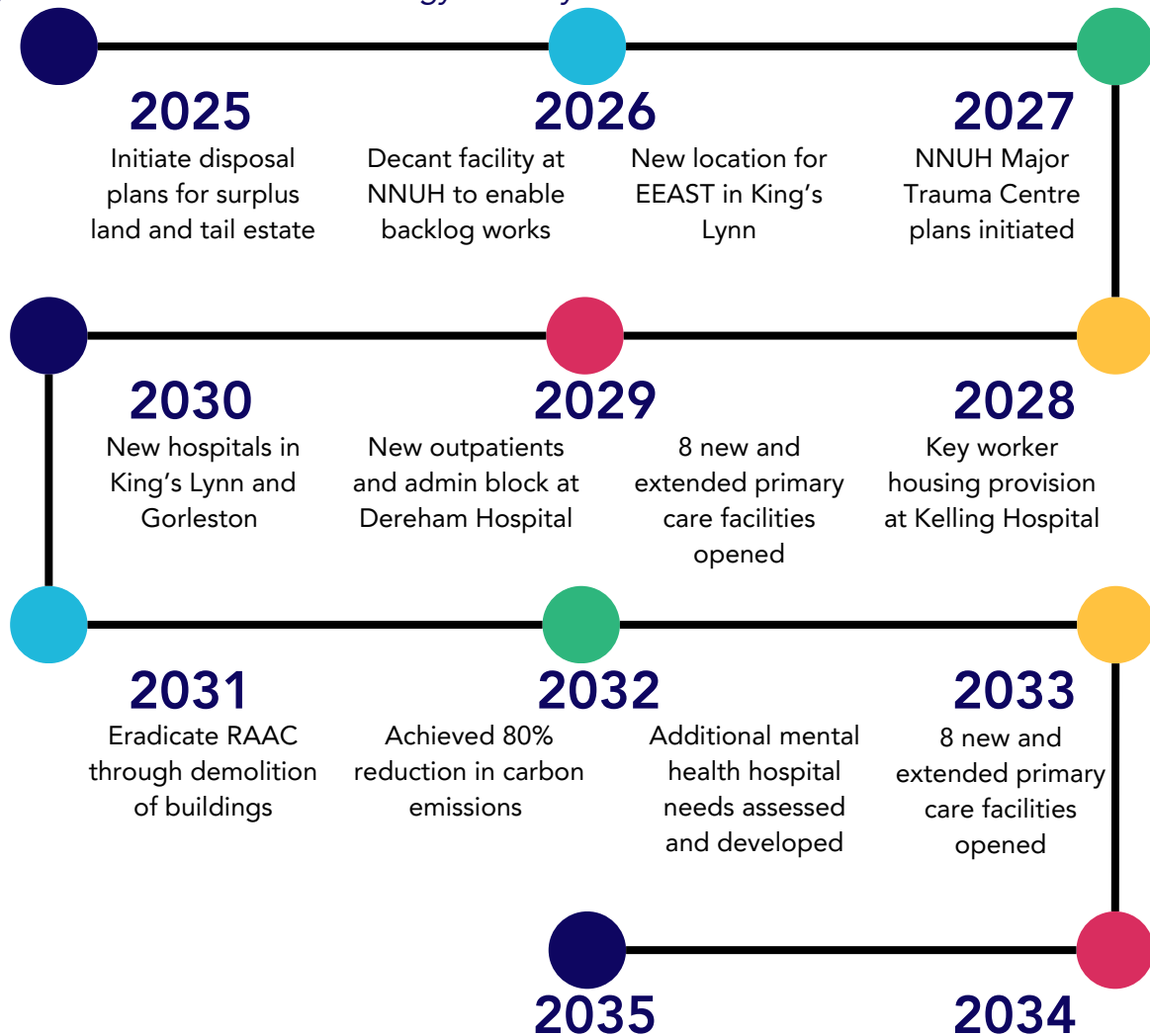
Over the last 5-years we have also successfully been added to the Governments New Hospital Programme; invested significant capital to mitigate and eradicate the risks from RAAC; and continued to modernise our estate infrastructure through prioritised investment. Further detail is captured in the 'where are we now' section of the strategy.

# Executive Summary

## 1.4 Our plans for the next 10-years

Building on from recent achievements and looking to the future, the timeline below provides an overview of significant infrastructure programmes and projects that are required to help us deliver our strategy and achieve our goals.

Figure 3: Our 2024 Estate Strategy Journey



As well as the significant infrastructure programmes and projects captured above, there are numerous other projects and ongoing capital investment requirements throughout the strategy period. These include;

- backlog maintenance, routine maintenance, and statutory compliance
- plant machinery and equipment
- investment to deliver net zero ambitions and decarbonise our estate
- investment to support and enable changing models of care

*Delivery of these programmes of work are reliant on resource and funding availability.*



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Norfolk and Waveney Integrated Care System

# Introduction

This section provides an overview of the Norfolk and Waveney Integrated Care System, its members, its goals and the geographical area covered. It also outlines the process followed to develop this strategy, the structure of the document, and the governance arrangements in place to manage its delivery.

# Introduction

## 2.1 The Norfolk and Waveney Integrated Care System

The Norfolk and Waveney Integrated Care System (ICS) is a collaboration of organisations that are working together – with staff, patients, their carers, families, and members of the public – to transform local services and help people lead longer, healthier and happier lives.

The ICS includes an Integrated Care Board (ICB) called NHS Norfolk and Waveney and an Integrated Care Partnership (ICP).

The ICB is a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget, and arranging for the provision of health services in the ICS area. It will bring the local NHS together to improve population health and care.

The ICP is a statutory committee jointly formed between the ICB and all upper-tier local authorities that fall within the ICS area. The ICP will bring together a broad alliance of partners concerned with improving the care, health, and wellbeing of the population, with membership determined locally. The ICP is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area.

As an ICS we have set ourselves three goals. These are what we aspire to achieve over and above everything else.

### **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.

### **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.

### **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.

# Introduction

## 2.1 The Norfolk and Waveney Integrated Care System

Integrated Care Systems bring together NHS organisations, councils and wider partners in a defined geographical area to deliver more joined-up approaches to improving health and care outcomes. ICSs remove barriers between organisations, and have the potential to drive improvements in population health and tackle inequalities by reaching beyond the NHS to address social and economic determinants of health.

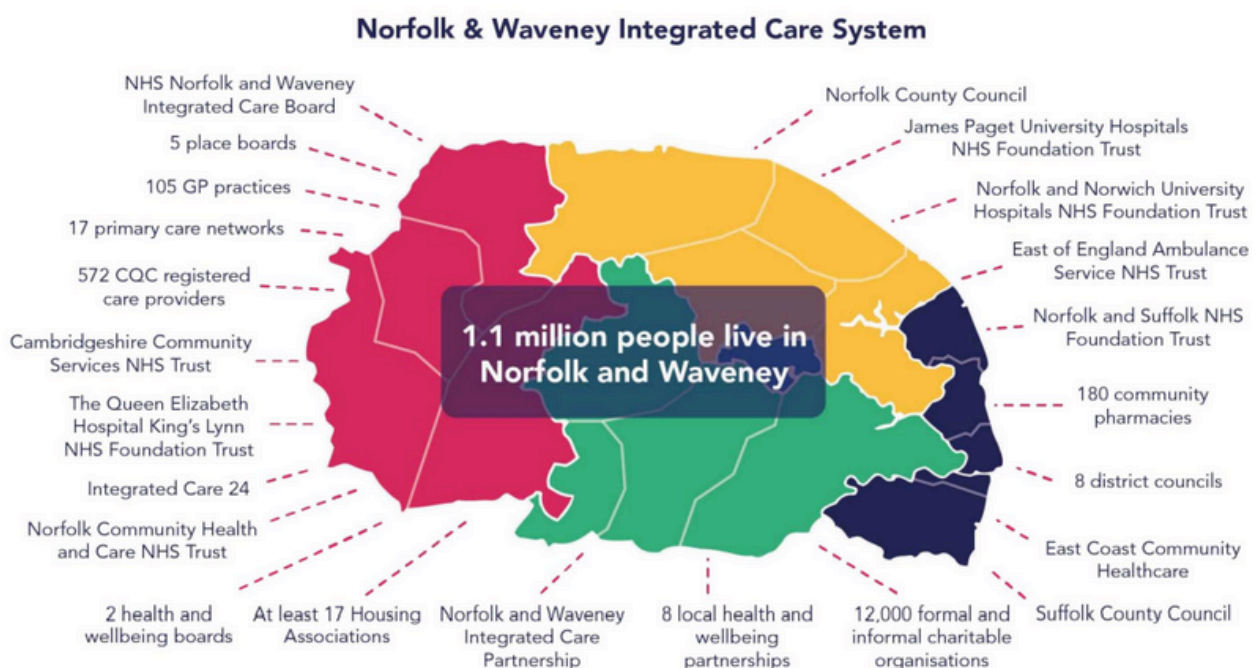
ICS partners share a common vision to improve health and care, backed by robust operational and financial plans, collective leadership and accountability.

The Norfolk and Waveney ICS, as with all ICSs in England, is working to:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Support broader social and economic development

The organisations that sit under the Norfolk and Waveney Integrated Care System umbrella, as well the geographical coverage of our 5 places highlighted by colour, are shown in the stakeholder map at Figure 4 below.

Figure 4: Our Integrated Care System Partners



# Introduction

## 2.2 Estates Infrastructure Strategy: Document Structure

This Estates Infrastructure Strategy is a refresh of our ICS Estate Strategy published in 2023. It has been updated to align with the new framework shared via NHS England's Infrastructure Strategy toolkit. The structure of the document remains largely unchanged and still sets out to answer three key questions: Where are we now? Where do we want to be? How do we get there?

The strategy has been developed with stakeholders across the ICS. A number of reviews and engagement sessions have taken place in order to develop our strategy and respond to the three questions posed.

This system-wide Estates Infrastructure Strategy seeks to show how the NHS estate across Norfolk and Waveney will be transformed to support new models of care, deliver better outcomes to patients, and provide best value for money.

Although this iteration of the strategy focusses primarily on the General Practice, Acute, Mental Health, Community, and Ambulance service areas and their estate, it will complement, inform, and be integral to wider integration developments between the NHS and all of its ICS partners.

It is anticipated that future iterations of the strategy should be developed to include areas such as; Dentistry, Pharmacy, Optometry, Social Care, and other healthcare services, including the voluntary sector.

Figure 5: Structure of the Estates Infrastructure Strategy



# Introduction

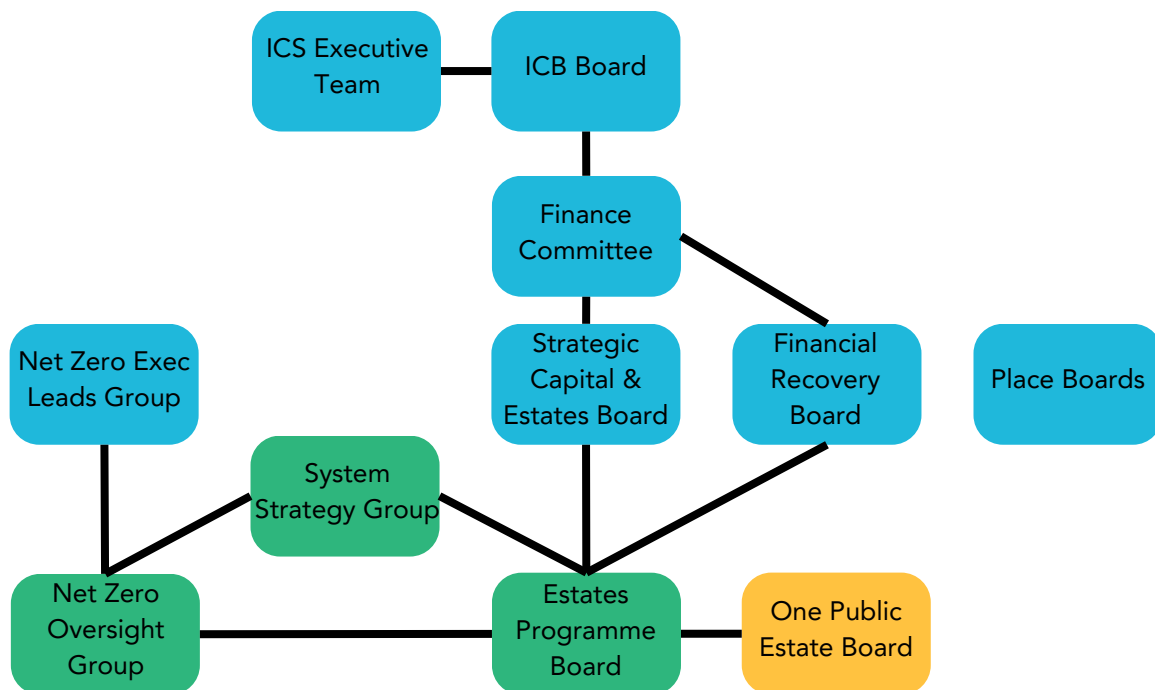
## 2.3 Estates Infrastructure Strategy: Governance

We have established a robust governance process for a system-wide estates team which will enable collaborative working at a system level and make investment decisions for the benefit of the system and our population as a whole.

The Estates Programme Board is one of several operational groups within the ICB. Its main role is to bring key system partners together to develop and deliver the strategic estates vision and objectives that support the Norfolk and Waveney Integrated Care System to realise its vision, purpose, goals, and deliver upon its priorities.

Our Estates Programme Board is comprised of members responsible for leading the estate infrastructure function across each NHS Trust and Primary Care. Membership also includes NHS England (NHSE), NHS Property Services (NHSPS), Community Health Partnerships (CHP), and One Public Estate (OPE) colleagues. The Board is chaired by our SRO for Estates at the ICB, and links operationally into the Strategic Capital & Estates Board.

Figure 6: Estates Programme Board Governance Structure



# Introduction

## 2.4 Estates Infrastructure Strategy: Strategic Planning

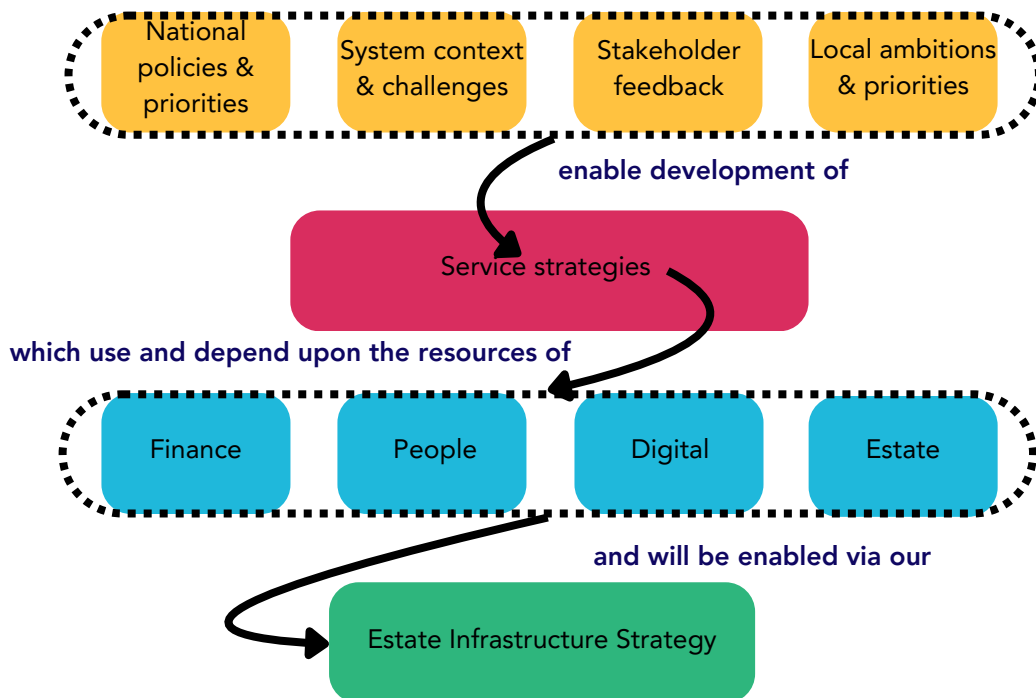
The environment within which the NHS operates is changing. The population is increasingly ageing, there are significant advances in medicine and surgery, patient expectations are changing and there is a need to harness research, innovation, and technology in delivery.

There are a number of predominant national policies and local drivers that this Estates Infrastructure Strategy echoes. These drivers guide, set, and inform 'where we want to be' and 'how we get there'.

Our Estates Infrastructure Strategy will capture how we will utilise, enable, support, and empower collaborative delivery, ensuring we are improving lives together through the delivery of shared visions, objectives, and priorities. This approach remains forward facing, supporting place-based clinical service strategies to achieve their objectives, working with other enabling workstreams toward transforming services.

The figure below helps illustrate the strategic planning process, how drivers enable the development of strategies, and how the estate is one of the core resources that in turn enables our clinical and service strategies.

Figure 7: The Strategic Planning Process





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# National Policies and Priorities

This section sets out the national context within which our Estates Infrastructure Strategy has been developed. It provides an overview of key national policy, plans, reviews, and priorities that must be considered and incorporated within our strategy.

# National Policies and Priorities

## 3.1 The NHS Long Term Plan

The NHS Long Term Plan sets out how the NHS will tackle the pressure its staff are facing while making extra funding go as far as possible. As it does so, it must accelerate the redesign of patient care to future-proof the NHS for the decade ahead.

It also sets out four major practical changes to the NHS service model, to be delivered over the following five years;

- Boosting 'out-of-hospital' care, and joining up primary and community health services.
- Reducing pressure on emergency hospital services.
- Digitally enabled primary and outpatient care.
- Increasing focus by local NHS organisations on population health and local partnerships.

There are some key opportunities for Estates outlined in the LTP including "the NHS will improve the way it uses its land, buildings and equipment." This includes the following key highlights;

- Improving quality and productivity, energy efficiency and dispose of unnecessary land to enable reinvestment while supporting the Government's target to build new homes for staff.
- System providers working together to reduce the amount of non-clinical space, freeing up space for clinical or other activity.
- In line with Lord Carter's recommendations, the NHS needs to exploit opportunities for consolidation of the non-clinical estate to improve efficiency with a 30% cost reduction target, less than 2.5% unoccupied space and less than 35% non-clinical space.
- Increase the provision of diagnostic equipment and services including digitisation of the service to meet the growing demand.

The LTP suggests that the NHS will continue to maximise the productivity benefits generated from estate, through improving utilisation of clinical space, ensuring build and maintenance is done sustainably, improving energy efficiency, and releasing properties that are no longer needed.

# National Policies & Priorities

## 3.2 The Hewitt Review of Integrated Care Systems

The Hewitt review considers how the oversight and governance of Integrated Care Systems (ICSs) can best enable them to succeed, balancing greater autonomy and robust accountability with a particular focus on real time data shared digitally with the Department of Health and Social Care, and on the availability and use of data across the health and care system for transparency and improvement.

ICSs represent the best opportunity in a generation for a transformation in our health and care system. Effective change will require the combination of new structures with changed cultures. Everyone needs to change, and everyone needs to play their part.

The review has identified 6 key principles, that will enable us to create the context in which ICSs can thrive and deliver. These are:

- Collaboration within and between systems and national bodies.
- A limited number of shared priorities.
- Allowing local leaders the space and time to lead.
- The right support.
- Balancing freedom with accountability.
- Enabling access to timely, transparent and high-quality data.

The review argues that, to achieve the best return from the current investment in the NHS, we need to consider health in terms of value rather than cost. To accelerate a shift in resource to where it is most needed – out of hospitals and into community and primary care settings – we should identify the most effective payment models and implement a new model with population-based budgets that will incentivise better outcomes and significantly improve productivity.

The key sections within the review include;

- From focusing on illness to promoting health.
- Delivering on the promise of systems.
- Unlocking the potential of primary and social care and building a sustainable, skilled workforce.
- Resetting our approach to finance to embed change.

# National Policies & Priorities

## 3.3 The Fuller Stocktake Report

The report from Dr Fuller on the next steps for integrating primary care discusses reimagining our approach to primary care estates and sets out a vision of integrated teams, providing joined up accessible care. But it also indicates that much of the general practice and wider primary care estate is not up to scratch. The focus of capital investment has been weighted towards secondary care – something that now needs to change.

The ICS has the reach to take a 'one public estate' approach and think creatively about primary care estates, considering:

- Developing primary care estates plans from the perspective of access, population health and health inequalities.
- Making use of local authority, third sector and community assets, building on the approach to COVID-19 vaccination, including places of worship, community centres, and allotments.
- Making creative use of void and vacant space in the NHS Property Services and Community Health Partnerships portfolio.
- Opportunities for co-locating primary care when bringing forward secondary care estates plans.
- Pragmatic, low-cost opportunities to repurpose existing space within local funding streams, as well as making use of the potential ability of the local authority to raise capital beyond NHS limits to fund new estates.
- Opportunities for locating primary care on the high street as part of local economic regeneration.

The re-focus towards primary care emphasises the 'bottom-up' development of service delivery and estate strategy. Defining the estate response begins within the 'Place', where integrating services locally can be supported with targeted management and investment in our estate, ensuring each of our primary care networks has a secure estate plan that underpins and enables the clinical strategy and forms part of the system estate strategy. Throughout this strategy period, focus will remain firmly on the thread that links local planning and delivery to the system change.

In response to the report, all 42 ICS chief executives committed to take forward the actions.

# National Policies & Priorities

## 3.4 The Naylor Review

In March 2017, Sir Robert Naylor produced his report for the Secretary of State titled 'NHS Property and Estates: Why the estate matters for patients'. The review identified the opportunity to release £2bn of NHS assets for reinvestment and deliver land for 26,000 new homes. The report outlined 17 separate recommendations relevant to national or local structures, the four following recommendations are of note:

- Systems should develop affordable estates and infrastructure plans with an associated capital strategy to deliver the 5 Year Forward View (5YFV) and address backlog maintenance. These plans should be supported by robust business cases. The new NHS Property Board should support the development of these plans.
- System estates plans and their delivery should be assessed against targets informed by the benchmarks developed for this review. Land vacated by the NHS should be prioritised for the development of residential homes for NHS staff, where there is a need.
- Substantial capital investment is needed to deliver service transformation in well-evidenced STP (now ICS) plans. This could be met by contributions from three sources: property disposals, private capital (for primary care) and from HM Treasury.

The Government's response to Sir Naylor's report accepted recommendations that local systems should develop affordable estates and infrastructure plans, and that local systems that fail to develop sufficiently stretching plans should not be granted access to capital funding.

In 2018/19 NHS England mandated the completion of sustainability and transformation partnership (STPs) estate strategies to inform 'STP Wave 4 and Wave 4b' capital funding. Those strategies included a prioritised capital pipeline, which now needs to be reviewed and updated.

# National Policies & Priorities

## 3.5 The Carter Review

Lord Carter produced a number of reports looking into productivity, efficiency and unwarranted variation across the NHS. The reviews identified significant variations in costs and practice which, if addressed, could save the NHS £5 billion.

The reports recommend that every trust have a strategic estates and facilities plan in place, including in the short term, a cost reduction plan based on the model hospital data and benchmarks, and in the longer term, a plan for investment and reconfiguration where appropriate for their whole estate, taking into account the Trust's future service requirements.

The Carter Report also sets specific targets for trusts to meet and report on yearly, these include;

- Unused floor area should be less than 2.5%.
- Non-clinical floor area should be less than 35%.
- Should have benchmarked estates cost reduction plans.
- Should have reconfiguration investment plans.
- Should have energy-saving and efficiency investment

As part of this review, a 'Model Hospital/Health System' platform has been developed to help indicate performance against benchmarks. The aim is to empower NHS leaders by giving them the necessary data and support to highlight areas to improve care for patients and make savings which can be reinvested in frontline care.

# National Policies & Priorities

## 3.6 Delivering a Net Zero National Health Service

In October 2020, the NHS published the 'Delivering a Net-Zero National Health Service' in response to the health emergency that climate change carries.

Climate change threatens the foundations of good health, with direct and immediate consequences for our patients, the public and the NHS. In 2020, the NHS became the first national health system in the world to commit to net zero emissions, launching its new National Programme for a Greener NHS.

Two clear and feasible targets emerge for the NHS net zero commitment, based on the scale of the challenge posed by climate change, current knowledge, and the interventions and assumptions that underpin this analysis:

- For the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
- For the emissions we can influence (our NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

NHS estate and facilities has a critical role to play in achieving this ambition. The operation of NHS facilities currently makes up 15% of the NHS Carbon Footprint Plus, of which 10% is building energy.

The NHS recently published its first Net Zero Building Standard. This creates a clear set of performance criteria relating to various elements of a net zero carbon building - both in construction and operation. The standard lays the foundation for major construction and refurbishment projects in the NHS that are expected over the next decade.

The standard sets out a vision for achieving whole-life net zero carbon buildings whilst improving patient care, with a clear roadmap for reducing operational building energy demands, embodied carbon in construction and the whole-life carbon of building elements used within them.

The building standard will be periodically updated to ensure it remains relevant as technology and modern methods of construction evolve.

# National Policies & Priorities

## 3.7 The Health Infrastructure Plan

The Health Infrastructure Plan (HIP) will deliver a long-term, rolling five-year programme of investment in health infrastructure, including capital to build new hospitals, modernise our primary care estate, invest in new diagnostics and technology, and help eradicate critical safety issues in the NHS estate.

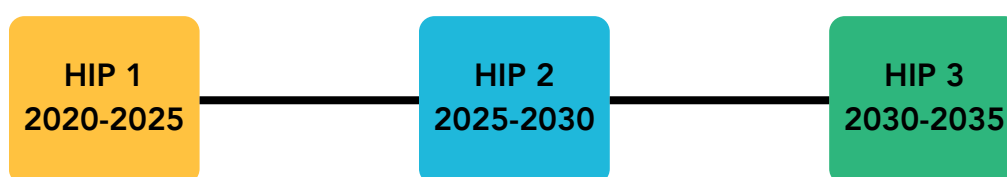
At the centre of this will be a new hospital building programme, to ensure the NHS' hospital estate supports the provision of world-class healthcare services. It is also about capital to modernise mental health facilities, improve primary care and build up infrastructure in interconnected areas such as public health and social care – all of which, together, ensure the best infrastructure needed by the NHS.

Our infrastructure is maintained and improved through capital investment, which is a key part of meeting current and future patient demand through ensuring patient safety, better health outcomes, reducing key cost drivers in the system and supporting the NHS workforce to do their jobs effectively, in well-designed and safe settings. Investment in well-designed buildings can also help improve productivity and reduce costs across the NHS estate, for example reducing maintenance costs, or reducing walking times for staff.

The plan's vision for NHS estate infrastructure is one where the NHS:

- provides a modern estate equal to delivering the vision for health and social care (most recently the 2019 NHS Long Term Plan) and new models of care.
- ensures local strategic estates planning reflects changing delivery models
- aligns with current and future clinical service strategies
- proactively takes steps to maintain assets and reduce backlog maintenance
- replaces what cannot be cost-effectively maintained and releases what it no longer needs, maximising receipts which can be reinvested into new premises and new services, boosting economic growth and creating new homes
- understands the cost of its estate, with comprehensive, accurate and comparable information underpinning decision making
- draws on expert advisers where it needs to but builds its own capabilities to become an effective informed client

Figure 8: Health Infrastructure Plan timeline



# National Policies & Priorities

## 3.8 NHS Estates and Facilities Workforce Action Plan

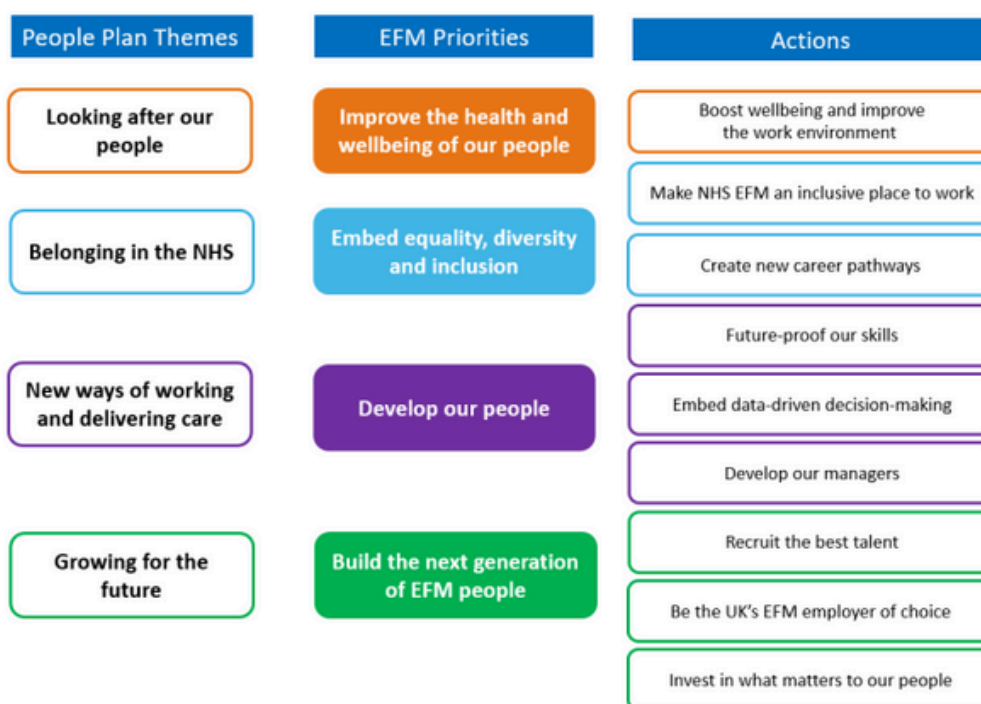
The NHS People Plan 2020/21: Action for us all and the NHS Estates and Facilities Workforce Action Plan focus on how we need more people, working differently, in a compassionate and inclusive culture to deliver patient care. Including an estate workforce plan within the ICS infrastructure strategy will identify how the ICS will contribute to these national objectives and ensure it has the capacity and capability in place to deliver complex ICS infrastructure requirements and ambitions.

The vision is to inspire a generation to join our team, so that together we redefine the industry standard for estates and facilities, while continually improving healthcare experiences for our patients.

This action plan sets out how the ambitions of the NHS People Plan, and NHS People Promise will be fulfilled for our estates and facilities workforce. The plan is a call to action for collaboration and positive action within the estates and facilities community and covers four priority areas, backed by nine key action areas:

- Improve the health and wellbeing of our people.
- Embed quality, diversity and inclusion.
- Develop our people.
- Build the next generation of Estates & Facilities Management people.

Figure 9: EFM workforce action plan themes, priorities and actions





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# Local Strategies and Priorities

This section highlights local context, and provides an overview of system strategies and priorities for Norfolk and Waveney. As a key enabler, our Estates Infrastructure Strategy must consider and incorporate the ambitions of the system.

# Local Strategies and Priorities

## 4.1 The Integrated Care Strategy

Our Integrated Care Partnership has published its transitional Integrated Care Strategy and Joint Health and Wellbeing Strategy, setting the agenda for our new Integrated Care System across Norfolk & Waveney.

Key to achieving our system-wide mission **to support the people of Norfolk and Waveney to live longer, healthier, and happier lives** are the following four priorities:

### Driving integration

Collaborating in the delivery of people-centred care to make sure services are joined-up, consistent and make sense to those who use them.

### Prioritising prevention

A shared commitment to supporting people to be healthy, independent, and resilient throughout life. Offering our help early to prevent and reduce demand for specialist services.

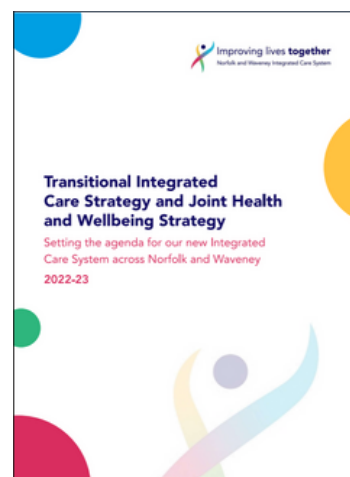
### Addressing inequalities

Providing support for those who are most vulnerable using resources and assets to address wider factors that impact on health and wellbeing.

### Enabling resilient communities

Supporting people to remain independent whenever possible, through promotion of self-care, early prevention, and digital technology where appropriate.

The Integrated Care Strategy and Joint Health and Wellbeing Strategy goes on to highlight the key challenges, priority actions, and how success can be monitored for each priority.



# Local Strategies & Priorities

## 4.2 The ICS Clinical Strategy

Our Clinical Strategy for Norfolk and Waveney is based on the experiences, hopes and ideas of the patients who use the NHS, the staff that work in it, and the communities it serves.

The strategy sets objectives that address the challenges, problems, and opportunities identified by patients, staff and the wider public. It details how NHS services will work together to achieve our goals, how we plan to improve areas of health within our population, and it describes the expectations that patients and staff have highlighted they want from their NHS in Norfolk and Waveney.

The image below provides a summary of our clinical objectives. These capture what patients and staff have told us they want from the NHS in Norfolk and Waveney, they explain how we plan to help improve certain areas of health within our population, and they detail how NHS services will work together to achieve our goals.

Figure 10: Norfolk and Waveney Clinical Strategy Objectives



## Local Strategies & Priorities

### 4.3 The Joint Forward Plan

The Joint Forward Plan (JFP) is our plan for the next five years, setting out what we will do, and where and how we are going to improve health and care services for our local population, their families and carers.

The JFP addresses the four core purposes of an ICS (highlighted in the introduction) and links to and is consistent with the Integrated Care Strategy and the Clinical Strategy for Norfolk and Waveney.

The JFP describes how we will meet our legal duties, how we will deliver national NHS commitments, such as recovering core services and improving productivity, as well as our plans to transform care across our eight areas of ambitions, highlighted below.

The plan describes the eight ambitions in detail, which are underpinned with objectives, trajectories, and milestones.

Figure 11: Joint Forward Plan Eight Ambitions

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

# Local Strategies & Priorities

## 4.4 The ICS Green Plan

In Norfolk and Waveney, we are committed to playing our part in meeting the critically important commitment of reaching net zero by 2045.

Our Green Plan provides the ICS with a co-ordinated and strategic approach to the net zero programme and sets out how we will embed, respond to, and help deliver the ambition of becoming the world's first 'net zero' national health service. Our plan sits alongside, and complements individual organisations' plans and focuses on enabling without duplicating, through which we will achieve Net Zero together.

Over the immediate 3-year plan period we will have established ourselves as an enabler of collaboration and sharing of best practice across our member organisations. All parts of the ICS will have decarbonisation fully embedded into their day-to-day operations, empowering a system-wide transition to Net Zero.

The plan identifies key areas to focus on over the next three years, and initiate action around what we will do, and are already doing, to respond to the environment and climate emergency. It is based on the guidance provided by national NHS teams and covers the following focus areas;

- Workforce and System Leadership
- Sustainable Models of Care
- Digital Transformation
- Travel and Transport
- Estates and Facilities
- Medicines
- Supply Chain and Procurement
- Food and Nutrition
- Adaptation
- Nature Connection and Biodiversity
- Primary Care

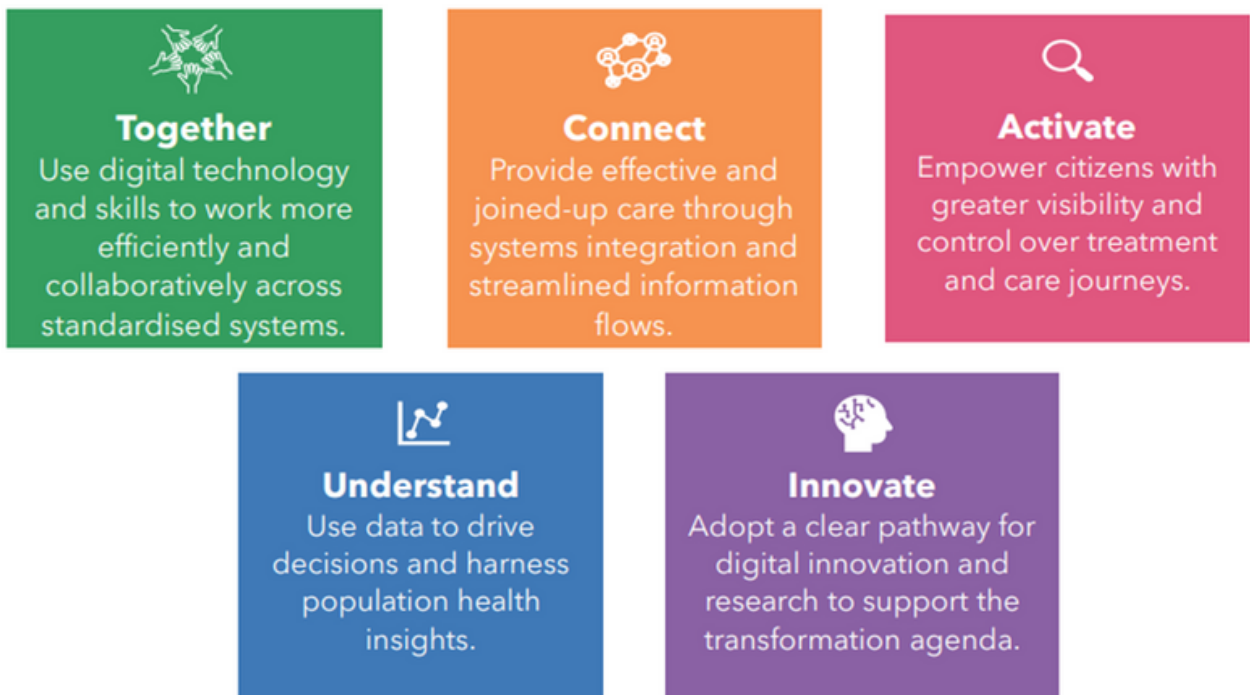


# Local Strategies & Priorities

## 4.5 The ICS Digital Transformation Strategic Plan

The Digital Transformation Strategic Plan and Roadmap outlines five strategic objectives, highlighted below. These are underpinned by guiding principles, and enable us to achieve our overarching aim - which is - ***a digitally-enabled Norfolk and Waveney where access to information, services and support make it easy to deliver high quality health and care for and with our citizens.***

Figure 12: Digital Transformation Plan Strategic Objectives



Our digital strategy will enable electronic patient records across health and care settings, delivery of a single waiting list, sharing information and deliver the technology to support patient preparation for their planned treatment and operations, and enable delivery of virtual wards.

Across primary care there will be integrated infrastructure such as Wi-Fi connectivity and cloud telephony.

Digital workforce tools and fully integrated infrastructure and connectivity will have a direct benefit to productivity. Artificial Intelligence and automation will also have a part to play and further increase productivity.

## Local Strategies & Priorities

### 4.6 The ICS People Plan

Our We Care Together People Plan describes how we will work towards our vision - **to have happy, healthy people delivering excellent compassionate care** - and enable us to achieve our system goal for Norfolk and Waveney to be the best place to work, mirroring the aspirations set out in the National People Plan.

The key objectives within our people plan are:

#### Creating Opportunities

We will introduce the skill mix required for new models of care, reduce vacancies, plan for retirements, create new roles and work collaboratively with education providers. Our focus will be a 'Grow Your Own' approach to deliver flexible career pathways.

#### Promoting Good Health

Our emphasis will be investing, promoting and implementing accessible health and wellbeing programmes, listening to people's experiences and expanding coaching and mentoring across our organisations.

#### Maximising Skills

This involves developing and implementing new roles across the system, enabling people to work to the top of their license and registration. We will build new approaches to supervision, training, mentoring and coaching; adopt new technology; design new career pathways; and create new quality improvement initiatives.

#### Creating a Positive Culture

A Norfolk and Waveney system culture that is positive, inclusive and engaging for all our people is a must in making the We Care Together People Plan a reality. This requires collaborative, diverse, and compassionate leadership. We will implement system-wide forums, agree workforce principles and develop a system approach to inclusion, equality and diversity.





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Norfolk and Waveney Integrated Care System

## Where are we now?

This section shows our current position; it provides insight into the demographics of Norfolk and Waveney, and the known areas of planned population growth. It highlights investment and progress made in the last five years, describes key infrastructure issues and challenges faced, and gives an overview of our infrastructure, it's size, condition, cost and performance.

# Where are we now?

## 5.1 Demographics and population of Norfolk and Waveney

The current registered population of Norfolk and Waveney is just over 1 million. Our population is generally older than the rest of England, with 1 in 4 being over 65.

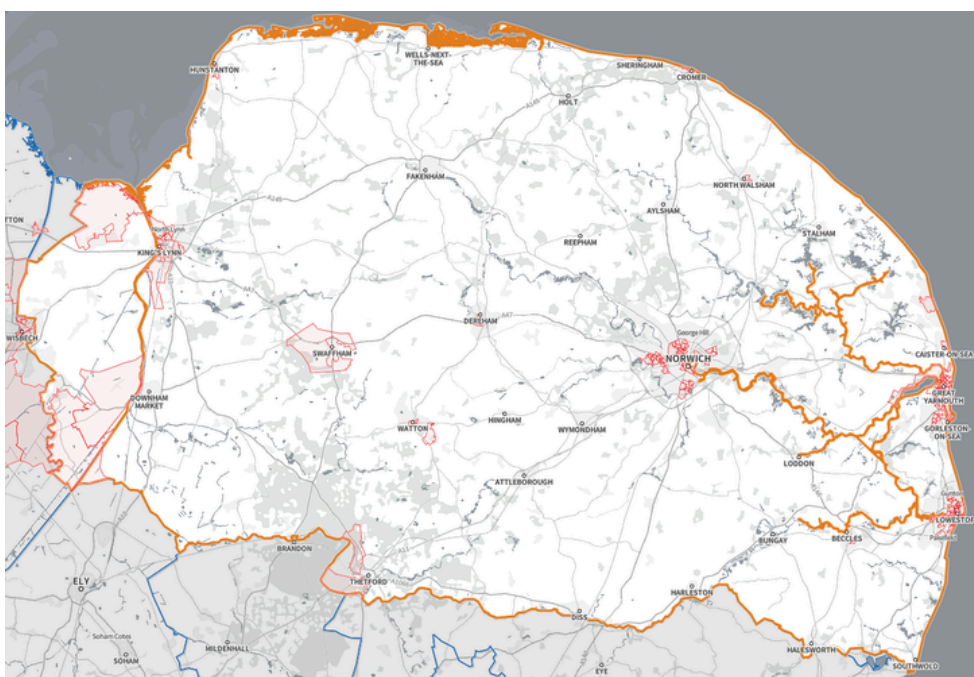
In Norfolk and Waveney, many health outcomes for people are as good or better than in England overall as a comparison, and males and females generally live longer lives than the England average. However, there are evident inequalities in outcomes for people living in deprived areas.

There are over 40 communities across Norfolk and Waveney where over 175,000 people live in the 20% most deprived areas in England (known as 'Core 20'). These communities are mainly in our urban areas of Great Yarmouth, King's Lynn, Lowestoft, Norwich and Thetford but there are areas of deprivation in some of our rural neighbourhoods too.

Health outcomes for these areas can be improved further, and system priorities will focus on Population Health Management, Reducing Inequalities, and Supporting Prevention.

The map below shows the 'Core 20' communities, where some or all of the residents live in the 20% most deprived areas in England.

Figure 13: 'Core 20' Communities across Norfolk and Waveney





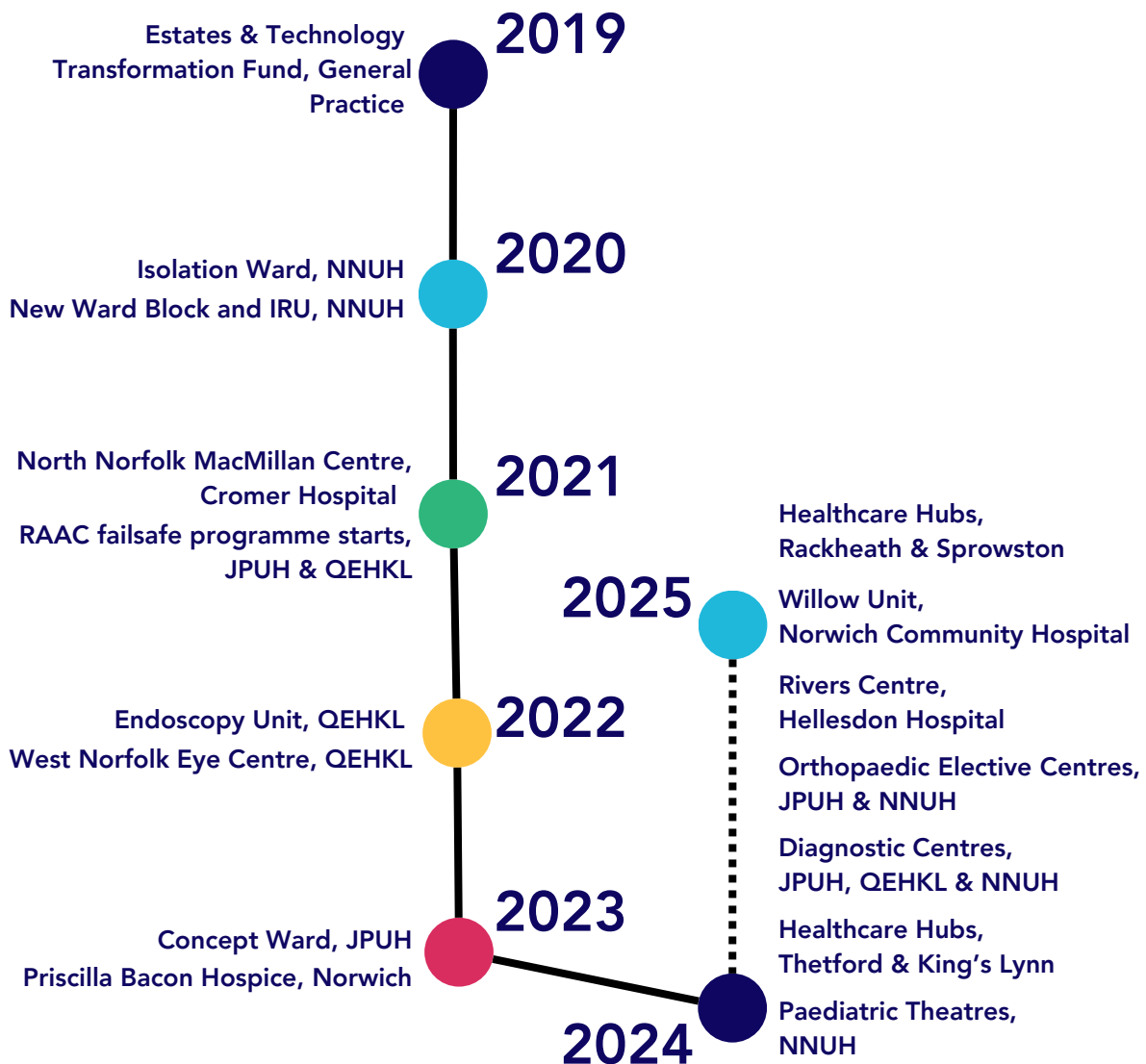
# Where are we now?

## 5.3 Significant Infrastructure Developments

In the summer of 2018, our ICS (formerly the STP) submitted its first system 'Estates Workbook' to NHS England. The workbook highlighted key estates priorities and issues for the STP, including how transformation of estate links to local clinical services to better meet the needs of patients.

Through prioritisation and successful business case submissions, the timeline below highlights a number of delivered and ongoing programmes of work that have been, and will be, key to helping us transform our estate infrastructure and its ability to enable clinical priorities across Norfolk and Waveney.

Figure 15: Timeline of delivered and ongoing infrastructure developments



## Where are we now?

### 5.4 Overview of the estate

Across Norfolk and Waveney there is a large and varied estate. Commissioned health & care in Norfolk & Waveney is delivered from circa 1600 locations. This strategy focuses on the 300 plus sites used by our general practice, acute, community and mental health care providers, and our ambulance service.


Our existing estate infrastructure is facing a number of key challenges and issues that we need to tackle, these include;

 2 acute hospitals constructed using RAAC, causing a significant health and safety risk and need of replacement.

A growing cost to eradicate backlog at our PFI hospital, without the capacity to decant and enable maintenance to take place. 


 Large parts of estate that is old, in poor condition and not functionally suitable for current use, and unable to support new models of care.

Over £185m cost to eradicate backlog maintenance, with almost 70% of the backlog classified as Critical Infrastructure Risk. 

 A significant number of clinical incidents due to estates failure, which can result in service closures, delays and inefficiency.

High levels of carbon emissions from our estate infrastructure and an imminent need to meet net zero targets. 

 Unwarranted variation across areas of estates and facilities running costs, and higher spend per square metre than Model Health System peer benchmarks.

Complex and fragmented building ownership with significant areas of 3rd party owned estate, impacting flexibility of use, integration, and typically higher costs. 

 Variation in the provision of estate infrastructure across the system, with some areas experiencing a lack of space and others with areas of underused space.

To provide a framework for decision making, we have applied the core-flex-tail categorisation to our estate infrastructure database, helping form the basis for investment prioritisation and operational service planning. We will also be able to identify where there is tail estate to be disposed of.

The following pages of this section provide an introduction to each organisation, their mapped estate from SHAPE, and a number of key performance metrics and data analysis from reports such as ERIC, PAM, PLACE, PCDG, and GNHS (*sourced 2023/24*). The type of organisation, the reports and submissions completed, and whether or not they are hosted by another ICB, will result in differing data and metrics being available and used.

## Where are we now?

### 5.5.1 Primary Care - General Practice

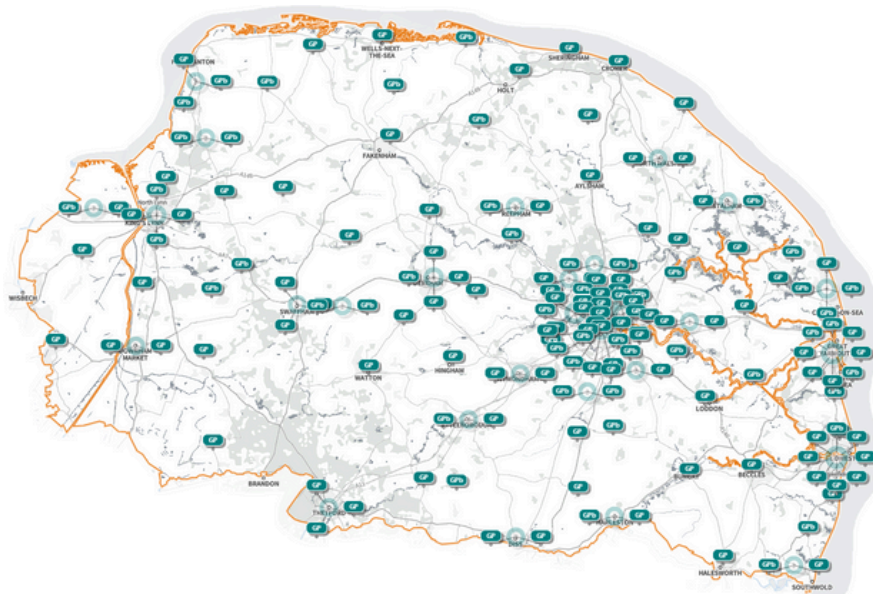
Across our 5 Place areas and 20 PCNs (Primary Care Networks), there are 105 GP practices providing general medical services and additional primary care based services across Norfolk and Waveney.

Our practices employ over 3,300 members of staff providing services to over one million registered patients. In total, the practices occupy 158 sites, including 54 branch sites. Around 50% of these sites are GP owned, and the other 50% are leased from either third party/private landlords, NHS Property Services, Community Health Partnerships, and NHS Trusts.

General Practice estate has a key role to play as an enabling function, ensuring the out of hospital network and capacity is robust, contributing to sustainable and flexible estate which can support population requirements, both from a population health management perspective but to also cope with housing developments and population growth.

Almost one third of practice premises are over 40 years old, with a number pre-dating the founding of the NHS back in 1948. A considerable proportion of the estate is not adequate, fit-for-purpose or suitable for delivering today's healthcare services. They are also often too small to support any additional roles, population growth or new models of care. As highlighted in the Fuller Stocktake report, there is a need, both nationally and locally, to review capital investment and funding availability, as well as its weighting/prioritisation towards primary care.

Figure 16: General Practice locations



## Where are we now?

### 5.5.1 General Practice Data Sheet

**158**

buildings occupied,  
including 54 branch sites

with over

**76,700**

square metres of occupied  
floor space

costing over

**£11 million**

on rent and other  
reimbursements

of the 80 buildings that  
have been surveyed to  
date, we have found that

there is significant backlog  
maintenance costs totalling over

**£900,000**

of which around

**£150,000**

is high or significant risk

there is also an estimated

**£1.6 million**

of forward maintenance

required in the next 2-5 years

estate categorisation has  
highlighted that we have

**41** core buildings

**104** flex buildings

**13** tail buildings

the owners and landlord  
split of our GP estate is

**80** GP owned

**58** 3rd Party/Private

**16** NHSPS and CHP

**4** NHS Trust

**32**

buildings are not  
functionally suitable

and a

**£5.3 million**

cost to make them

functionally suitable

\*backlog and functionality costs were accurate at the time of survey, and do not factor in price rises and inflation

\*general practice backlog is the responsibility of the practice owner/landlord and is not paid by NHS capital

## Where are we now?

### 5.5.2 Acute - Norfolk and Norwich University Hospitals

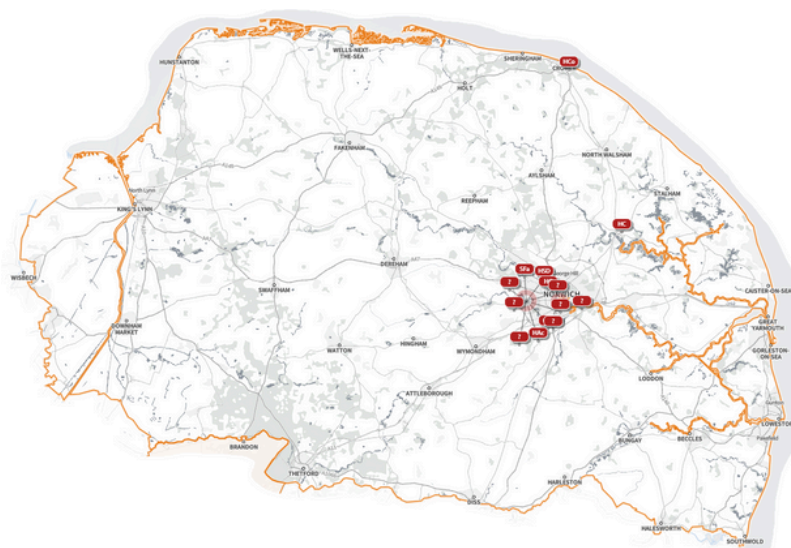
The Norfolk & Norwich University Hospitals Foundation Trust is an acute teaching hospital trust and provides care to around one million people across Norfolk. Patients are also referred from further afield to access specialist services.

The Trust employs over 8,000 members of staff, and their main site located in Norwich, the Norfolk & Norwich Hospital, is an acute teaching hospital with over 1,040 overnight and 145 day case beds. The trust also runs the Jenny Lind Children's Hospital, located at the Norfolk & Norwich Hospital site, as well as Cromer and District Hospital located in North Norfolk. The trust also occupies a number of other sites where services are provided in local communities.

The Norfolk & Norwich Hospital opened in 2001 and was built under the private finance initiative (PFI), whereby a private sector consortium builds and maintains the building and leases it back to the NHS. The trust has its first option to break from its lease in 2037.

There is an urgent requirement to address the backlog of works at the Norfolk & Norwich Hospital. This backlog has grown over the last ten years due to the increased demand on the site which has prevented the trust being able to provide the PFI provider with access to undertake the works. Whilst this continues to be the case, there is an increased risk of a lack of capacity due to wards and theatres needing to be shut in an unplanned way in order for critical works to be completed. On top of this, there is significant backlog maintenance across the estate, including the Trust owned Cromer Hospital, and staff accommodation properties.

Figure 17: NNUH locations



## Where are we now?

### 5.5.2 Norfolk and Norwich University Hospitals Data Sheet

**15**

main buildings occupied and reported (others used ad-hoc and not reported) with over

**140,600**

square metres of occupied floor space. 77% of which is the PFI hospital.

in total costing over

**£121 million**

in estates and facilities running costs; over £860 per square metre

around

**35%**

of the estate is non-clinical

**0%**

is reported as under-used

there is significant backlog maintenance costs totalling over

**£74 million**

of which over

**£30 million**

is critical infrastructure risk

estate categorisation has highlighted that we have

**5**

core buildings

**8**

flex buildings

**2**

tail buildings

the owners and landlord split of NNUH estate is

**9**

3rd Party/Private

**3**

Freehold

**1**

PFI

**1**

NHS Trust

**1**

NHSPS and CHP

**67,474** MWh

of energy consumption, producing

**15,594** tCO<sub>2</sub>e

**82%**

PLACE score across 8 domains

**59%**

PAM score across 6 domains

## Where are we now?

### 5.5.3 Acute - Queen Elizabeth Hospital, King's Lynn

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust is an acute trust with a catchment area that covers West Norfolk, parts of North Norfolk and Breckland, as well as parts of North Cambridgeshire and South Lincolnshire.

The Trust employs more than 4,000 members of staff and volunteers, and their main site located in King's Lynn, the Queen Elizabeth Hospital, is an acute district general hospital with over 540 overnight and 55 day case beds. The Trust also occupies a number of other sites where services such as local maternity and neo-natal services, dermatology, ophthalmology, phlebotomy and more, are provided in local communities.

The Queen Elizabeth Hospital was constructed around 1980 and had a life expectancy and useful life of 30 years, meaning it is now in much need of replacement. The hospital was built as one of the 'best buy' hospitals using light weight concrete planks known as RAAC (Reinforced Aerated, Autoclaved Concrete).

The Trust is part of the New Hospital Programme which will help eliminate RAAC and provide a new hospital that is fit for the future and enable the trust to provide outstanding care in world-class facilities, meeting the demand of a growing and ageing population.

Figure 18: QEHLK locations



## Where are we now?

### 5.5.3 Queen Elizabeth Hospital Data Sheet

**1** main building occupied and reported (others used but not reported) with over

**63,067**

square metres of occupied floor space.

in total costing over

**£29 million**

in estates and facilities running costs; over £461 per square metre

around

**36%**

of the estate is non-clinical

**5.6%**

is reported as under-used

there is significant backlog maintenance costs totalling over

**£104 million**

of which

**£85 million**

is critical infrastructure risk

estate categorisation has highlighted that we have

**0** core buildings

**1** flex building

**0** tail buildings

the owners and landlord split of QEHLK estate is

**1** NHS Trust

**37,262** MWh

of energy consumption, producing

**7,869** tCO<sub>2</sub>e

**88%**

PLACE score across 8 domains

**78%**

PAM score across 6 domains

## Where are we now?

### 5.5.4 Acute - James Paget University Hospital

The James Paget University Hospitals Foundation Trust is an acute trust with a catchment area that covers Great Yarmouth, Lowestoft and Waveney.

The Trust employs more than 4,000 members of staff and volunteers, and their main site located in Gorleston, the James Paget Hospital, is an acute university hospital with over 445 overnight and 85 day case beds. The Trust also occupies a number of other sites where services are provided in local communities.

The James Paget Hospital was constructed around 1980 and had a life expectancy and useful life of 30 years, meaning it is now in much need of replacement. The hospital was built as one of the 'best buy' hospitals using light weight concrete planks known as RAAC (Reinforced Aerated, Autoclaved Concrete).

The Trust is part of the New Hospital Programme which will help eliminate RAAC and provide a new hospital that is fit for the future and enable the trust to provide outstanding care in world-class facilities, meeting the demand of a growing and ageing population.

Figure 19: JPUH locations



## Where are we now?

### 5.5.4 James Paget University Hospital Data Sheet

**2** main buildings occupied and reported (others used but not reported) with over

**61,325**

square metres of occupied floor space.

in total costing over

**£28 million**

in estates and facilities running costs; over £457 per square metre

around

**32%**

of the estate is non-clinical

**0%**

is reported as under-used

there is significant backlog maintenance costs totalling over

**£49 million**

of which

**£35.14 million**

is critical infrastructure risk

estate categorisation has highlighted that we have

**1** core building

**1** flex building

**0** tail buildings

the owners and landlord split of JPUH estate is

**2** NHS Trust

**21,227** MWh

of energy consumption, producing

**4,804** tCO<sub>2</sub>e

**93%**

PLACE score across 8 domains

**76%**

PAM score across 6 domains



## Where are we now?

### 5.5.5 Norfolk and Suffolk NHS FT Data Sheet

**32**

main buildings occupied and reported (11 others used but not reported) with over

**83,819**

square metres of occupied floor space.

in total costing over

**£28 million**

in estates and facilities running costs; over £345 per square metre

around

**50%**

of the estate is non-clinical

**8.6%**

is reported as under-used

there is significant backlog maintenance costs totalling over

**£27 million**

of which

**£734,000**

is critical infrastructure risk

estate categorisation has highlighted that we have

**14** core buildings

**11** flex buildings

**7** tail buildings

the owners and landlord split of NSFT estate is

**18** Freehold

**11** 3rd Party/Private

**1** PFI

**1** NHS Trust

**1** NHSPS and CHP

**25,780** MWh of energy consumption, producing

**5,878** tCO<sub>2</sub>e

**96%** PLACE score across 8 domains

**79%** PAM score across 6 domains

## Where are we now?

### 5.5.6 Community - Norfolk Community Health & Care

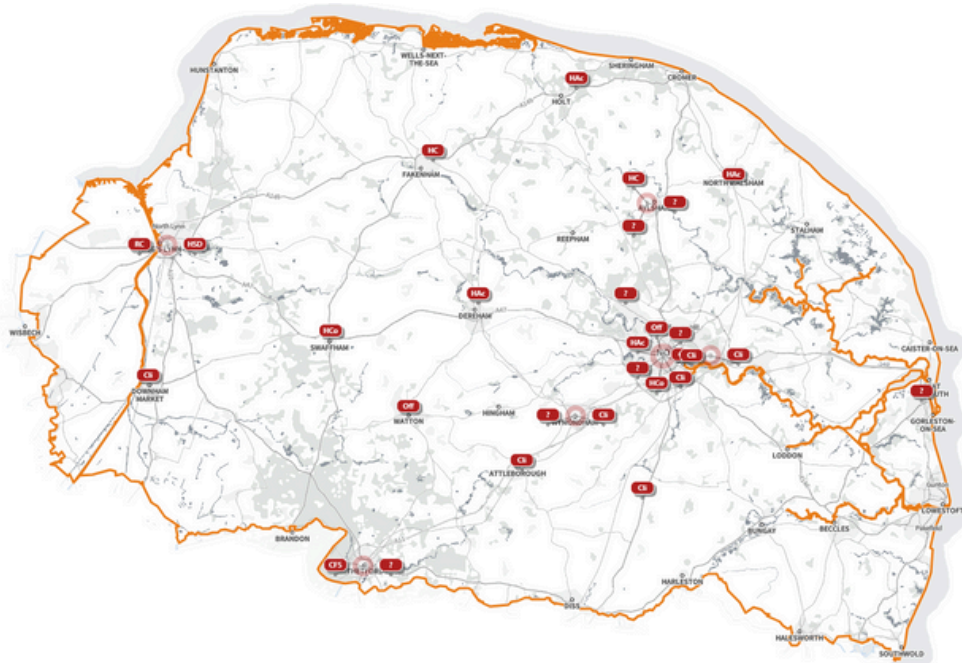
The Norfolk Community Health & Care NHS Trust is a community NHS trust which serves over 900,000 people across Norfolk.

The Trust employs over 2,500 members of staff and has over 200 overnight beds, providing a mix of general and specialist care, across 7 community hospital sites. As well as these sites that provide a mixture of inpatient and outpatient services, the Trust also occupies a further 20 or so sites where services are provided in local communities as well as patients' homes.

Parts of the Trust's occupied estate is in need of significant investment to reduce backlog maintenance and provide suitable estate. A vast majority of the estate infrastructure occupied by NCH&C is over 40 years old, with a handful of buildings pre-dating the NHS.

Some areas of the estate are under-utilised, which offers potential for additional co-location of services, particularly at some of the larger hospital sites where investment could be prioritised to support new models of care.

Figure 21: NCH&C locations



## Where are we now?

### 5.5.6 Norfolk Community Health & Care Data Sheet

**29**

main buildings occupied and reported (11 others used but not reported) with over

**40,769**

square metres of occupied floor space.

in total costing over

**£14 million**

in estates and facilities running costs; over £349 per square metre

around

**33%**

of the estate is non-clinical

**4.5%**

is reported as under-used

there is significant backlog maintenance costs totalling over

**£3.48 million**

of which

**£734,800**

is critical infrastructure risk

estate categorisation has highlighted that we have

**17**

core buildings

**12**

flex buildings

**0**

tail buildings

the owners and landlord split of NCH&C estate is

**20**

Freehold

**6**

3rd Party/Private

**2**

NHSPS and CHP

**1**

NHS Trust

**8,420**

MWh of energy consumption, producing

**1,933**

tCO<sub>2</sub>e

**90%**

PLACE score across 8 domains

**79%**

PAM score across 6 domains

## Where are we now?

### 5.5.7 Community - East Coast Community Healthcare CIC

East Coast Community Healthcare (CIC) is a staff-owned social enterprise, providing community-based NHS services across Great Yarmouth and Waveney. As a social enterprise, ECCH uses any surplus money and resources for the benefit of local communities, which includes development of its estate's infrastructure.

The company has around 700 members of staff that provide services at its one community hospital site, Beccles Hospital, a number of health centres and primary care sites, as well as across the community in patients' homes.

ECCH own their headquarters at Hamilton House in Lowestoft following its purchase and redevelopment in 2017. The rest of their occupied estate is leased, predominantly through NHS Property Services and NHS Trusts.

Figure 22: ECCH locations



**13** buildings occupied  
with over **6,000**  
square metres of occupied  
floor space.

estate categorisation has  
highlighted that we have

**7** core buildings

**6** flex buildings

**0** tail buildings

owners and landlord split is

**7** NHSPS and CHP

**4** NHS Trust

**1** Freehold

**1** 3rd Party/Private

## Where are we now?

### 5.5.8 Ambulance - East of England Ambulance Service

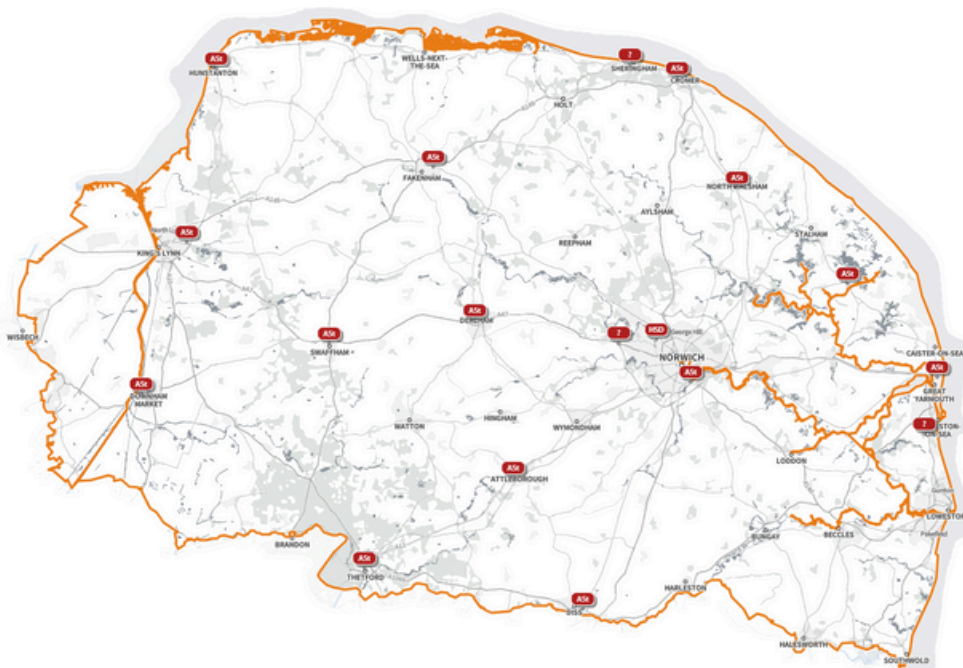
The East of England Ambulance Service NHS Trust are hosted by the Suffolk and North East Essex Integrated Care Board. The Trust provide accident and emergency services for people in need of urgent medical treatment and transport across Bedfordshire, Hertfordshire, Essex, Cambridgeshire as well as Norfolk and Suffolk. This area is made of around 6.3 million people and 7,500 square miles.

The Trust employs over 5,000 members of staff and over 1,000 volunteers. The Trust's three main ambulance operation centres are located in Bedford, Chelmsford and Norwich. In total, the Trust occupies over 130 sites, with around 30 across Norfolk and Waveney.

The fleet is made up of over; 500 frontline vehicles, 70 rapid response vehicles, 190 non-emergency ambulances, and 50 hazardous area response team, major incidents and resilience vehicles.

The ambulance service operate a hub and spoke model. Emergency Clinical Advice and Triage Centres (ECAT) are supported by spokes of local service delivery options across local Integrated Care Systems. In Norfolk and Waveney, EEAST have outgrown their space in King's Lynn, which is also impacted by the New Hospital Programme, and there is a need to find an appropriate alternative site in King's Lynn for this service.

Figure 23: EEAST locations



## Where are we now?

### 5.5.9 Community - Cambridgeshire Community Services

Cambridgeshire Community Services Health NHS Trust (CCS) are hosted by the Cambridgeshire and Peterborough Integrated Care Board. The Trust provide a range of health and care services across Cambridgeshire, Bedfordshire, Norfolk and Suffolk.

CCS employs over 3,000 members of staff providing services to over three million people. Locally, CCS provide a range of services to children, young people and families across Norfolk and Waveney, as well as the Integrated Contraception and Sexual Health Service (iCASH).

### 5.5.10 Mental Health - Hertfordshire Partnership

Hertfordshire Partnership University NHS Foundation Trust (HPFT) are hosted by the Hertfordshire and West Essex Integrated Care Board. The Trust supports people with mental ill health, learning disabilities and autism across Hertfordshire, Essex, Buckinghamshire, and Norfolk and Waveney.

HPFT employ around 4,000 people who deliver services within the community and in inpatient settings. Locally, HPFT provide Learning Disability and Forensic Services at Little Plumstead Hospital.

### 5.5.11 NHS PS and CHP

NHS Property Services (NHS PS) and Community Health Partnerships (CHP) are both companies owned by the Department of Health and Social Care. Nationally, they own and/or manage over 3,500 properties, ranging from hospitals to general practices.

Across Norfolk and Waveney there are 28 properties in the ownership of, or leased by, NHS Property Services and three in the ownership of Community Health Partnerships, where they act as landlord to a range of tenants and service providers.

Parts of the NHS PS estate that has been surveyed has highlighted areas of poor condition and significant backlog maintenance costs, totalling almost £7 million.

Parts of the NHS PS and CHP estate are also underutilised, resulting in the ICB paying void costs for these areas. To prevent this, opportunities to either maximise occupancy and improve utilisation, or to rationalise and hand back will need to be investigated alongside estate infrastructure categorisation and service planning.



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## Where do we want to be?

This section sets out how we aim to support and enable the ICS to deliver upon its mission, strategies and priorities, the vision and strategic goals for our systems estates infrastructure, and a specific set of SMART objectives which we can monitor performance against.

# Where do we want to be?

## 6.1 Supporting and enabling system priorities

*Our mission as an Integrated Care System is to help the people of Norfolk and Waveney to live longer, healthier, and happier lives.*

Our Joint Forward Plan has been developed to set out the actions we will take to help us work towards this mission as a system. It highlights what we will do, why, and where and how we are going to improve health and care services for our local population, their families and carers.

The plan links to our Integrated Care Strategy and Joint Health and Wellbeing Strategies, it addresses the national and local purposes and commitments, and it is aligned and helps drive system and organisational strategies.

Though not duplicated here, the Joint Forward Plan illustrates where we want to be as a system, and this Estates Infrastructure Strategy captures how our estate and infrastructure can enable, support, and empower collaborative working, ensuring we are improving lives together through the delivery of shared visions, objectives, and priorities.

Our estates infrastructure, alongside other enabling functions such as digital, workforce and finance, have an integral role to play in the transformation and integration of our health and care services. This strategy illustrates how we aim to provide a system-wide person-centred estate that serves the needs of all its users, enhancing both patient and staff experience.

# Where do we want to be?

## 6.2 Our estates infrastructure vision and strategic goals

*Our vision and overall aim is to provide estate infrastructure that allows delivery of the right care in the right place, enables better patient outcomes, and empowers health, social care and third sector staff to provide the best possible care.*

To help provide direction towards our vision, we have agreed on four key goals. These goals will help address the challenges faced, respond to system priorities, and drive the development and transformation of our estate infrastructure.

Our four goals are:

### To improve access

Provide smarter and better health and care infrastructure that supports the delivery of transformational models of care, ensures that the right services can be delivered in the right place, and enables multi-disciplinary collaboration and joined up care at every level.



### To improve quality and condition

Design, build and operate safe, flexible, modern, fit-for-purpose and well maintained estate infrastructure that offers an improved working and training environment for our workforce, enhances positive experience and serves the needs of all its users.



### To improve environmental sustainability

Develop stronger, greener buildings that support our journey to net zero by implementing interventions to adapt and decarbonise our existing buildings as well ensuring all new estate infrastructure meets the NHS Net Zero Building Standards.



### To improve efficiency

Increase collaborative approaches to demand and capacity, prioritised capital investment, procurement frameworks and policy, and workforce planning and recruitment that ensures efficient use of our resources, offers greater value for money and financial sustainability.



## Where do we want to be?

### 6.2.1 To improve access

Provide smarter and better health and care infrastructure that supports the delivery of transformational models of care, ensures that the right services can be delivered in the right place, and enables multi-disciplinary collaboration and joined up care at every level.



To achieve this goal we will develop our estates infrastructure and aim to..

Boost out of hospital care, reduce pressures on acute hospital sites and services, and join up primary and community health services by investing in and building the right capacity in the right places.

Provide estate infrastructure that can support and enable our teams to maximise digital and virtual opportunities.

Collaboratively develop capacity that enables multi-disciplinary working at system, place, and neighbourhood levels. Making informed choices around where services are delivered.

Actively use our systems infrastructure in a way that benefits the health of our local communities, helps people live in healthy places, promotes healthy lifestyles, and supports and facilitates prevention and addresses health inequalities.

Provide flexible access to shared space for our staff across Norfolk and Waveney that is not restricted by organisational boundaries.

Deliver initiatives that offer local integrated services aligned to the communities they serve through the 'one public estate' approach.

Develop infrastructure that provides a sustainable service for the future, meets growing demands, and improves clinical outcomes.

## Where do we want to be?

### 6.2.2 To improve quality and condition

Design, build and operate estate infrastructure that is safe, flexible, modern, fit-for-purpose and well-maintained, and offers an improved working and training environment for our workforce, enhances positive experience and serves the needs of all its users.



To achieve this goal we will develop our estates infrastructure and aim to..

Provide safe and fit-for-purpose estate by tackling backlog maintenance across our estate and replacing our two RAAC hospitals.

Optimise our existing estate but also develop new and improved health and care infrastructure that supports the delivery of transformational models of care.

Design, build and operate estate infrastructure that meets national standards and guidance, such as the Health Building Notes, Health Technical Memoranda, Net Zero Building Standard, and BREEAM.

Utilise Modern Methods of Construction and innovative practices to create high quality, flexible buildings off-site and at pace, where appropriate and practical to do so.

Provide estate that offers an improved working and training environment for our workforce and contributes to successful recruitment and retention programmes.

Create capacity, through clinical space as well as teaching and seminar space, that enables and enhances our ability to train staff.

Implement proactive maintenance management systems to improve the performance, reliability, quality, and productivity of our estate infrastructure.

Design, build, and operate estate infrastructure alongside Infection Prevention & Control colleagues, ensuring our health and social care services deliver safe care and no person's health and wellbeing is harmed by preventable infections.

## Where do we want to be?

### 6.2.3 To improve environmental sustainability

Develop stronger, greener buildings that support our journey to net zero by implementing interventions to adapt and decarbonise our existing buildings as well ensuring all new estate infrastructure meets the NHS Net Zero Building Standards.



To achieve this goal we will develop our estates infrastructure and aim to..

Adapt and make healthcare buildings as resilient as possible, minimising potential disruptions to patient care from climate change and extreme weather events.

Minimise our overall energy consumption and maximise the efficiency of every kWh of energy used.

Remove reliance on fossil fuels by switching to clean and renewable energy, whilst supporting green economic growth.

Use our buildings and land in ways that supports our long-term environmental sustainability and increase use and access to our own NHS green spaces, supporting local community engagement with nature and improving biodiversity.

Develop all new buildings and major refurbishment projects, including the New Hospital Programme and primary care upgrades, to comply with the new NHS Net Zero Building Standard and Biodiversity Net Gain requirements.

Harness digital technology and systems that support and streamline services, resources, and help reduce our carbon footprint.

Drive further carbon footprint reduction attributed to estates infrastructure through strategic reduction of back-office estate, underused space, and rationalisation of surplus and tail estate, where appropriate.

## Where do we want to be?

### 6.2.4 To improve efficiency

Increase collaborative approaches to demand and capacity, prioritised capital investment, procurement frameworks and policy, and workforce planning and recruitment that ensures efficient use of our resources, offers greater value for money and financial sustainability.



To achieve this goal we will develop our estates infrastructure and aim to..

Reduce costs attributed to estates infrastructure through strategic reduction of non-clinical estate, improved utilisation of core estate, and rationalisation of surplus and tail estate, where appropriate.

Develop visibility of opportunities across system infrastructure which will enable us to make best use of and fully optimise our built infrastructure, and maximise integration and multi-disciplinary working.

Implement a clear framework for investment decisions, develop robust business cases that prioritise investment and help deliver our goals, and maximise the funding available to us.

Generate capital receipts through the disposal of surplus land and/or tail estate and reinvest in order to expand core estate, aligned to priorities.

Utilise digital innovation and enhanced infrastructure to form smart buildings that help reduce running costs and drive financial efficiency.

Collectively deliver cost improvement plans and remove unwarranted variation, helping reduce financial deficits.

Work with our Procurement Collaborative to deliver efficiencies and cost reductions via streamlined procurement, economies of scale, and standardised contracts, frameworks and specifications.

# Where do we want to be?

## 6.3 Our SMART objectives and KPIs

Our SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) objectives help further define the 'where we want to be' and provide the indicators against which we can monitor our progress towards 'what good looks like'. The objectives set out in the table below, in line with our four goals, respond to the drivers and challenges set out earlier in this strategy, are aligned to Model Health System benchmarking and indicate our targeted improvement during the strategy period.

Table 1: SMART objectives and KPIs

Objective	Current position	Target position
Improve our PAM scores. An annual assessment focussed on safety and efficiency at our NHS Trusts **	74%	80% +
Improve PLACE scores. An annual assessment focused on the quality of our inpatient settings) **	89%	90% +
Increase access to Core estate, reducing both Flex and Tail estate *	32%	50% +
Increase access to, and our ratio of, clinical capacity vs non clinical capacity **	62%	70% +
Eradicate the safety risk and our use of buildings constructed of RAAC *	2	0
Remove all Critical Infrastructure Risk (CIR) backlog from our estate *	> £160m	£0
Reduce carbon emissions and consumption from building energy & water, achieving an 80% by 2032 **	36.1k tCO <sub>2</sub> e	< 15k tCO <sub>2</sub> e
Reduce estates and facilities running costs in line with Model Health System peer benchmarks ** (target adjusted annually in line with benchmarks)	£569 m2	£499 m2
Reduce empty and under-utilised estate, and remove NHSPS and CHP void costs *	> 3%	2.5%



Improving lives **together**

Norfolk and Waveney Integrated Care System

## How do we get there?

This section illustrates how we will deliver the Estates Infrastructure Strategy through programmes and projects, how we will support integrated working across estates teams to achieve the vision, and how we will move to deliver strategic aims across the whole system.

# How do we get there?

## 7.1 Enabling the delivery of our strategy

There are a number of key enablers, without which, we would be unable to deliver our Estates Infrastructure Strategy. These enablers are:

### **Our Workforce**

We will work together to ensure we have access to the right expertise by developing, attracting, recruiting and retaining a skilled workforce. We must help our teams evolve as job roles and responsibilities do, providing the training as data and digital, smart buildings, sustainability and net zero and other aspects become fundamental parts of our day to day.

By working collaboratively we have the opportunity to implement a consistent and system-wide approach, taking a 'single workforce' view and building a more efficient, shared and streamlined team.

We will align our workforce programme to the national Estates and Facilities Workforce Action Plan, and their programme to review and address our most pressing issue – building a diverse, high-performing workforce, filling skill gaps and providing people with the tools, support and development opportunities to ensure we have a robust and resilient team in place for our future needs.

### **Data and intelligence**

There is a need to realise the scope data and intelligence has to play in the transformation of how we operate in the future, and the impacts and benefits digital technology will have on our buildings.

Data is fundamental in everything we do, and as our buildings and systems become more connected we will see an ever increasing collection of data available. This provides us with the opportunity to build on and maximise our use of comprehensive datasets to inform our decision making, and develop digital tools to improve our performance.

As highlighted at the beginning of this strategy, we already have access to a wealth of data but we need to start;

- using it more effectively and efficiently
- work together to improve the sharing, integration and consistency of data
- implement digital technology to make the data more accessible, automated and intelligent

# How do we get there?

## 7.1 Enabling the delivery of our strategy

### Investment

We need significant capital investment in our estate infrastructure, backed up by suitable revenue budgets, in order for us to support and enable system ambitions and priorities, and to deliver our strategy vision and goals.

As NHS capital continues to be constrained, it alone will not be able to support our transformational needs. The ICB has implemented governance processes through its Strategic Capital and Estates Board to ensure investment requirements are listed and prioritised collaboratively, revenue impacts are highlighted, and investment decisions benefit the system and our population as a whole.

The ICB has a role to play in identifying and communicating local and national funding opportunities, supporting the alignment of available capital to prioritised programmes and projects, and ensuring proactive collaborative development of business cases places us in a strong position to secure funding.

### Leadership and governance

Strong leadership and the appropriate governance processes are a necessity to the delivery of our strategy. Difficult decisions will need to be made as the demands on our infrastructure change and new models of care and digital innovations impact the locations, size, and type of estate infrastructure required.

Our Strategic Capital and Estates Board will help progress the development and delivery of this strategy. This Board will focus on the strategic conversations that need to take place in order to prioritise investment in our infrastructure, and lead cross-system programmes of work around our long-term infrastructure needs.

We will also need to work closely with colleagues at system, place and neighbourhood levels to ensure strategic infrastructure discussions are taking place locally and are fully aligned with service development.

We are collectively stronger than the sum of our parts, and we must work across our providers, our NHS property companies, our local authorities and one public estate colleagues, and others to build on our current collaborations and partnerships as well as form new ones.

# How do we get there?

## 7.2 Categorising our estate infrastructure

We have worked with system partners to undertake an initial review and system-wide categorisation of our estate infrastructure, categorising our assets as either core, flex or tail. The ICB will continue to assess and validate this categorisation in line with our strategy goals.

### Core estate

Our core estate infrastructure is defined as being good quality, fit for purpose and future-proof estate that aligns with the NHS Long Term Plan, local clinical strategies and ambitions, and enables our estates infrastructure strategy vision and goals.



We will prioritise and maximise use of our core estate, and focus most of our transformational and strategic ambitions around our core infrastructure.

### Flex estate

Our flex estate is of an acceptable quality, or provides unique access to services, but does not fully enable the ambitions set out in national and local plans.



Additional work is required to understand whether these buildings will become core or tail in the medium to long term.

Master plans and robust business cases will be developed and put forward for those that can become core, and where investment should be prioritised. Alternatively, replacement and disposal plans will be developed for those that are unsuitable for investment and should transition to tail and be phased out.

### Tail estate

Our tail estate is of poor quality and not fit-for-purpose or suitable for patient facing services, and should be phased out when alternative estate is available. It does not, and will never be able to, enable our estates infrastructure strategy vision and goals.



We will phase out the use of any identified tail estate, and develop plans to provide alternative estate infrastructure solutions, where required, as soon as possible.

## How do we get there?

### 7.3 Improving access by providing care closer to home

The World Health Organization has argued that providing more focus on primary and community care is the most inclusive, effective and efficient way to enhance people's physical and mental health and wellbeing. It adds, it will help to provide integrated services that meet people's health needs throughout their life, address the broader determinants of health, and empower individuals, families and communities to take charge of their own health (World Health Organization 2019).

This approach is not about the closure of hospitals and reducing what is already a low bed baseline, nor is it viable to consider reducing funding for hospitals. It is about changing the focus of the health and care system towards primary and community health and care across leadership, culture and implementation. We need to ensure that each sector is freed up to provide the care that it is best equipped to deliver, and that future growth in funding and staffing is directed proportionately more to primary and community health and care services.

We will look at opportunities and plan for the different types of infrastructure needed locally. Health and care services could be offered and provided from primary and community hubs, wellbeing hubs, community diagnostic centres, health on the high street, health and care campuses, and/or at home through virtual wards and other telehealth services.

From an estates infrastructure perspective, we will enable this approach by:

- Directing capital and revenue investment in estates and technology for primary and community based health and care services through prioritisation frameworks.
- Ensuring that the estate available to primary and community based services is developed to facilitate multi-disciplinary teamworking at place and neighbourhood levels.
- Investing in and developing our estate to accommodate a flexible and growing workforce, supporting and enabling the NHS Long Term Workforce Plan.
- Working with our Acute Hospital Collaborative Board and Place Boards to map ambitions related to the delivery of care outside of the acute hospital settings.
- Following a one public estate approach and working with colleagues to allow services use of shared facilities; to promote joined-up, integrated working without organisational and contractual boundaries.

## How do we get there?

### 7.4 Improving access by transforming our hospital estate

Our hospitals provide access to emergency care, complex health care treatments and procedures, and facilities for those that require additional rehabilitation before they are well enough to return home. As well as the increasing focus on providing care closer to home, we must also continue to ensure we have the right capacity across our hospital estate.

Through the Government's New Hospital Programme, Norfolk and Waveney will see the replacement of both the James Paget Hospital in Gorleston and the Queen Elizabeth Hospital in King's Lynn, by 2030.

The New Hospital Programme provides a fantastic opportunity to not only remove the Critical Infrastructure Risk at these sites, but to transform our acute hospital estate and the way services are accessed, by incorporating new ways of working and models of care, investing in digital technologies and innovations, matching the Net Zero aspirations, and aligning infrastructure to long-term clinical plans.

Throughout 2023-24, in-depth demand and capacity modelling is taking place to determine future requirements for all three of our acute hospitals. This modelling looks at both on-site and off-site capacity needs by modelling factors such as current demand and supply imbalances, demographic changes, non-demographic changes and activity-type assumptions and changes to calculate future activity demands and capacity needs. The outputs from this demand and capacity modelling will inform the new hospital business cases over the coming months, as well identify the development, investment and acquisition needs in order to support new models of care at off-site locations.

There is also work underway to review our community bed provision and a significant redesign of our intermediate care offer. These will assess the capacity needs of our community inpatient beds, that are there to provide short-term rehabilitation services to people that require additional support following discharge from hospital. It will also look at our intermediate care bed needs, that provide capacity to those that no longer require hospitalisation but are not ready to return home.

With regards to Mental Health bed capacity, we will continue to tackle our reliance on out of area placements. Part of the solution is our new Rivers project, providing additional beds at Hellesdon Hospital. However, future needs assessments will be undertaken, alongside safe staffing and beds per ward assessments, to ensure access is improved and reliance on out of area beds is reduced.

## How do we get there?

### 7.5 Improving quality and condition by eradicating RAAC

Reinforced Autoclaved Aerated Concrete (RAAC) is different from normal concrete. It is a lightweight, bubbly and relatively weak form of concrete that was often used in schools and hospitals from the 1960s to the mid 1980s.

Following the catastrophic RAAC plank failure at a school, the Standing Committee on Structural Safety (SCOSS) alert in 2019 indicated that RAAC planks are a known issue and that the useful life of such planks has been estimated to be around 30 years. The alert recommends that RAAC planks now past their expected service life are replaced.

Following an NHSE request in 2022 for all organisations to reassess their estates portfolio for RAAC (initial assessments of secondary care settings undertaken in 2019), the ICB led and coordinated reviews and assessments alongside primary care and provider estate colleagues and confirmed the three instances of RAAC across Norfolk and Waveney NHS estates infrastructure as;

- Queen Elizabeth Hospital, King's Lynn
- James Paget University Hospital, Gorleston
- Norwich Community Hospital, Norwich

#### **James Paget and Queen Elizabeth Hospitals**

The James Paget and Queen Elizabeth Hospitals surpassed their useful life more than 10 years ago. Working with structural engineers, programmes of work have been put in place to manage the installation of failsafe systems to support RAAC planks at both hospitals.

Installing end bearing supports, props and failsafe systems help maximise safety but do not extend the life of these buildings, and therefore the only long-term sustainable solution is to build two new hospitals through the New Hospital Programme (NHP).

Both hospitals are part of the NHP priority list and will continue to work through business case stages in 2024-25, with plans for construction to be complete and new buildings operational by 2030.

#### **Norwich Community Hospital**

RAAC roofing planks were identified in the hospitals disused laundry building. A demolition plan was developed and funding sought via NHSE to demolish the building and eradicate RAAC. The building was demolished in 2024.

## How do we get there?

### 7.6 Improving quality and condition by tackling backlog

Backlog maintenance represents the amount of capital investment needed to bring a building up to an appropriate standard. It includes all improvements needed regardless of the risk to safety and resilience but excludes refurbishment or improvements.

As NHS capital continues to be constrained, the levels of backlog maintenance across our estates infrastructure continues to grow. Our reported backlog maintenance costs in 2022-23 were over £185m, an increase of over £50m from 2020-21.

Almost 70% of our backlog maintenance has been reported as Critical Infrastructure Risk (CIR). CIR is the total of all high and significant risk backlog maintenance. It represents the amount of capital investment needed to eliminate safety and resilience risks from the operational estate.

As well as NHS Trust estate reported via Model Health System, approximately half of our general practice buildings have been surveyed and revealed a total backlog maintenance cost of over £900,000.

We also have a significant and growing backlog maintenance cost at our PFI hospital, the Norfolk and Norwich. Although PFI estate should be maintained as part of the contractual agreement, the ever increasing demand being placed on the hospital has resulted in the Trust being unable to provide the PFI provider with access to undertake the necessary works.

As backlog maintenance grows, so does the risk of buildings, wards, theatres etc needing to be shut in an unplanned way in order for critical works to be completed.

During this strategy period we will develop and embed a co-ordinated approach to assess the condition of our estate through facet surveys, filling any existing gaps and allowing consistent planning and investment to reduce backlog maintenance.

We will develop plans to reduce backlog maintenance either through investment in core and flex estate or disposal of tail. We will prioritise capital investment to ensure CIR backlog is removed from any core estate, and levels are as close to zero as practically possible across our flex estate, where it will become core.

We will also support NNUH plans for decant capacity that will enable all backlog maintenance works to be carried by the PFI provider and its contractual obligations.

## How do we get there?

### 7.7 Improving sustainability through a net zero estate

The NHS estate has a critical role to play in achieving net zero and the Estates Net Zero Carbon Delivery Plan and its Technical Annex details a four step approach and six themes around which we can deliver a net zero carbon NHS estate by 2040. The technical annex details the interventions, activities and target dates required to achieve the strategic actions set out, and this will provide the framework for our programme of work.

Energy consumption is the top priority for estates and facilities, and accounts for the vast majority of emissions under the direct control of the NHS. Significant action is required in this area over the next ten years to make progress and to deliver on NHS commitments.

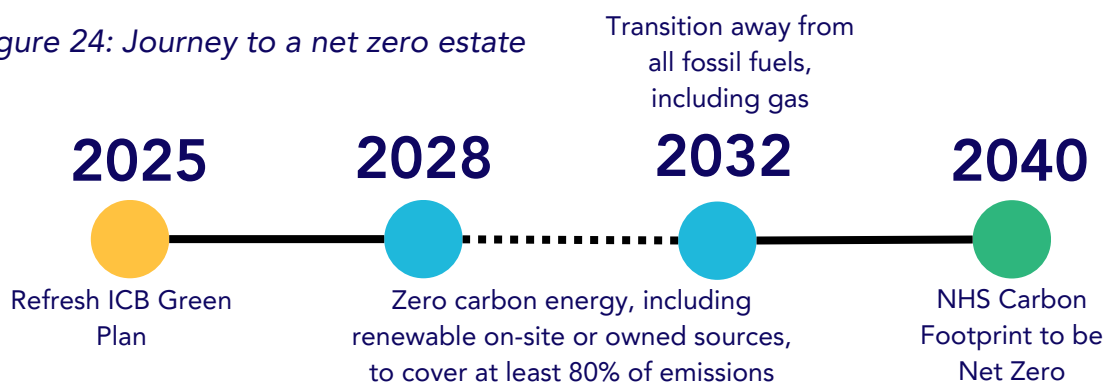
Working with NHS East of England, exercises are already underway to explore the opportunities via District Heat Networks, Solar, and low carbon technologies such as; heat pumps, geothermal, hydrogen, and waste heat sources.

To facilitate progress the ICB will continue to work with local and national colleagues to understand, appraise, and map the options and technologies available and identify those best suited for decarbonising our buildings based on types, size and demand profiles.

A key challenge we will need to tackle is cost. Although reports make clear that many interventions described are either cost-neutral or can provide an immediate cost benefit, the reality is budgets are under extraordinary levels of pressure, meaning investment in energy efficiency and renewable energy struggles to compete with keeping our healthcare facilities operational. We will consider and link this challenge in to how we prioritise our capital investment in order to deliver our strategy.

The timeline below highlights the key milestones and dates on our journey to net zero.

Figure 24: Journey to a net zero estate



## How do we get there?

### 7.8 Improving efficiency and reducing estate running costs

For a number of years the system has operated with an underlying financial deficit, this means that overall expenditure on health and social care services has been greater than the resources made available.

The financial climate we face continues to be very challenging, and there are expectations that we need to be able to do more with less.

Our estate infrastructure costs a significant amount of money to run, costing in excess of £230 million per annum or over £560 per square metre occupied.

We need to offer greater value for money and financial sustainability by developing short and long-term collaborative approaches in the way we plan, develop and operate our estate infrastructure. We need to be considering areas where we can make cost savings and/or realise financial benefits.

We need to provide a streamlined estate that still allows us to deliver our strategy vision and goals and enables and supports clinical strategy and priorities.

We need to be realistic and manage expectations, but there are a number of areas that we will plan for and deliver over the short, medium and long-term, ensuring efficient use of our resources. Some of the areas we will look at include:

- Fast-tracking disposal of estate categorised as tail. Removing any spend against buildings that are not fit-for-purpose or suitable for health care delivery.
- Assessing further co-location opportunities with our NHS and public sector partners to make better use of our collective estate. Maximising utilisation of core estate, and supporting disposal of tail where alternatives are required.
- Developing and investing in energy efficient buildings, reducing our carbon emissions as well as our running costs.
- Working with our procurement teams to deliver cost saving opportunities from collaborative and joint procurement of hard and soft facilities management services.
- Sharing workforce resource and developing system-wide expertise to reduce duplication, filling gaps and maximising the value of skills and knowledge across the system.
- Generating income through disposal and capital receipts, or receipt of rent where partners use NHS land to deliver wider health benefits.

## How do we get there?

### 7.9 Creating access for a growing population

Since 2019, the responsibility for providing an NHS response to planning consultations and applications from the Local Planning Authorities (LPAs) has shifted from NHSE to local systems. The ICB Estates Team now manage this process on behalf of the ICB and its partner trusts.

The Planning in Health Protocol has been developed as an engagement protocol, containing a documented process outlining the input and linking of relevant NHS organisations and Public Health agencies with local planning authorities, helping plan for housing growth and the health infrastructure required to serve that growth.

As part of the process, the ICB calculates and models the impacts of population growth and requests capital contributions through Section 106 (S106) and/or Community Infrastructure Levy (CIL) as part of the consultation response.

There are a number of instances where we have been successful in obtaining S106 and/or CIL capital contributions to help us expand our infrastructure. There are also examples of infrastructure initiatives between the ICB and local councils that will provide much needed health infrastructure where the population is growing and existing buildings are over capacity. These are shown on our prioritised investment timeline.

However, there are also restrictions in health's ability to bid for and use CIL in certain areas, so we will work with our local authority colleagues to unblock these.

We will continue to build on our collaborative relationships with our LPA colleagues and developers to ensure the impacts from housing developments and a growing population are calculated, planned for, and mitigated.

Capital from developer contributions, and/or joint venture proposals with LPAs, will be aligned to our Estates Infrastructure Strategy and prioritised Capital Investment Pipeline to ensure expansion of our infrastructure capacity grows in line with the demand upon it. We will also work with our digital colleagues to understand programmes of work and projects they are leading on where developer contributions may offer other efficient ways to improve access as an alternative to bricks and mortar.

As part of the Levelling Up and Regeneration Bill, there are proposals to introduce a new infrastructure levy over a 10-year period, replacing current CIL and S106 approaches. We will work with our LPA colleagues to understand the impacts of the proposed new levy, and any required changes to our protocol and processes.

# How do we get there?

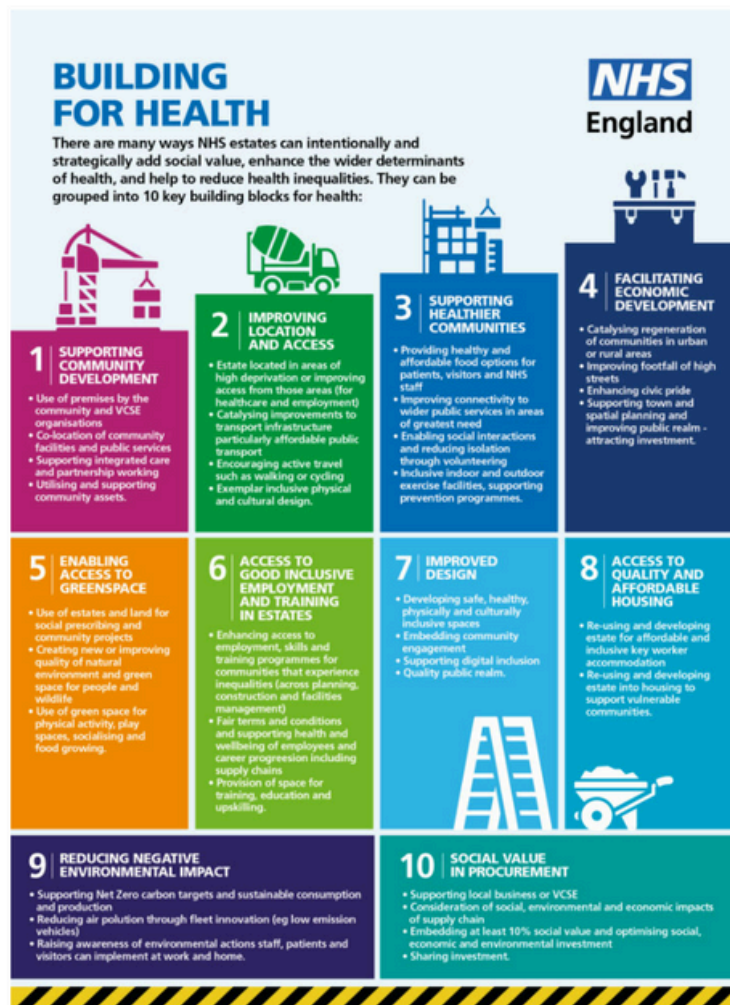
## 7.10 Embedding the 'building for health' principles

A well-maintained and well-designed estate is the bedrock on which clinical services are delivered. It is essential that our estate infrastructure meets current and future service needs, provides good patient experience, offers a high-quality healing environment, and supports the NHS and government's net zero carbon strategies.

NHS England have summarised the key ways in which estates and facilities can play their role in reducing health inequalities, through their 10 building blocks for building for health.

Locally, we will put more focus on estate infrastructure needs for prevention and addressing health inequalities, and apply these building blocks throughout planning, design, construction and operational phases of our estate infrastructure development.

Figure 25: Building for health 10 building blocks



# How do we get there?

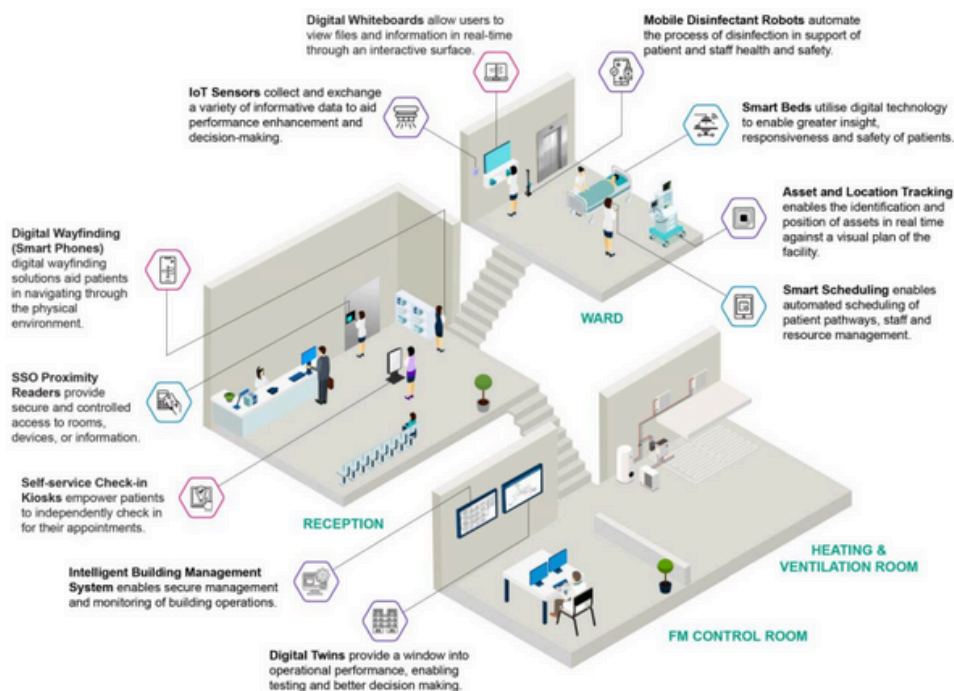
## 7.11 Developing Smart Buildings

As illustrated in the Digital Chapter of the NHP Manual, technology offers the opportunity to drive much-needed change and can have a wide-ranging impact on the application and location of health services, with strong implications for the future of hospitals. The Intelligent Hospital concept is an ideal which aims to help define the operational processes, environments, people and assets which are continually changing to maintain pace with emerging technologies and new digital capabilities.

One part of this concept is Smart Buildings; digitally connected structures that combine optimised building and operational automation with intelligent space management to enhance user experience, increase productivity, reduce costs, and mitigate physical and cybersecurity risks. Smart buildings enable better control of the facilities, their environmental factors and operations across functions, enable enhanced monitoring and reporting and support ways to collaborate digitally, bringing systems, technologies and data together.

We will work collaboratively with our digital and clinical colleagues to embed this concept, not just within our New Hospital Programme, but across all parts of our system. Integration can enable smarter, more user-friendly and efficient facilities and environments that better respond to the needs of patients, staff and other external stakeholders.

Figure 26: Smart building infographic

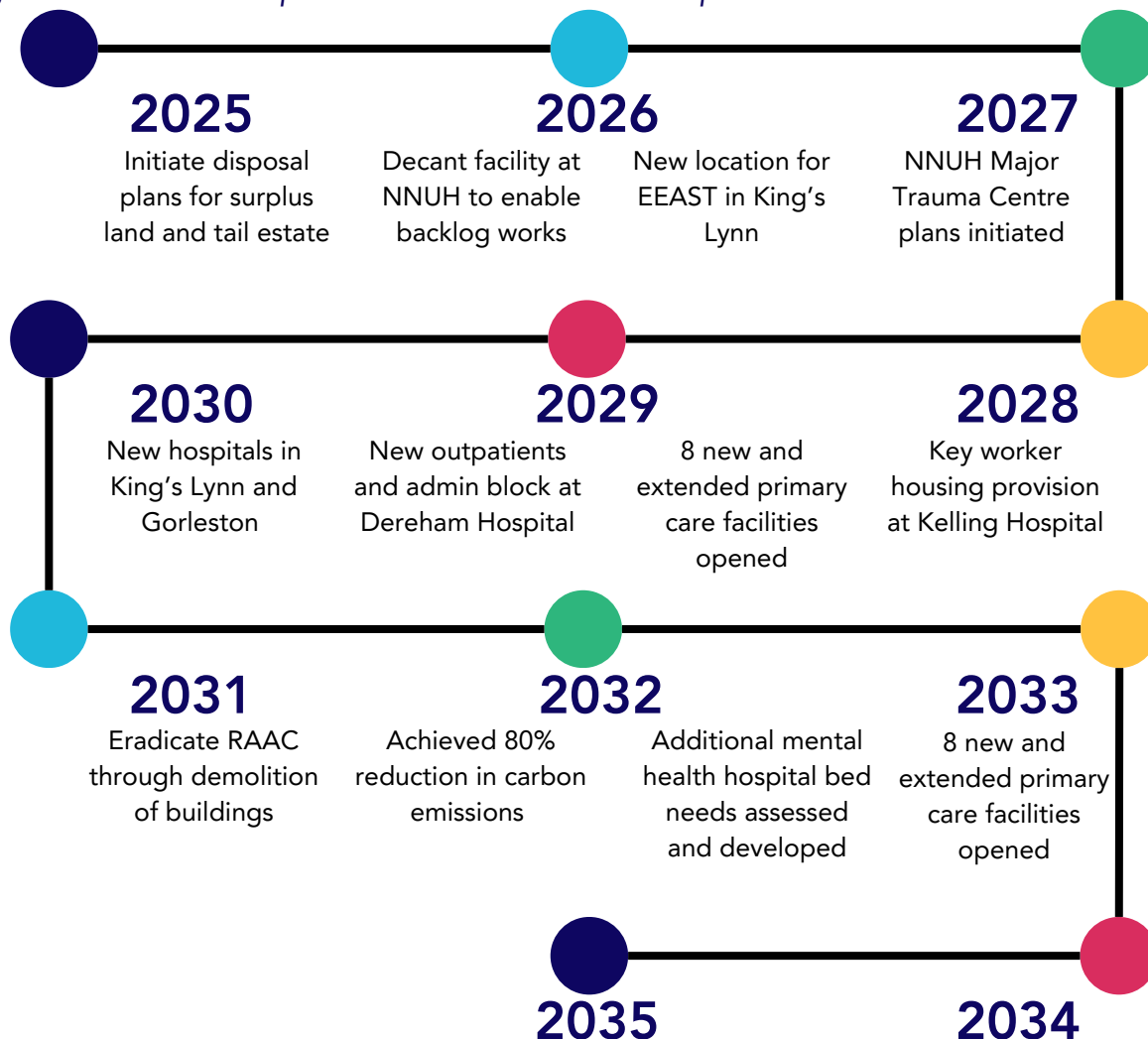


# How do we get there?

## 7.12 Delivering our goals through prioritised investment

The timeline below provides an overview of some of the significant infrastructure programmes and projects that are required to help us deliver our strategy and achieve our goals. These programmes form part of our capital investment pipeline.

Figure 27: Timeline of planned infrastructure developments



As well as the significant infrastructure programmes and projects captured above, there are numerous other projects and ongoing capital investment requirements throughout the strategy period. These include;

- backlog maintenance, routine maintenance, and statutory compliance
- plant machinery and equipment
- investment to deliver net zero ambitions and decarbonise our estate
- investment to support and enable changing models of care

Delivery of these programmes of work are reliant on resource and funding availability.

## How do we get there?

### 7.12 Delivering our goals through prioritised investment

The table below lists some of the significant schemes and projects that form our 10-year capital investment pipeline, and highlights their alignment to our goals and programmes of work. A complete 10-year investment pipeline has been developed and will be updated annually through Strategic Capital Board.

Table 2: Significant programmes, projects and estimated costs

Programme / Project	Estimated costs
<p><b>Improving access by providing care closer to home</b> Increase capacity in our general practice buildings through the development of up to 16 new builds and/or extensions during this strategy period.</p>	£150 m
<p><b>Improving access by providing care closer to home</b> Develop and expand capacity across our primary and community estate to support new models of care and shift from acute settings.</p>	£ tbc
<p><b>Improving access by transforming our hospital estate</b> Develop two new hospitals, in King's Lynn and Gorleston, providing estate fit for the future, whilst removing the critical infrastructure risk of RAAC.</p>	£2.5 - £3 bn
<p><b>Improving access by transforming our hospital estate</b> Development of a Major Trauma Centre at the Norfolk &amp; Norwich University Hospital.</p>	£20 m
<p><b>Improving access by transforming our hospital estate</b> Development of our community and mental health hospital estate, providing the right sized estate and capacity to support patient pathways.</p>	£80 m
<p><b>Improving quality and condition by tackling backlog maintenance</b> Improving the quality and condition of our estate infrastructure, whilst removing the associated risks. Figure includes costs for any required decant provision.</p>	£165 m
<p><b>Improving environmental sustainability through a net zero estate</b> Reducing our energy consumption and emissions by investing in energy efficient technology, plant and machinery, and building fabric; non-fossil fuel heating; and on-site renewables.</p>	£80 m

# How do we get there?

## 7.13 Wider programmes of work to support delivery

### **Biodiversity Net Gain and Nature Recovery**

Biodiversity Net Gain (BNG) is a way of creating and improving natural habitats. BNG makes sure development has a measurably positive impact on biodiversity, compared to what was there before development.

In February 2024 it became mandatory for developers to deliver a BNG of 10%, meaning a development will result in more or better quality natural habitat than there was before development.

We will consider what planned and proposed estate infrastructure developments need to consider BNG and develop appropriate plans to achieve the 10% gain, through developments on-site and/or off-site.

We will identify system sites that have plans, or the potential to, enhance and develop green spaces, that can be offered as off-site options and support partner estate infrastructure developments. We will also work with our local authority colleagues to explore and develop plans to sell biodiversity units as a land manager.

### **Climate Change and Adaptation**

Climate change adaptation means responding to both the projected and current impacts of climate change and adverse weather events.

We need to develop a clear understanding of the risks to service continuity and patient health across Norfolk and Waveney, and from this develop estate infrastructure investment and action priorities needed to mitigate these.

To support short and long-term adaptation planning and its inclusion with the systems Green Plan there are a number of initial actions we will take:

- following its submission, we will review the latest ERIC returns to assess reported flooding and overheating occurrences that triggered risk assessments, and ensure appropriate actions are taken
- refresh our mapping of estate assets and utilise the SHAPE tool to highlight those at risk of flooding from rivers and seas (Environment Agency data), and ensure appropriate contingency plans are in place
- evaluate findings against estate infrastructure categorisation and impacts of proposed activities and/or developments

## How do we get there?

### 7.13 Wider programmes of work to support delivery

#### Key worker housing

To enable delivery of 'Our People Plan' and support recruitment and retention, we need to consider the accommodation needs of our workforce.

There are existing residential accommodations associated with our three acute providers. The ICB and partner organisations will work with our workforce colleagues to assess and map our needs across the system and ensure plans are captured within our estate infrastructure strategy and capital investment pipelines. A recent White Paper 'Delivering NHS Homes' provides several delivery models for consideration.

#### Supported and Independent Living

There is limited accommodation specifically designed for people living with different needs such as learning disabilities and autism, and we need to develop more specialist accommodation to improve access and meet the needs of people with multiple, complex needs.

We will also work closely with our local authority colleagues to understand and support their Independent Living Programme (housing with care). The evidence for this type of housing to reduce pressure on health and social care is well-documented and includes evidence of a reduction in A&E admissions, a reduction in falls, an increase in wellbeing and mental health and a reduction in GP appointments.

We will develop opportunities for how we can better use our existing NHS sites to create the right health and social care infrastructure and develop opportunities to use surplus land to bring forward specialist housing developments that support people to live well in the community.

#### Research and Innovation

Research has a central role to play in providing the evidence we need so we can improve services, improve quality, improve outcomes and reduce unfair differences in health outcomes experienced by some people in Norfolk and Waveney. Innovations can transform how people receive care, for example by allowing them to be monitored in their own home rather than stay in hospital.

As well as providing estate capacity that allows research and innovation to take place, we will work with our colleagues to promote innovation and develop processes that help identify, test, evaluate and implement innovations that help deliver our goals of improving access, improving quality and condition, improving environmental sustainability, and improving efficiency.

# How do we get there?

## 7.14 Next steps and initial actions over the next 12 months

### Estates infrastructure strategy programme and action planning

- Develop specific action plans and timelines for key initiatives, to build on the broad strategies and goals set out and provide detailed steps for achieving the goals to enhance the strategy's practicality and accountability.

### Workforce

- Identify skills gaps and workforce challenges, and develop plans for collaborative recruitment and sharing of expertise
- Explore system-wide apprenticeship opportunities and utilise NHSE's apprenticeship toolkit to explore offers and funding routes
- Assess performance against E&F workforce action plan KPIs and develop improvement plans

### Data and intelligence

- Work with Community Health Partnerships on the ICS SHAPE Atlas Programme, undertaking data validation and gap analysis work
- Carry out peer reviews of estate infrastructure performance using the latest data reports and submissions, and agree plans for improvement

### Investment

- Validate prioritisation of capital investment pipeline and incorporate strategy goals as part of our prioritisation matrix
- Identify investment and acquisition requirements in order to provide estate infrastructure capacity
- Identify potential alternative funding routes for projects without an identified funding source
- Continue to develop the capital investment pipeline as plans are developed and costed investment requirements come forwards

### Leadership and governance

- Map responsibilities of the committees, boards, and groups from across the system (ICB, Place, PCN, provider collaboratives, and individual organisations) and gain clarity on who is responsible for what and the roles each have to play in delivery of the strategy
- Ensure there is appropriate estate team membership at Place Boards, NHP Boards and other decision making committees and boards where estate infrastructure needs to be considered proactively
- Continued estate membership at the System Strategy Group to ensure continued alignment between system strategies and priorities

# How do we get there?

## 7.14 Next steps and initial actions over the next 12 months

### Categorisation

- Develop master plans for core estate, flex to core estate, and develop disposal plans for existing tail estate and future flex to tail estate
- Continue to utilise data to guide and validate the strategic categorisation of our buildings into core, flex and tail

### Improving access

- Work with system committees and boards to understand clinical models and gain clarity on out-of-hospital requirements and future demand on estate infrastructure
- Work with ICB and provider colleagues to understand capacity requirements at our hospitals and inpatient settings
- Develop a 'library' and promote all estate available for shared and sessional use, including both clinical and non-clinical

### Improving quality and condition

- Agree plans to undertake condition surveys where we currently do not hold them
- Assess latest backlog maintenance risk and costs against estate categorisation and develop prioritised reduction plans and investment needs
- Review outputs from building surveys, PLACE assessments, patient surveys and staff feedback to identify where and how the quality of our estate infrastructure needs to be improved, and develop prioritised investment plans

### Improving Sustainability

- Work with ICB Net Zero Lead to ensure estates focus area is updated accordingly via the Green Plan refresh
- Develop a baseline for all estate infrastructure emissions and ability to track our progress to net zero
- Assess decarbonisation plans and latest carbon emission and consumption data against estate categorisation and develop prioritised reduction plans and investment plans
- Continue to work with the Local Authority's Clean Growth Team on the developing Norfolk Energy Plan

### Improving efficiency

- Develop and agree plans and timelines for disposal of surplus and tail estate
- Map areas of underutilised estate, assess against estate categorisation and develop plans to reduce
- Work with the Financial Recovery Board to present and agree opportunities, develop cost improvement plans, and gain 'buy-in' to drive delivery

# How do we get there?

## 7.14 Next steps and initial actions over the next 12 months

### Planning and population growth

- Unblock CIL restrictions in Greater Norwich and West Norfolk
- Develop/finalise local plan area infrastructure delivery plans in response to housing developments and population growth
- Identify digital innovations that could help improve access and potentially be funded via CIL and/or S106

### Building for health

- Continue to work through our System Strategy Group to identify how our estate infrastructure can support and enable our Population Health Management Strategy and Health Inequalities Framework for Action

### Smart buildings

- Assess the NHP approaches to smart buildings and share learning, research and technologies that could benefit all
- Ensure investment requirements in digital technologies are captured and prioritised through capital planning

### Biodiversity Net Gain and Nature Recovery

- Ensure all relevant infrastructure developments consider biodiversity and include plans to achieve the required 10% net gain
- Develop a list of NHS sites that have the potential to offer 'off-site' options for enhanced biodiversity

### Adaptation and climate change

- Review the latest ERIC returns to assess reported flooding and overheating occurrences that triggered risk assessments, and ensure appropriate actions are planned/taken
- Refresh our mapping of estate assets and utilise the SHAPE tool to highlight those at risk of flooding, and ensure appropriate contingency plans are in place
- Evaluate findings against estate infrastructure categorisation and impacts of proposed activities and/or developments
- Build into processes the use risk of flooding data to support decision making on future developments and/or acquisitions

### Research and innovation

- Develop systematic processes for the identification, selection, and governance of innovations that improve estate infrastructure and its ability to meet population healthcare needs and tackle clinical challenges.

# How do we get there?

## 7.15 Risk Management

The table below illustrates a number of the risks that are likely to have a big impact on the delivery of our strategy. A complete risk register has been developed and will be managed through our Estates Programme Board.

Table 3: Critical risks

Risk	Rating	Mitigation
Without identified funding routes and models, both capital and revenue, we will be unable to deliver this estates infrastructure strategy	Critical	Develop a prioritised and costed capital investment pipeline Explore a range of funding routes and models Develop and submit business cases
New Hospital delays and eradication of RAAC by 2030 will increase the risk of catastrophic failure and closure	Critical	Business Case development and submission Construction of 2 new hospitals by 2030
If the Net Zero agenda is not resourced and financed sufficiently then there is a risk that national and local targets will be missed	Critical	Calculate carbon footprint Develop complete suite of decarbonisation plans Develop a prioritised and costed capital investment pipeline
There is a risk that existing buildings are not suitable to support new models of care and the shift of acute activity	Critical	Undertake 6 facet surveys Agree works required to improve existing estate Develop a prioritised and costed capital investment pipeline
Competition for specific roles will be exacerbated by large programmes such as NHP, Sizewell C etc, resulting in recruitment and retention challenges	Critical	Identify existing and future needs Pursue collaborative and shared workforce approaches Work with local education institutes to collaborate and provide course provision and development

## How do we get there?

### 7.16 Monitoring and review

This strategy is intended to be a live document and part of an iterative process requiring regular review and updating as necessary to ensure that it remains relevant.

It is expected that this strategy will be reviewed on an annual basis with timing dictated by policy changes, local strategy, and events which will have a significant impact on our NHS estate. This will ensure that the detail contained within the document remains accurate and up to date, and that the strategy will be best placed to satisfy the demands of the changing political landscape. The involvement of all Norfolk and Waveney partners in this review process will be key to ensuring that the strategy is effective in contributing to our estate being used to its best potential.

As the Integrated Care System matures and further service strategies are published, this estate infrastructure strategy will follow suit. It is anticipated that the next iteration of our strategy will go beyond its current focus on NHS infrastructure and capture the wider public, voluntary, community and social enterprise estate.

We will produce annual operating plans based on this ten-year strategy, alongside the strategy implementation and development plan. The annual operating plans will be used to monitor progress against this strategy vision, goals and objectives.

Annual review of estates and facilities costs (across the system budget), and the analysis of the various data sources and benchmarks will be used to measure performance against the SMART objectives. Developing strategies and operating plans will define additional efficiency opportunities and objectives.

Our Estates Programme Board will be responsible for implementation and monitoring delivery of the strategy and operating plans.





Improving lives **together**

Norfolk and Waveney Integrated Care System

## Data & References

This section provides an overview of the data and information sources used to inform this strategy, references to national and local strategies, and the input from colleagues and partners that have helped develop this strategy.

# Data and document references

## Datasets

- Estates Return Information Collection (ERIC)
- Premises Assurance Model (PAM)
- Patient Led Assessment of the Care Environment (PLACE)
- Primary Care Data Gathering (PCDG)

## Data Systems

- Model Health System
- Strategic Health Asset Planning and Evaluation (SHAPE)
- Energy Dashboard

## National Policy

- The NHS Long Term Plan
- The Hewitt Review
- The Fuller Stocktake Report
- The Naylor Review
- The Carter Review
- Delivering a Net Zero National Health Service
- The Health Infrastructure Plan
- NHS Estates and Facilities Workforce Action Plan

## Local Strategy

- The Integrated Care Strategy and Joint Health and Wellbeing Strategy
- The ICS Clinical Strategy
- The Joint Forward Plan
- The ICS Green Plan
- The ICS Digital Transformation Strategic Plan
- The ICS People Plan

## Guidance and additional reference

- Health Building Notes (HBNs)
- Health Technical Memoranda (HTMs)
- NHS Net Zero Building Standard
- NHS Long Term Workforce Plan
- Standing Committee on Structural Safety (SCOSS) 2019 Alert
- Estates Net Zero Carbon Delivery Plan and its Technical Annex
- Planning in Health Protocol
- Building for Health
- New Hospital Programme - Digital Chapter
- Delivering NHS Homes

## Figure references

- Figure 1 - Our Estate Infrastructure Strategy on a page
  - Figure 2 - Our 2018 Estate Strategy Journey
  - Figure 3 - Our 2024 Estate Strategy Journey
  - Figure 4 - Our Integrated Care System Partners
  - Figure 5 - Structure of the Estates Infrastructure Strategy
  - Figure 6 - Estates Programme Board Governance Structure
  - Figure 7 - The Strategic Planning Process
  - Figure 8 - Health Infrastructure Plan timeline
  - Figure 9 - EFM workforce action plan themes, priorities and actions
  - Figure 10 - Norfolk and Waveney Clinical Strategy Objectives
  - Figure 11 - Joint Forward Plan Eight Ambitions
  - Figure 12 - Digital Transformation Plan Strategic Objectives
  - Figure 13 - Core 20 Communities across Norfolk and Waveney
  - Figure 14 - Areas of housing developments and population growth to 2033
  - Figure 15 - Timeline of delivered and ongoing infrastructure developments
  - Figure 16 - General Practice locations
  - Figure 17 - NNUH locations
  - Figure 18 - QEHLK locations
  - Figure 19 - JPUH locations
  - Figure 20 - NSFT locations
  - Figure 21 - NCH&C locations
  - Figure 22 - ECCH locations
  - Figure 23 - EEAST locations
  - Figure 24 - Journey to a net zero estate
  - Figure 25 - Building for health 10 building blocks
  - Figure 26 - Smart building infographic
  - Figure 27 - Timeline of planned infrastructure developments
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- Table 1 - SMART objectives and KPIs
  - Table 2 - Significant programmes, projects and estimated costs
  - Table 3 - Critical risks

# Acknowledgements

The NHS Norfolk and Waveney ICB Estates team would like to thank all those who took time to be part of our engagement sessions and provide comment and contributions that have informed the development of our Estates Infrastructure Strategy.

Site visits and face to face discussions, virtual workshops and meetings, and drop-in sessions have been held with ICB, NHS Trust, and partner organisation colleagues to talk through strategy content, individual strategies, the challenges faced, plans and ambitions, and to capture feedback and comment on our draft documents.

As well as being presented to our Executive Management Team, Strategic Capital Board, and Estates Programme Board, we also discussed it at our System Strategy Group. This has helped us ensure its alignment to system strategies and priorities, and the wider engagement and input from patients, service users, staff, and organisations across the Norfolk & Waveney Integrated Care System.

The strategy has been developed by the Estates Team at the Norfolk and Waveney ICB, with input from;

- Primary Care
- Queen Elizabeth Hospital NHS Foundation Trust
- Norfolk and Suffolk NHS Foundation Trust
- Norfolk Community Health and Care NHS Trust
- East Coast Community Healthcare CIC
- James Paget University Hospitals NHS Foundation Trust
- Norfolk and Norwich University Hospitals NHS Foundation Trust
- East of England Ambulance Service NHS Trust
- Norfolk County Council, One Public Estate
- Cambridgeshire Community Services NHS Trust
- Community Health Partnerships
- NHS Property Services
- Quality Governance and Delivery, ICB
- Infection Prevention and Control, ICB
- Research and Innovation, ICB
- Finance, ICB
- Executive Management, ICB



