

Meeting of the Board of Norfolk and Waveney Integrated Care Board

Wed 25 September 2024, 13:30 - 16:30

Agenda

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

0 min

00. Agenda for Part 1 ICB Board 25.09.24.pdf (4 pages)

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

0 min

13:30 - 13:30 **2. Questions**

0 min

13:30 - 13:30 **3. Minutes from previous meeting and matters arising**

0 min

03. DRAFT NW ICB Board Part 1 Minutes 17072024.pdf (7 pages)

13:30 - 13:30 **4. Declarations of interest**

0 min

04. Board - Sept 24.pdf (5 pages)

13:30 - 13:30 **5. Chair’s Action Log**

0 min

05. Chairs Action Log Sept 2024.pdf (1 pages)

13:30 - 13:30 **6. Action log – things we have said we will do**

0 min

06. ICB Board Action Log Sept 2024.pdf (1 pages)

13:30 - 13:30 **7. Chair and Chief Executive’s Report - to follow**

0 min

07. Chair and Chief Executive's Board report - Final.pdf (7 pages)

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

0 min

13:30 - 13:30 **8. NHS App Lived Experience Item**

0 min

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

0 min

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19/09/2024 14:02:47

13:30 - 13:30 ***Strategy and Partnerships***

0 min

13:30 - 13:30 **10. ICP update and report**

0 min

📄 10. ICP Committee Report to Board FINAL v1 170924.pdf (18 pages)

13:30 - 13:30 **11. Report from the Commissioning and Performance Committee**

0 min

📄 11. Report from the Commissioning and Performance Comm 09.24.pdf (5 pages)

13:30 - 13:30 ***System Oversight***

0 min

13:30 - 13:30 **12. Annual Reporting and Accounts 23/24**

0 min

📄 12. Sept 2024 Board ARA cover paper.pdf (2 pages)

📄 12.1 N&W Annual Report & Accounts 2023-24 WEBSITE FINAL.pdf (166 pages)

13:30 - 13:30 **13. Board Assurance Framework (including approval of a revised Risk Management Framework for the ICB)**

0 min

📄 13. Risk Management report to board.pdf (2 pages)

📄 13.1 App1-Board Assurance Framework.pdf (20 pages)

📄 13.2 App2-Board Operational Risk Register.pdf (24 pages)

13:30 - 13:30 **14. Governance Handbook**

0 min

📄 14. GovHandbook-COVERPAPER Sept 2024.pdf (4 pages)

📄 14.1 SoRD committee amendments.pdf (26 pages)

📄 14.2 Section 13-Protocol-questions-to-board.pdf (1 pages)

📄 14.3 APP D-Patients Communities Committee TOR v1.6.pdf (8 pages)

📄 14.4 APP E-Finance TOR August 2024 ~ Final.pdf (13 pages)

📄 14.5 APP G-Quality Committee Refresh v2.1 AB EK.pdf (9 pages)

📄 14.6 APP H-CommPerformance Committee TORJuly 2024.pdf (9 pages)

📄 14.7 APP I COI Committee ToRtrack.pdf (6 pages)

13:30 - 13:30 ***Commissioning, Delivery and Performance***

0 min

13:30 - 13:30 **15. Research and Evaluation (Innovation) Annual Report**

0 min

📄 15. R&E annual report 23_24 coversheet Sept 24.pdf (5 pages)

📄 15.1 Research Evaluation AR 23-24 FINAL.pdf (42 pages)

13:30 - 13:30 **16. Financial Report for Month 5**

0 min

 16. ICB Finance Report - Month 5 202425 - Board.pdf (10 pages)

13:30 - 13:30 **17. Report from the Finance Committee**

0 min

 17. Report from the Finance Committee 09.24.pdf (5 pages)

13:30 - 13:30 ***Committees Escalation Reports and Questions from the public***

0 min

13:30 - 13:30 **18. Report from the Quality and Safety Committee**

0 min

 18. Report from the Quality and Safety Committee 09.24.pdf (8 pages)

13:30 - 13:30 **19. Report from the Primary Care Commissioning Committee**

0 min

 19. Report from the Primary Care Comm Committee 09.24.pdf (7 pages)

13:30 - 13:30 **20. Report from the Audit and Risk Committee**

0 min

13:30 - 13:30 **21. Report from the Remuneration, People and Culture Committee**

0 min

13:30 - 13:30 **22. Questions from the Public**

0 min

13:30 - 13:30 **23. Any other business**

0 min

Davey Heidi
19/09/2024 14:02:47

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

Wednesday, 25 September 2024 1.30pm – 4.30pm

Virtually via MS Teams

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

Our goals:

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

Our values:



Questions

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

- 1. Please submit questions no later than 12 noon on the 20 September 2024, via e-mail to: nwicb.contactus@nhs.net.**
- 2. Questions will be collated and asked at the relevant item on the agenda at the discretion of the Chair.**
- 3. Questions can also be asked during the meeting by members of the public relating to an agenda item by those present or watching live at the discretion of the Chair.**

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Chair: Rt Hon. Patricia Hewitt

Item	Time	Agenda Item	Lead
Introductory Items			
1.	1.30	Welcome and introductions - Apologies for absence	Chair
2.		Questions Notification of any questions from members of the public on agenda items for response at the appropriate time on the agenda	Chair
3.		Minutes from previous meeting and matters arising To approve the part 1 public minutes of the previous Board meeting.	Chair
4.		Declarations of interest To declare any interests that board members may have specific to agenda items that could influence the decisions they make. Declarations made by members of the ICB Board are listed in the ICB's Register of Interests. The Register is available via the ICB's website.	Chair
5.		Chair's Action Log To receive an update from the Chair on actions taken since the last meeting.	Chair
6.		Action log – things we have said we will do To make sure the ICB completes all the actions it agrees are needed.	Chair
7.	1.35	Chair and Chief Executive's Report To note an update from the Chair and the Chief Executive of the ICB about the work the ICB has done since the last meeting.	Chair and Tracey Bleakley
Learning from People, Staff, and Communities			
8.	1.45	We will hear about how the local health system is helping and supporting patients to access and use the NHS App. The presentation will also share the lived experiences of those already using the App, the benefits to patients and the positive impacts to those delivering health services.	Tricia D'Orsi
9.		Report from Patients and Communities Committee	Aliona Derrett
Strategy and Partnerships			

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Item	Time	Agenda Item	Lead
10.	2.15	ICP update and report To provide the Integrated Care Board with an update on the work of the Health and Wellbeing Board and Integrated Care Partnership.	Cllr Bill Borrett
11.	2.30	Report from the Commissioning and Performance Committee	Hein Van Den Wildenberg
System Oversight			
12.	2.45	Annual Reporting and Accounts 23/24 To present the second Annual Report and Accounts for the NHS Norfolk and Waveney Integrated Care Board for the period 1 April 2023 to 31 March 2024.	Tracey Bleakley/ Steven Course
13.	2.55	Board Assurance Framework A review of the risks (things that might go wrong and how we can alleviate them) within the Integrated Care system.	Karen Barker
14.	3.05	Governance Handbook The ICB Board is being asked to approve amendments to the Governance Handbook's Scheme of Reservation and Delegation, committee's terms of reference and a new section 13 about the process for submitting questions to the Board.	Karen Barker
Commissioning, Delivery and Performance			
15.	3.10	Research and Evaluation (Innovation) Annual Report To share the NWICB Research and Evaluation Team annual report April 2023-March 2024.	Dr Frankie Swords/ Dr Clara Yates
16.	3.30	Financial Report for Month 5 To receive a summary of the financial position as at month 5	Steven Course
17.		Report from the Finance Committee	Hein Van Den Wildenberg
Remaining Committees Reports and Questions from the public			
18.	4.00	Report from the Quality and Safety Committee	Aliona Derrett
19.		Report from the Primary Care Commissioning Committee	Debbie Bartlett
20.		Report from the Audit and Risk Committee As the meeting date of 18 September will not allow time for preparation of a full written report, the report will be received at the 27 November public Board meeting.	David Holt

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Item	Time	Agenda Item	Lead
21.		Report from the Remuneration, People and Culture Committee There is no update from the Committee as there has not been a Part 1 meeting since the previous Board. A report will be received at the 27 November public Board meeting.	Cathy Armor
22.		Questions from the Public. Where questions in advance relate to items on the agenda.	Chair
23.	4.25	Any other business	Chair
Date, time, and venue of next meeting: 1.30pm – 4.30pm Wednesday 27 November 2024 at Hethel Engineering Centre, Wymondham			
Any queries or items for the next agenda please contact: nwicb.corporateaffairs@nhs.net			

Some explanations of terms used in this Agenda.

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

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

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

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

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

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

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

NHS Norfolk and Waveney Integrated Care Board
DRAFT Minutes of the meeting on Thursday, 17 July 2024

PART 1 – Meeting in public

Board members present:

- Rt Hon. Patricia Hewitt (PH), Chair, NHS Norfolk and Waveney ICB
- Tracey Bleakley (TB), Chief Executive, NHS Norfolk and Waveney ICB
- Steven Course (SC), Executive Director of Finance, NHS Norfolk and Waveney ICB
- Dr Frankie Swords (FS), Executive Medical Director, NHS Norfolk and Waveney ICB
- Tricia D'Orsi (TDO), Executive Director of Nursing, NHS Norfolk and Waveney ICB
- Hein Van Den Wildenberg (HvdW), Non-Executive Member, NHS Norfolk and Waveney ICB
- Cathy Armor (CA), Non-Executive Member, NHS Norfolk and Waveney ICB
- Cllr Bill Borett (BB), Chair, Norfolk Health and Wellbeing Board, and Chair, Norfolk and Waveney ICP
- Stuart Keeble (SK), Local Authority Partner Member
- Aliona Derrett (AD), Non-Executive Member, NHS Norfolk and Waveney ICB

Participants and observers in attendance:

- Andrew Palmer (AP), Executive Director of Performance, Transformation and Strategy, and Deputy Chief Executive, NHS Norfolk and Waveney ICB
- Karen Barker (KB), Executive Director of Corporate Affairs and ICS Development, NHS Norfolk and Waveney ICB
- Jocelyn Pike (JP), Acting Executive Director of Mental Health Transformation, NHS Norfolk and Waveney ICB
- Ian Riley (IR), Executive Director of Digital and Data, NHS Norfolk and Waveney ICB
- Andrew Jones (AJ), Deputy Director of People, NHS Norfolk and Waveney ICB
- Alex Steward (AS), Chief Executive, Healthwatch Norfolk

Attending to support the meeting:

- Dr Caroline Barry (CB), Palliative Care Consultant and Clinical Advisor, NHS Norfolk and Waveney ICB
- Suzanne Meredith (SM), Deputy Director of Public Health for Norfolk County Council and Associate Director of Population Health Management for NHS Norfolk and Waveney ICB
- Andrew Barnes (AB), Chair, The Priscilla Bacon Hospice Charity
- Tim How (TH), Chair of Trustees, The Norfolk Hospice – Tapping House

1.	Welcome and introductions - apologies for absence	
	The Chair welcomed everyone to the meeting.	
	The Chair noted that the agenda had a focus on palliative and end of life care, and thanked Andrew Barnes, Chair of the charitable trust which supports Priscilla Bacon Lodge Hospice, for hosting the Board's meeting.	

	Apologies were received from the following Board members: - David Holt (DH), Non-Executive Member, NHS Norfolk and Waveney ICB - Emma Ratzer (ER), Voluntary, Community and Social Enterprise Sector Board Member - Dr Hilary Byrne (HB), Partner Member – NHS Primary Medical Services - Jonathan Barber (JBa), Partner Member – NHS Trusts (Acutes) - Caroline Donovan (CD), Partner Member – NHS Trusts	
2.	Minutes from previous meeting and matters arising	
	The draft minutes from the meeting held on 22 May 2024 were approved as an accurate record of the meeting.	
3.	Declarations of interest	
	The Chair noted that declarations of interest were kept up-to-date and were available on the ICB's website.	
4.	Chair's action log	
	The Chair noted she had taken an action since the last Board meeting, this was to: Approve the ICB's Annual Report. This was because the Board was not quorate at its previous meeting. Therefore under section 4.9.4 of the Standing Orders set-out in the Constitution, the Chair reviewed the Audit and Risk Committee Report and approved the final report.	
5.	Action log	
	The action log was noted. The following updates were given. - AJ noted that benchmarking information for the Equality Duty Standards and Workforce Race Equality Standards was being collected and the ICB was looking at self-assessments across Norfolk and Waveney. He added that the data was likely to be published in September 2024, with EDI coming to Board to propose refreshed objectives. - The Chair noted that all other remaining actions had closed.	
6.	Chair and Chief Executive's Report	
	The Chair acknowledged that it had been a busy few weeks following the General Election and that she had been contributing to the discussions taking place with the new government. TB introduced the item by highlighting key points from the report, including that the ICB was focussing on the future following two successful years of being an ICB. She added that the ICB's re-organisation was coming to an end. TB highlighted the importance of focusing on our finances and maintaining financial sustainability. She also noted that a public meeting was held in Cromer on 16 July 2024 regarding Benjamin Court and that a report about the engagement exercise would be published in due course. The report was noted.	

Items for Sharing and Board Consideration		
7.	Palliative care support for people in Norfolk and Waveney	
	PD'O introduced this item by highlighting how important it was that the Board heard stories from patients, staff and communities. She thanked Dr Caroline Barry for working with Martin to share his story about living with Motor Neurone Disease. The Chair reflected on a powerful and emotional story, and thanked Martin for putting a spotlight on his condition and care. PD'O commented that it was important we empower our patients and that Martin's story raised vitally important areas of care. She added that stories like this help us understand our challenges. The Board formally thanked Martin for sharing his story and the Chair agreed to move onto item 8, whereby questions would be covered jointly.	
8.	Update on the work of the Norfolk and Waveney Palliative and End of Life Care (PEoLC) Programme	
	FS introduced Dr Caroline Barry (CB), Consultant in Palliative Care and ICB Clinical Advisor. CB began by talking about the new statutory duty to provide palliative care which was introduced when ICBs were created. She explained that the ICB had taken stock of services and that the review showed we were delivering well against our priorities, but that there were also some gaps. She added that the gaps had informed our medium and long term plans and programmes of work to better coordinate end of life care. Questions and comments from board members: • AD noted the review had identified variation in provision and asked what we are doing in the short term to improve equity. • FS noted that the ICB had nine urgent and six medium term priorities specifically referring to medication use and availability, education, death literacy, data and digital. • SK referenced the development of a data dashboard and ensuring that we feed the important elements of Martin's story into our plans, acknowledging that our society isn't well equipped to have conversations about death. • CA asked a question regarding a reference in the papers to 'expect respect' and 'no barriers here' and what these meant. CB advised that 'expect respect' relates to a personalised treatment document which replaced the previously known 'do not resuscitate' (DNR) and 'no barriers' was a term which referred to practices introduced to raise awareness and create more inclusive conversations. TB thanked all presenters and Martin, and explained that palliative care would be a focus for our new model of care, ensuring people could die in a place of their choice. TB noted that at a recent meeting with Amanda Pritchard, Chief Executive of NHS England, she was shocked to learn how	

	much money was spent on providing care in acute hospitals where patients do not want to die. TB invited comments from HW and AB who were present in the audience representing local hospice's in Norfolk and Waveney. TH emphasised the importance of talking about death and noted that Norfolk Hospice had recently invested in a person who's role was to create 'passionate communities' and to empower them in talking about death. TH also noted how challenging their financial position was and urged government to invest money into hospice care. The Chair responded noting that there was an opportunity in the development of the NHS's new ten-year plan to say what we would want to see happen in this area. AB noted that PBL is funded through NCH&C, but that he wanted the conversations to be steered towards our strategic direction and was interested in what services should be provided in order to get the greatest impact with our money. The Chair commented that our partnership (NHS, Local Authrotiy, VCSE and others) must use all available resources to get the best possible services and outcomes.	
9.	Improving the health of the population using population health management approaches	
	SM introduced the item by highlighting that the strategy had been based on proven methods which is why it had been successful. She explained that the report focussed on developments in cardiovascular disease and how many high risk patients would be supported by the proposed interventions. Questions and comments from board members: • BB noted his support and how important prevention is to the system, and that for very modest capital the service provided great outcomes. • SK welcomed the report and acknowledged that it was helpful to look over the evaluation and that understanding cohorts and the balance of data would develop with time and need more support. • HvdW asked how we get as many GPs to sign up as possible, noting that resilience to general practice is a risk. • JP reported that as a result of interventions, 93% of those referred through the model have accessed talking thereapies, which put Norfolk and Waveney third in the country. • AD asked about the accessibility of our communications. • SM advised that we look at programmes and evaluate and make changes as necessary to improve our communications. • DB noted her support and that Norfolk County Council had delivered positive work in collaboration with the ICB. She suggested the	

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	strategy was presented to the Primary Care Commissioning Committee. • PD'O suggested that we should consider doing more with regards to learning disabilities and autism.	
10.	ICP update and report	
	BB introduced the report by advising on the role of the Integrated Care Partnership and how they operate, highlighting the differences to health and wellbeing boards. The report was noted.	
Finance and Corporate Affairs		
11.	Financial Report for Month 2	
	SC introduced the item noting that the ICB had reported a year-to-date break-even position, which was in line with the organisation's plan, and that the forecast out-turn position was break-even. Questions and comments from board members: • AD commented on the plan and the importance of making sure we meet our target. • SC noted that financial recovery plans were in place to test our assumptions and to gain assurances. • PD'O noted the position concerning Continuing Healthcare and assured the board that there was lots of work going on in this space regarding financial management. She added that the ICB was working with Norfolk County Council on complex high cost packages of care for people with learning disabilities and autism, and that deep dives were taking place in this area to help control costs.	
12.	Board Assurance Framework	
	KB highlighted that the framework was set around the eight ambitions in the Joint Forward Plan. She noted that there were previously 24 risks on the framework, but that these had now been mapped to the priorities and any other risks have been moved to the newly created ORR. She added that in September the Board would receive a revised risk framework, and that this would be reviewed by the Audit and Risk Committee before coming to Board. Questions and comments from board members: • HvdW encouraged the ICB to look at the ORR and noted that NHS dental services were a strategic risk and should be mapped with the other primary care risk. He also noted that the ICB's underlying deficit was one of the ICB's biggest strategic risks. • CA commented that with regards to BAF5 that it would be helpful to unpick the point about pockets of deprivation at a future meeting.	

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Committees update and questions from the public		
13.	Report from the Quality and Safety Committee	
	AD noted the new quality dashboard and reported that the committee had recently discussed Martha's rule and received a detailed LEDER report. FS also commended the research and evaluation report, highlighting that 87% of GPs were now research active and the team was hosting £14m of research grants which were directly improving quality and patient care. The report was noted, and the recommendation to endorse and ratify report was agreed.	
14.	Report from the Finance Committee	
	HvdW noted that the committee had discussed the work that was in progress for the next financial year, and that the ICB's Financial Recovery Board was functioning well. The report was noted.	
15.	Report from the Primary Care Commissioning Committee	
	DB noted that the committee was reviewing its risks, in particular it had agreed a new dental risk. She added that the Additional Roles Reimbursement Scheme would now also include community health and wellbeing roles, which would lead to more direct ways to support prevention. FS commented that the BMA ballot to consider collective action should be considered as a significant risk and explained that the ICB was working closely with primary care and the Local Medical Committee. The report was noted.	
16.	Report from the Commissioning and Performance Committee	
	HvdW noted the committee had received a report about learning disabilities and autism which set-out a three year transformation plan. He added the committee was also receiving regular assurance on specialised commissioning. The report was noted	
17.	Report from the Patients and Communities Committee	
	AD explained a working group had been established to help increase the attendance of experts by experience at the committee and to resolve issues that were acting as a barrier to achieving this. AD also highlighted the ongoing work regarding the VCSE sector, North Norfolk Place Board and Population Health Management as set out in the paper. Action: FS to bring a report to the Board on aging well	FS

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18.	Report from the Remuneration, People and Culture Committee	
	CA noted the committee was gaining better oversight on bank and agency spend across the system which was helping to improve system efficiencies. The report was noted.	
19.	Report from the Audit and Risk Committee	
	There was no report from the committee to this Board meeting.	
20.	Questions from the public	
	The Chair noted that one question had been raised on 16 July 2024, however the matter was not in relation to an item on the agenda and therefore a response would be issued and shared on the ICB's website. An additional question was raised by a member of the public attending virtually in regards to a commissioning decision. The Chair agreed that a discussion would be held offline to assist and that the ICB would publish its response.	
21.	Any other business	
	The Chair asked EMT members to think about how the Board could get a more rounded view (through the committees) of what was happening at 'place' level. Action: EMT to agree how to feed 'place' updates through to Board, via committees. AD noted that 'place' was reporting into the Patients and Communities Committee and discussions were taking place with the ICB's Executive Director for Patients and Communities. The Chair noted that it may be helpful if the committees used a consistent style and format for reports to the Board.	EMT
Date, time and venue of next meeting: 1.30pm – 3.30pm Wednesday 25 September 2024 virtually via Microsoft teams.		
Any queries or items for the next agenda please contact: nwicb.corporateaffairs@nhs.net		

Minutes agreed as accurate record of meeting:Signed:
Chair

Date:

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ICB Board Meeting 17/07/2024

NHS Norfolk and Waveney Integrated Care Board (ICB) Register of Interests										
Declared interests of the Board										
Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
Patricia Hewitt	Chair, Norfolk and Waveney ICB	FTI Consulting	X			Direct	Senior advisor, FTI Consulting	2015	Present	Since January 2022 I have not undertaken any work on healthcare or life sciences. Will declare at relevant meetings if a risk arises.
		Newnham College Cambridge			X	Direct	Honorary Associate, Newnham College Cambridge	2018	Present	No conflicts have arisen or foreseen
		Oxford India Centre for Sustainable Development			X	Direct	Chair, Oxford India Centre for Sustainable Development	2018	Present	No conflicts have arisen or foreseen
		ORA Choral Ensemble			X	Direct	Chair, trustees, ORA Choral Ensemble	2020	Present	No conflicts have arisen or foreseen
		Age UK Norfolk			X	Direct	Volunteer, Age UK Norfolk	2020	Present	Declaration of interest made in any relevant conversation
		Future Public Services Taskforce			X	Direct	Member, advisory board, Future Public Services Taskforce, Demos	Sep-23	Present	No conflicts have arisen or foreseen
Catherine Armor	Non-Executive Member, Norfolk and Waveney ICB	Educational Association			X	Direct	Trustee, Workers’ Educational Association	Dec-23	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		Norwich University of the Arts			X	Direct	Deputy Chair of Council, Norwich University of the Arts	2019	Present	
		Evolution Academy Trust			X	Direct	Trustee, Evolution Academy Trust	2022	Present	
		Cambridge University Press Pension Schemes		X		Direct	Trustee, Cambridge University Press Pension Schemes	2018	Present	
		East of England Ambulance Service NHS Trust				Indirect	Daughter-in-law is Technician for East of England Ambulance Service NHS Trust		Present	
		Brundall Medical Practice			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the
Jon Barber	Partner Member - Acute, Norfolk and Waveney ICB	Broadland St Benedicts			X	Direct	Non-executive Director of Broadland St Benedicts – the property development subsidiary of Broadland housing Group	2020	Present	Although risks are minimal this will always be declared as with Trust Board declaration of interests
		James Paget University Hospitals		X		Direct	Deputy CEO of James Paget University Hospitals NHS FT	2022	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Great Yarmouth & Waveney		X		Direct	GY&W Place Chair	Ongoing		
		Acle GP Partnership			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Debbie Bartlett	Partner Member - Local Authority (Norfolk), Norfolk and Waveney ICB	Norfolk County Council		X		Direct	Interim Executive Director Adult Social Services, Norfolk County Council	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.

NHS Norfolk and Waveney Integrated Care Board (ICB) Register of Interests										
Declared interests of the Board										
Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
		Diss Parish Fields			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Tracey Bleakley	Chief Executive Officer, Norfolk and Waveney ICB	Drayton & St Faiths Medical Practice			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Bill Borrett	Norfolk Health & Wellbeing Board Chair	North Elmham Surgery			X	Direct	Registered patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Norfolk County Council	X			Direct	Elected Member of Norfolk County Council, Elmham and Mattishall Division	Ongoing		Low risk. If there is an issue it will be raised at the time..
		Norfolk County Council	X			Direct	Cabinet Member for Adult Social Care and Public Health	Ongoing		
		Norfolk County Council	X			Direct	Chair of Norfolk Health and Wellbeing Board	Ongoing		
		Breckland District Council	X			Direct	Elected Member of Breckland District Council, Upper Wensum Ward	Ongoing		
		Norfolk County Council	X			Direct	Chair of Governance and Audit Committee	Ongoing		
		Manor Farm	X			Direct	Farmer within Dereham patch	Ongoing		
Dr Hilary Byrne	Partner Member - Primary Medical Services	Attleborough Surgeries	X			Direct	GP Partner at Attleborough Surgeries	2001	Present	To be raised at all meetings to discuss prescribing or similar subject. Risk to be discussed on an individual basis. Individual to be prepared to leave the meeting if necessary.
		MPT Healthcare Ltd	X			Direct	Director of MPT Healthcare Ltd	2020	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Norfolk Community Health and Care Trust (NCH&C)				Indirect	Spouse is employee of NCH&C (Improvement Manager)	2021	Present	
		South Norfolk PCN				Indirect	Clinical Director of SNHIP Primary Care Network	2022	Present	
Steven Course	Executive Director of Finance, Norfolk and Waveney ICB	March Physiotherapy Clinic Limited				Indirect	Wife is a Physiotherapist for March Physiotherapy Clinic Limited	2015	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards March Physiotherapy Clinic Limited
Aliona Derrett	Non-Executive Member, Norfolk and Waveney ICB	Norfolk and Norwich University Hospitals NHS FT				Indirect	My son-in-law, Richard Wharton, is a consultant surgeon at NNUHFT	2004	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair. supported by the

NHS Norfolk and Waveney Integrated Care Board (ICB) Register of Interests										
Declared interests of the Board										
Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
		Hear for Norfolk	X			Direct	I am the Chief Executive of Hear for Norfolk (Norfolk Deaf Association). The charity holds contracts with the N&W ICB.	2010	Present	Conflicts Lead and managed in the public interest.
		Derrett Consultancy Ltd	X			Direct	I am the Director of Derrett Consultancy Ltd.	2018	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		Norfolk and Waveney MIND				Indirect	My husband, Robin Derrett, is the HR Director at Norfolk & Waveney MIND. MIND holds contracts with the N&W ICB	2021	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		MoldovaDAR Ltd	X			Direct	I am Director of MoldovaDAR Ltd	Ongoing		Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		St Stephen's Gate Medical Practice			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
Caroline Donovan	Partner Member - Mental Health and Community	Norfolk and Suffolk NHS Foundation Trust	X			Direct	Chief Executive Officer, Norfolk and Suffolk NHS Foundation Trust	2023	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		CMD - Health	X			Direct	Director CMD - Health	2023	2023	Previous role in consultancy with no activity from October 2023
Patricia D'Orsi	Executive Director of Nursing, Norfolk and Waveney ICB	Royal College of Nursing		X		Direct	Member of Royal College of Nursing	Ongoing		Inform Chair and will not take part in any discussions or decisions relating to RCN
David Holt	Non-Executive Member, Norfolk and Waveney ICB	Solebay Health Centre			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Ministry of Defence	X			Direct	Non Executive Director, Audit and Risk Assurance Committee, Ministry of Defence	2022	Present	In the unlikely event that a decision having an impact on either of the declared parties arises, a decision will be made with the relevant chair to assess the risks. Appropriate action will be taken accordingly.
		Newberry Clinic				Indirect	Wife is Consultant Community Paediatrician, Newberry Clinic (Great Yarmouth)	Ongoing		
Stuart Keeble	Director of Public Health and Communities for Suffolk and member elect of Norfolk and Waveney ICB	Nothing to Declare					N/A			N/A

NHS Norfolk and Waveney Integrated Care Board (ICB) Register of Interests										
Declared interests of the Board										
Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
Andrew Palmer	Deputy Chief Executive Officer, Norfolk and Waveney ICB	James Paget University Hospitals				Indirect	My wife works at the JPUH, in a non-decision making role	Ongoing		Any decision relating specifically to the JPUH should ideally be made by the ICB's CEO. However, in their absence the
Emma Ratzer	Partner Member - VCSE	Norfolk & Waveney Integrated Care Board	X			Direct	My employing organisation holds contracts with NWICB	2009	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards Community Access Trust
		VCSE Assembly			X	Direct	I am CEO of a voluntary sector organisation operating in NWCCG and Independent Chair of NWVCSE Assembly	2021	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
Dr Frankie Swords	Executive Medical Director, Norfolk and Waveney ICB	Norfolk and Norwich University Hospitals		X		Direct	Honorary Consultant Physician and Endocrinologist at Norfolk and Norwich University Hospitals NHS FT (1 day a week)	2008	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest
		Multiple patient charities		X		Direct	Ad hoc Clinical Advisor for multiple patient charities - Addison Self Help Group - Pituitary Patient Support Group - Turner syndrome Society	2008	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest
		British Medical Association		X		Direct	Member of the British Medical Association	1999	Present	Inform Chair and will not take part in any discussions or decisions relating to BMA
		Emerging Futures and St Martin's Housing Trust				Indirect	Husband is a mental health counsellor and undertakes work independently and with the private provider Better Help, and VCSE providers: Emerging Futures and St Martin's Housing Trust	Sep-22	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of counselling services by Emerging Futures, St Martin's Housing Trust or Better Help
		Long Stratton Medical Partnership			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Hein van den Wildenberg	Non-Executive Member, Norfolk and Waveney ICB	Lakenham Surgery			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Broadland Housing Association	X			Direct	Non-Executive Director and Board Member for Broadland Housing Association	2024	Present	Will excuse myself from any decisions relating to Broadland Housing Association

NHS Norfolk and Waveney Integrated Care Board (ICB) Register of Interests										
Declared interests of the Board										
Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
		College of West Anglia			X	Direct	Governor at College of West Anglia (Note: the College hosts the School of Nursing, in partnership with QEHKL and borough council)	2021	Present	Low risk. If there is an issue it will be raised at the time.

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NORFOLK & WAVENEY ICB Chairs Action Log - Wednesday 25 September 2024				
Date	Matter	Details of discussion	Decision	Date Reported to ICB Board
25-sep	Multi Storey Car Park (MSCP) BC	The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEHL) new hospital build programme includes a requirement for a Multi Storey Car Park. Details of funding and revenue plans for this element of the build were shared with the Chief Executive, Executive Director of Finance and Chair by email with supporting documentation for consideration.	The Chief Executive and Executive Director of Finance wrote to the Chair on 29 August 2024 via email to advise their joint support for the draft letter of approval for the multi storey car park. Chair then confirmed her support by return on behalf of the Board also on 29 August 2024.	25-sep-24

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NORFOLK & WAVENEY ICB Action Log Part 1 - Wednesday 25 September 2024							
No:	Date of Meeting	Description		RESP	Due Date	ACTION / UPDATE	Status
24	23-Jan-24	Information about system benchmarking against the EDS2 and WRES.	EO to provide the Board with information about system benchmarking against the EDS2 and WRES.	EO	sep-24	Following the EDI board deep dive we will incorporate this action in to a broader action to progress an ICS EDI plan and delivery of the NHSE High Impact Actions. This will come back in Quarter 2. AJ noted that bencharking information EDS2 and WRES data is likely to be published in Sept 2024, with EDI coming to Board to propose refreshed objectives Action to be updated at the meeting Sept 2024.	Open
28	17-Jul-24	ICB Board to receive update on Aging well	Item on Board agenda for Part 1 November meeting	FS	nov-24	Action to be completed at the meeting Nov 2024.	Propose Closure of Action
29	17-Jul-24	EMT to agree how to feed Place updates through to Board, via committees	A session on Place has been added to the ICB Board Deep Dive forward plan.	KB	sep-24	A session on Place has been added to the ICB Board Deep Dive forward plan.	Propose Closure of Action
30	17-Jul-24	Correct Committee Reports to Board Template titles	Consistent and correct titles to be used on Committee Reports to Board	HD	sep-24	Complete and consistent titles used in the September Board Pack	Propose Closure of Action

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Subject:	Chair and Chief Executive's report
Presented by:	Rt Hon. Patricia Hewitt, Chair, NHS Norfolk and Waveney ICB Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney ICB
Prepared by:	Rt Hon. Patricia Hewitt, Chair, NHS Norfolk and Waveney ICB Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney ICB
Submitted to:	ICB Board
Date:	25 September 2024

Purpose of paper:

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

Executive Summary:

The report covers the following:

- A. Independent Investigation of the National Health Service in England
- B. NHS finances
- C. Reducing waits for planned care
- D. Investing in our buildings and equipment to improve people's care
- E. GP collective action
- F. Seasonal resilience and planning for winter
- G. Integrated Performance Report
- H. Engaging with our MPs and the new Government
- I. Appointments
- J. Meetings and visits

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Report

A. Independent Investigation of the National Health Service in England

Board members will have read the 'Independent Investigation of the National Health Service in England' by The Rt Hon. Professor the Lord Darzi. The report describes in detail the challenges the NHS faces and sets the scene for the ten-year plan being developed.

The overriding conclusion is that "the NHS is in critical condition, but its vital signs are strong". The challenges are many and they are significant, but there is also a clear endorsement of the approach we are taking. The analysis reinforces the need to shift from hospital to community, from treatment to prevention, and from analogue to digital, as well as from centralised to local, and from siloed to system. These are all key tenets of our strategy in Norfolk and Waveney.

We welcome the intention to build the ten-year NHS plan bottom-up based on what is already working, as well as the endorsement of ICBs described in the report and the recommendation that there is no top-down reorganisation of the NHS. We look forward to hearing more from the Government as they respond to the report and develop the ten-year plan.

B. NHS finances

The financial position is very challenging. The NHS organisations in our system are collectively £17m behind our plan at month five. The main reason for this is that we are behind with the delivery of our programme of efficiencies for the year, although this isn't the sole factor, for example the last round of industrial action also had an impact. As an ICB we are reporting a breakeven position at month five, although there is significant pressure on our budgets.

We are committed to staying within our agreed budget, as we did last year. It is going to be hard, but the Government and NHS England have made their expectations very clear that there is no extra money for the NHS – we must live within our means. We continue to work with partners to identify and deliver the required efficiencies and productivity increases, while also working to maintain and improve outcomes. Current areas of focus that will deliver quick returns include reducing the length of stay of inpatients, reducing bank and agency staff spend, the standardisation of clinical products and the use of biosimilars. We will continue to keep the Board informed of our financial position.

C. Reducing waits for planned care

The new Labour government has pledged to ensure 92 per cent of patients wait no longer than 18 weeks from referral to treatment within five years, and we are committed to achieving this for residents of Norfolk and Waveney. Partners from across the system have been working on our plan for how we will achieve this.

Since the pandemic we have been successful in tackling the longest waits. Achieving this has been the result of close collaboration between our hospital trusts, making

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effective use of all available capacity, and strengthening our relationships and mutual aid arrangements across healthcare systems. We have a good base to work from.

Our immediate challenge is to ensure that no patients are waiting longer than 65 weeks for planned care. All of our acute hospital trusts are working hard on this with the ICB and system partners. As a system we have just over a 1,000 patients currently waiting over 65 weeks and we are focused on treating these people as quickly as we can, including by sourcing additional capacity from the independent sector. Our efforts will be boosted by the end of the junior doctors strikes, as well as the significant investments we are making in buildings and equipment set-out below.

D. Investing in our buildings and equipment to improve people's care

As Board members will know, the Government has announced a review of the national New Hospitals Programme. We are awaiting confirmation of what that means for the James Paget and Queen Elizabeth Hospitals, but in the meantime over the summer some of the really significant investments we have made in our buildings and equipment have come to fruition. These investments are a vital part of our plans for tackling the waiting lists that built up during the COVID-19 pandemic and for improving people's care.

The first patients are now being treated at the new Community Diagnostic Centre at the James Paget Hospital, increasing the number of Ultrasound, X-ray, CT and MRI scans we can offer. The centre is the first phase of opening up further imaging services for patients, with additional diagnostic centres opening within the James Paget's forthcoming Orthopaedic Elective Hub this autumn and at Northgate Hospital in Great Yarmouth in 2025. A Community Diagnostic Centre will also be opening at the Queen Elizabeth Hospital in October, with a further centre opening at the Norfolk and Norwich early next year.

The new state-of-the-art Norfolk and Norwich Orthopaedic Centre has welcomed its first patients at the Norfolk and Norwich University Hospital. The 50-strong Trauma and Orthopaedics team began treating patients in the centre in July. Some of the most up to date surgical equipment has been provided by the N&N Hospitals Charity, which supported the build with a £2m grant – the biggest single grant in its history.

A new theatres building is also taking shape at the James Paget University Hospital. The new Orthopaedic Elective Hub will operate seven days a week, 50 weeks per year, and will be dedicated to operations such as hip and knee replacements. It will provide enough capacity not only for the hospital's annual planned orthopaedic operations, but also additional cases from across the Norfolk and Waveney healthcare system.

E. GP collective action

As the Board will know, the British Medical Association (BMA) is the trade union and professional body for doctors and medical students in the UK, and on 1 August 2024 the BMA's committee of GPs voted to take collective action. As GPs are self-employed or employed by a practice (and not by the NHS), they can't strike in the same way as nurses and junior doctors have done recently. However, they can take

action which could impact on patients, for example by limiting the number of appointments with patients to the 'recommended safe maximum' of 25 a day.

We prepared for the possibility of collective action over the summer, working with practices and the Local Medical Committee (LMC), as well as the wider system. Since the start of August we have been working closely with practices and the LMC to understand the impact and adjust our response accordingly, and we will continue to monitor the situation carefully.

F. Seasonal resilience and planning for winter

On 16 September, NHS England wrote to systems to confirm the operating assumptions for the remainder of this financial year and plans for winter. The letter includes actions to support people to stay well over winter, primarily through vaccinations, as well as steps to maintain patient safety and experience.

We want to thank everyone again for the incredible efforts that have gone into improving urgent and emergency care in Norfolk and Waveney – together we have made real progress over the past year and this has improved care for our residents. As Board members will have seen, our achievements have been recognised by NHS England and we have progressed out of 'Tier one' for urgent and emergency care and into 'Tier two'. This reflects the sustained improvement in performance and the progress towards the national targets for ambulance response times and the four-hour emergency department target.

As a 'Tier two' system we will continue to receive some national support, however this will be lighter touch than previously. We recognise that there is still more to do to deliver the ambitions in the national recovery plan for urgent and emergency care. We are working hard on this together and ensuring we are prepared for winter.

G. Integrated Performance Report

We are really pleased to let you know that we are going to bring an integrated performance report to the ICB Board meeting in November. This has taken time to develop and will be an important part of our system oversight and leadership. We will of course take share it with providers too so that they can discuss it with their boards.

The performance report will sit alongside all of the work we do to improve the quality of care, as well as our financial management. We know that this financial year will be incredibly challenging – for both the NHS and our partners – and that we will need to transform care while also delivering efficiencies and productivity increases. Having a comprehensive and shared understanding of our finances, performance and quality will support us to do this.

H. Engaging with our MPs and the new Government

Over the past couple of months we have invested time in getting to know our new MPs and engaging with those who were re-elected too. We have met with them as a group as well as some individually. We have also heard more from the new Government, individual ministers and NHS England about plans for the future.

Two weeks' ago, as Chief Executive I attended a leadership event with NHS England and other chief executives, where we were joined by the new Secretary of State. It was the first time that colleagues could remember a Secretary of State meeting with ICBs or commissioner chief executives, which hopefully signals the start of a positive working relationship and recognition of the importance of ICBs.

I. Appointments

There have been two really important appointments made over the summer. Neill Moloney has just started as the new chief executive of the East of England Ambulance Service NHS Trust and Ian Wake has been appointed as Executive Director of Adult Social Services at Norfolk County Council (he is currently the Executive Director of Adult and Health at Thurrock Council, and will take up the role from the end of October). They are both good additions to the system, each with a strong track record, and we look forward to working with them.

J. Meetings and visits

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

As Chair, meetings and visits have included:

- As noted above, Tracey and I have been meeting with our local MPs and new ministers, including the Secretary of State for Health and Social Care.
- I have also had a first meeting with the new Police and Crime Commissioner, Sarah Taylor. We discussed the challenges and opportunities facing health services and the Police.
- I continue to be part of the advisory group for a taskforce established by the independent think tank, Demos, on the Future of Public Services. Our most recent work has been looking funding models.
- Tracey and I paid a really interesting visit to the East Anglian Air Ambulance to discuss how the service has developed and plans for the future.
- Tracey and I also met with the chair and chief executive of Health Innovation East to talk through the support they have provided to Norfolk and Waveney over the past 12-18 months and the areas where we could work together in future.
- I met with Clare Cullens, chief executive of Norfolk Community Foundation, to consider how we could build on the very successful Nourishing Norfolk programme that is now supporting over 31,000 people to access affordable and importantly nutritious food on their doorstep.
- Along with other members of the ICB Board, I attended a session with colleagues from the Queen Elizabeth Hospital about the New Hospitals Programme and the development of the strategic outline case. It was incredibly helpful to have the opportunity to explore the detailed work informing the case. Tracey and I also visited the hospital to meet with board members and governors, which was really interesting and gave us an

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opportunity to talk in person about the plans for the new hospital and much more.

- We both attended the Norfolk Health and Wellbeing Board / Integrated Care Partnership meeting, where we discussed the vital work done by the adults and children's safeguarding partnerships, as well as the excellent work we are doing to join-up services through the Better Care Fund and to address health inequalities through the new strategic framework for action.
- I attended a three-day healthcare conference in Vancouver organised by Beamtree, an Australian-based AI and analytics firm supporting health services, with attendees from the UK, Australia, Canada, Belgium, India, the Netherlands and the US. This provided an invaluable opportunity to reflect on the challenges that healthcare systems are facing in all developed countries and what we can learn from each other. In line with our conflicts of interest policy, I paid my own expenses; Beamtree's hospitality was limited to the conference itself.

As Chief Executive, meetings and visits have included:

- There continues to be a strong focus on our finances and efficiencies, both for the ICB and the system, so I have been involved in a number of regional and local meetings about this, along with other executive colleagues.
- Reducing waiting times for elective care is a priority for the NHS and the new Government, and I have been involved in meetings about this, including a call with Jim Mackey, National Director of Elective Recovery.
- We held the ICB's Executive Management Team meeting in-person and took the opportunity to visit colleagues running our Unscheduled Care Coordination Hub. The service is making a real difference to how we care for people, helping to avoid unnecessarily taking people to hospital. It was recently highlighted in NHS England's guidance about implementing a single point of access as an example of good practice.
- I've taken part in meetings and discussions about Benjamin Court to review and consider the findings of the engagement exercise conducted by Healthwatch Norfolk.
- I joined a meeting with colleagues from Healthwatch Norfolk, Holkham Hall and the Ernest Cook Trust, which provides and funds outdoor learning programmes for children and young people. We discussed how we could help to engage children and young people from underserved communities in nature, using Norfolk's natural assets to improve their mental health and wellbeing.
- I met with Professor Oliver Shanley OBE, who along with Louise Ashley, is covering Catherine Morgan's role as the regional Chief Nursing Officer while she is on secondment. Oliver is supporting the regional team one day per week regarding mental health.
- I am a member of Suffolk's Special Educational Needs and Disabilities Improvement Board. At our most recent meeting we discussed the recent Ofsted report, both the areas highlighted as good practice, as well as the

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steps we need to take to address the areas for improvement that were identified.

- I attended the 'Stars of EEAST 2024' awards ceremony to recognise the outstanding achievements of the ambulance service's staff and volunteers. It was a great event and from an ICB perspective we really appreciate the efforts made by EEAST staff over the last year to reduce ambulance handover delays and improve response times, as well as everything they do for Norfolk and Waveney residents.
- I am also attending the dental summit organised by Healthwatch Norfolk, which will provide an opportunity to hear from some patients, to discuss the challenges we face and to provide an update on the actions we are taking to improve services and people's oral health.

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Agenda item: 09

Subject:	Report from the Patients and Communities Committee
Presented by:	Aliona Derrett, Chair of the Patients and Communities Committee
Prepared by:	Rachael Parker, Executive Assistant - Norfolk and Waveney ICB
Submitted to:	Integrated Care Board – Board Meeting
Date:	25 September 2024

Purpose of paper:

To provide the Board with an update on the work of the Patients and Communities Committee for the period to 25 September 2024

Committee:	Patients and Communities Committee
Committee Chair:	Aliona Derrett, Non-Executive Director
Meetings since the previous update on 17 July 2024	Monday 22 July 2024
Overall objectives of the committee:	- Monitoring and coming back to the 'so what' conversation question during meetings - As part of the deep dive sessions – all presentations and presenters must include – as a result of doing this, what has changed, including experience, outcomes and access. This will be a core focus of the Committee to scrutinise these metrics. - How many people are we reaching/connecting with as part of engagement and co-production activities? - What evidence is there to identify how health inequalities are reducing?
Main purpose of meeting:	To provide the ICB with assurance that it is delivering its functions in a way that meets the needs of patients and communities, that is based on engagement and feedback from local people and groups, and that takes account of and reduces the health inequalities experienced by individuals and communities.

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	To scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care.
BAF and any significant risks relevant / aligned to this Committee:	• BAF01 – Health Inequalities and Population Health Management • BAF05 – Increasing numbers and complexity of the ageing population in Norfolk and Waveney
Key items for assurance/noting:	Update on CYP and Flourish including Neurodiverse Provision: The committee received an update on Flourish – the overarching system ambition for all children and young people in Norfolk and Waveney. The update also included Neurodevelopmental Disorder (NDD) provision and an overview of the existing commissioned services, pilots, and new interventions for neurodiversity. The committee noted that the Joint Forward Plan (JFP) includes some specific ambitions for babies, children, and young people, and a specific workstream has been added to the JFP this year around neurodiverse provision. A system collaborative has been developed with the ICB, Norfolk County Council, NCHC and NSFT and there is a real commitment to work together for children and young people. Key areas of focus for the collaborative include needs associated with neurodiversity and mental health. For NDD it was noted there are lots of different workstreams pulling together to understand what the opportunities are and how can they be delivered, or what the barriers are. The diagnostic backlog is also a challenge but there is a lot of pre (and post) diagnostic support available, and a digital library is currently under construction. Lived Experience Representation Proposal: The committee received a proposal that would see the ICB utilise existing groups and structures to strategically involve lived experience in the ICBs work. In addition, to work more closely with local Healthwatch patient groups to involve people with lived experience in a way that is planned and creates better outcomes for local people. The committee supported the proposal and agreed the engagement needs to be meaningful, and the inclusion of lived experience representatives in deep dives and the early stages of coproduction and having that voice throughout the commissioning cycle will be key. Healthwatch Norfolk Annual Report: The committee viewed a short video that gave a snapshot of Healthwatch Norfolk's work over the past year. The committee commented on the volume of work undertaken during the year and were pleased to learn that many of the recommendations

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	made by Healthwatch Norfolk had been actioned by system providers because of the projects. Healthwatch Suffolk Update: Healthwatch Suffolk provided an update on projects that are focused on or involve Waveney, including: • Ageing in Suffolk – exploring views about getting older in the county to shape and inform the Healthwatch Suffolk annual report. • Spinal care in Suffolk – working with the East of England Spinal Network to explore people’s experiences of accessing help and services for back, neck and spinal issues and conditions in Suffolk. • Elective care and support in Suffolk which will explore people’s experience of waiting for elective care and support in Suffolk. This project is being supported by the James Paget University Hospital (JPUH). • Dementia support in Suffolk – which aims to find out how people’s experiences are sharing future support, including the development of a countywide strategy and future services. Spotlight on: Great Yarmouth & Waveney (GYW) Place Board: The GYW Place Board chair updated the committee on the work of the Place Board. It was noted the Board had good representation from all strategic partners and it has a very clear ambition which is underpinned and driven by a robust understanding of GYW health inequalities. Key workstreams include UEC, transformation, mental health prevention, health equalities, and primary care network development. It was noted that although resources and capacity are tight, the board has a group of willing volunteers to focus on the workstreams. The committee heard about some of the projects the board had been working on including building on some of the work the JPUH is doing as a national pilot site for smoking cessation in pregnant people and patients. Other projects highlighted included: • The issue of vaping in underage people. • Working with Sport England to help the GYW population be more active. • Health Connect Services – supporting individuals to recover following a hospital admission and to prevent a readmission. • Lowestoft Healthy Hearts Programme – focussing on cardiovascular disease (CVD) and healthy hearts. Lowestoft was identified as having some very poor health outcomes, particularly around CVD. The committee commented that the Healthy Hearts programme, which was based on Community Voices findings, was a very good example of where system providers have engaged with people and communities and actions have been taken as a

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	result. The committee was pleased to see the way in which GYW Place Board had embraced prevention and addressing health inequalities. Population Health and Inequalities Board Update: The committee noted the formal process for the procurement of the population health software was well underway, and the ICB Head of Health Inequalities and VCSE Partnering had been appointed. The update also included some examples which demonstrated the scale and scope of some of the projects including 27,000 texts which had been sent as part of the diabetes education programme, the Lowestoft Healthy Hearts Programme, the warm homes initiative, and the weight management initiative. Ageing Well Programme Board Update: The committee received an update on the Ageing Well programme with a particular focus on the dementia workstream. The committee was pleased to note the strong VCSE support for the programme including good representation from the Later Life Network at each of the workstreams, and that specialty advisors had been appointed for ageing well, dementia, and frailty. It was noted the dementia workstream is a long-term project spanning five years. There are seven areas which will be key areas of focus and links with carers, patients, patients with dementia, and key stakeholders will increase to identify what their key priorities are. Ensuring organisations sign up to the Dementia Charter is also a key area of focus. The committee was pleased to hear about carer involvement and engagement. A member of the North Norfolk Dementia Working Group, who attended the committee meeting and is a carer for a family member with dementia, commented that what was most significant was the identification of a pathway and what input is needed by both statutory and VCSE organisations along the pathway, ensuring carers can understand the pathway too so they know where to go at different stages in their journey.
Items for escalation to Board:	None
Items requiring approval:	None
Confirmation that the meeting was quorate:	Yes

Key Risks

Clinical and Quality:

The Committee's Chair is also the Chair of the Quality and Safety Committee so can bring

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	oversight and awareness of both agendas to each Committee as required.
Finance and Performance:	The committee has attendees from the Integrated Commissioning Team to input in relation to provider performance.
Impact Assessment (environmental and equalities):	N/A
Reputation:	The committee is held bi-monthly in public and includes membership from: - Healthwatch Norfolk and Suffolk - VCSE - Health and Wellbeing Boards in Norfolk and Suffolk - Public Health - Primary Care - Place - Health Inequalities Recruitment of Lived Experience representation is in progress
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	The report supports the Patient and Communities elements of the NHS Constitution.
Conflicts of Interest:	Committee member's interests are documented and managed according to ICB policy.

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Agenda item: 10

Subject:	Health and Wellbeing Board and Integrated Care Partnership Committee Report
Presented by:	Cllr Bill Borrett - Chair ICP/HWB
Prepared by:	Steph Butcher
Submitted to:	Integrated Care Board – Board Meeting
Date:	25 September 2024

Purpose of paper:

A report from the Chair to provide the Integrated Care Board with an update on the work of the Health and Wellbeing Board and Integrated Care Partnership from the meeting held on 4th September 2024.

Committee:	Health and Wellbeing Board and Integrated Care Partnership
Committee Chair:	Cllr Bill Borrett
Meetings since the previous update on	4 th September 2024
Overall objectives of the committee:	The Norfolk Health and Wellbeing Board (HWB) and Integrated Care Partnership (ICP) for Norfolk and Waveney play a key role to promote the closer collaboration of the partners across the Norfolk and Waveney Integrated Care System (ICS). They bring together health and social care providers, the NHS, local government, the voluntary, community and social enterprise (VCSE) sector, and other partners. They drive and enhance integrated approaches to address challenges that the health and care system partners cannot address on their own. This includes prioritising prevention, reducing health inequalities, and addressing the wider social and economic factors affecting our communities. The ICP is also responsible for coordinating the development of an Integrated Care Strategy for Norfolk and Waveney . This document is the key strategy for the whole ICS in Norfolk and Waveney. It sets out the challenges and opportunities to improving short- and long-term health and care outcomes.

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Main purpose of meeting:	The meeting held on 4 th September is one of the quarterly meetings of the HWB and ICP to discuss key areas of work for our Integrated Care System.
BAF and any significant risks relevant / aligned to this Committee:	N/A
Key items for assurance/noting :	Health and Wellbeing Board Core 20+ Ambassadors Programme Tracey Williams from the ICB was asked to outline to Members of the Board the Core20plus5 Ambassador programme as the third cohort is now open for expressions of interest. The Core20PLUS Ambassadors programme is an opportunity for those working in healthcare who are actively improving health inequalities and are keen to spread/share their experience and/or further enhance their knowledge and understanding on Healthcare Inequalities They have opened the programme up to local government and VCSE partners and any level of role would gain from the programme. It is a 12-month programme which includes self-directed learning and development to support people in enhancing their knowledge/skills to take action and contribute to healthcare inequalities improvement initiatives and strategies. The ask is that Core20PLUS Ambassadors are actively improving healthcare inequalities at any level (local, ICS, regional or national). Impact and innovative approach are more important than seniority. There is no time allowance or payment associated with the role. Travel expenses will be refunded for required travel to national Core20PLUS Ambassador events. Applications can be made via this Expression of Interest form. The deadline for submissions is 20 September 2024. Further supporting documents to help with applications can be found on Health Inequalities Improvement FutureNHS page, but please note you will have to register (free) to access those in detail. Enquiries about the Core20PLUS Ambassadors Scheme can be directed to england.Core20PLUSAmbassadors@nhs.net

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Retirement

On behalf of the Health and Wellbeing Board and the Integrated Care Partnership, I thanked Debbie Bartlett Executive Director for Adult Social Care, for all her hard work and contribution over the years to the communities of Norfolk and wished her a long and happy retirement.

Urgent Matters Arising

We were informed by the Norfolk Community Safety Partnership that the Domestic Homicide Review for “Sarah” has now been published on the Norfolk Constabulary’s website. This is to enable lessons to be learned and shared as widely and thoroughly as possible to reduce the risk of such tragedies happening in the future. [Please read the statement about the report which highlights its importance.](#)

The **publication of the Domestic Homicide Review report for “Sarah”**, [to read this report in more detail please go to \[norfolk.pcc.gov.uk\]\(https://norfolk.pcc.gov.uk\)](#). An executive summary is also available.

The Constabulary are working closely with the Suicide Prevention Lead for the county on delivering the relevant recommendations, as well as the EDI lead and HR leads.

Norfolk Safeguarding Childrens Partnership (NSCP) Annual Report

This item updated members on the NSCP Annual Report which summarised the local arrangements for safeguarding children. The report provided a comprehensive overview of both the NSCP’s achievements as well as the challenges it has faced during this period.

It covered: Governance and strategic overview; the voice of the child; independent scrutiny; data and performance intelligence; progress against NSCP priorities; learning from local and national Child Safeguarding Practice Reviews; training and workforce development; and funding arrangements.

The NSCP had also produced a Children and Young People’s (CYP) version of the annual report. The Board heard that this was co-produced with CYP and that they showed insightfulness and a data-driven mindset. The NSCP was awarded an All Together Quality Mark in which they were commended for including the views of CYP. Areas of improvement that were suggested included consulting a

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wider variety of children and young people and for it to be more widely distributed.

The scope of the report runs from 1 April 2023 to 31 March 2024.

The Annual review can be found on Page 19 of the committee papers [here](#) and on the NSCP website [here](#).

Norfolk Safeguarding Adults Board (NSAB) Annual Report for 2023/24

The Norfolk Safeguarding Adults Board (NSAB) annual report highlighted the NSAB and the wider partnership's adult safeguarding activity during 2023/24. It was also noted that there was joint working with the NSCP with respects to transition and coverage of safeguarding activity.

The report set out the work to safeguard those at risk of abuse and harm in a very busy and challenging time for all involved within the safeguarding adult's arena; particularly as the legacy from the pandemic, increasing pressure on all systems and the cost-of-living crisis continues to be seen.

The NSAB annual report provided key summaries on adult safeguarding activity covering the following topics:

- Safeguarding Adults Review, findings and recommendations.
- Activity summaries from NSAB's three statutory partners: the local authority, Norfolk Constabulary and the Integrated Care Board.
- NSAB's key achievements during 2023/24.
- Review of the business plan.
- NSAB's website and social media.

The Board heard that the conversation around safeguarding was moving from being 'everyone's business' to being 'everyday businesses. NSAB had taken up opportunities to raise the profile of Norfolk through a collaboration with the Durham Safeguarding Board.

The Annual report can be found on Page 75 of the committee papers [here](#) and will be available shortly on the NSAB website [here](#).

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Better Care Fund Annual Report, the BCF 2023-2025 Submission and the Market Sustainability return (MSIF) - Review of Core Schemes

The BCF is a nationally mandated programme, launched in 2013 with the aim of joining up Health and Adult Social Care services, to support people to manage their own health and wellbeing and live independently. Delivered locally under a statutory requirement of HWBs, it is jointly prepared and delivered by Local Authorities and NHS partners. The BCF comprises four funds, the minimum (Core) NHS contribution, the improved BCF (iBCF), Additional Discharge Fund (ADF) and Disabled Facilities Grant (DFG).

It has been acknowledged that overall delivery of the BCF has improved joint working between Health and Social Care across the system.

At the end of the year 2023-24, we successfully delivered against three key metrics: Avoidable Admissions, Discharge to Normal Place of Residence and Reablement. Whilst Urgent & Emergency care pressures remained high, services such as Network of Escalation Avoidance (NEAT) team, community urgent care response and Community Support service, all contributed to Admission Avoidance figures with improved support from multi-disciplinary teams and the Voluntary Sector, within communities.

During the year the joint NCC and ICB BCF Team carried out a review of all the services funded through the core BCF. Schemes were assessed against the BCF criteria, national and local priorities. The report findings were presented at the last Board meeting and recommendations will be implemented in the coming months.

The updated plan for 2024-25 includes no major changes from the two-year plan that was agreed in 2023.

We ended the year as planned with a balanced budget with three of the five key national metrics being met. The in-year review demonstrated the positive impact the BCF is having across Norfolk and the End of Year report acknowledges that the BCF has improved joint working between Health and Social Care in our system.

The Demand and Capacity reporting set out the plans to ensure capacity in Health and Social Care services to meet the demands of people being discharged from hospital and those identified in the community as needing additional support to avoid an unnecessary hospital admission. The

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plan had been jointly planned with Officers responsible for the Market Sustainability and Improvement Fund (MSIF).

The Market Sustainability Improvement Fund (MSIF) was announced as part of the autumn statement in November 2022. The primary purpose of the fund is to support local authorities to make tangible improvements to adult social care services in their area, with a particular focus on building capacity and improving market sustainability

As part of the requirements for this funding, every Local Authority must produce two returns. The first is a report that covers spend information including how the MSIF has been allocated against the three target areas. This report also requires a high-level summary of key information related to how this funding is being spent and impact. The second is a Capacity Plan, where Local Authorities are required to submit qualitative and quantitative data on capacity within the Adult Social Care market. This includes projections concerning capacity in 2024-25 and an assessment against this.

The production of the capacity plan was cross referenced against information returned, as part of the Better Care Fund (BCF). This included information on the measures that were put in place during winter 2023 to 2024, to ensure there was sufficient capacity across the social care markets and how successful these measures were.

The submissions can be found [here](#) on page 127 of the committee papers.

The Board agreed to sign off the BCF 2023/24 End of Year Report, the BCF submission for 2024-25 and endorse the work of the Market Sustainability Improvement Fund (MSIF) and how the funding has been allocated against the target areas, identified as part of the grant requirements and priorities for Adult Social Care.

Norfolk Health Protection Assurance Board Report 2024

The Board heard an overview of the Health Protection Assurance Board and an update on local health protection assurance arrangements.

Health protection is an integrated approach to infectious diseases and environmental hazards to health. Post pandemic, the refreshed Health Protection Assurance Board (HPAB) covers the wider breadth of health protection issues for the county of Norfolk, providing assurance to the Director

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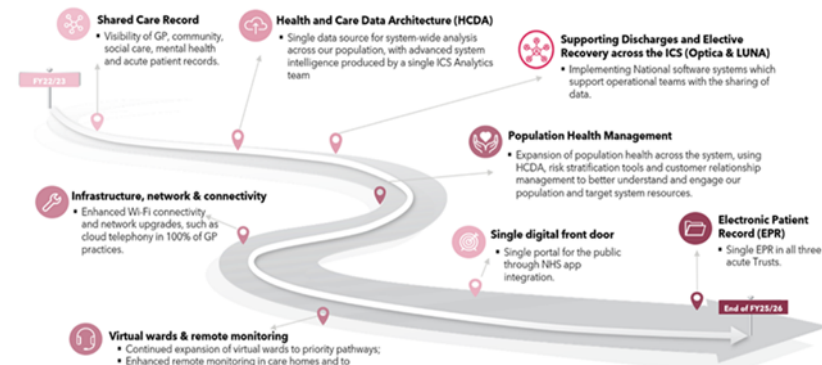
	of Public Health that robust health protection systems are in place. The Covid-19 Pandemic highlighted the importance of preventive measures and systems that can respond to emergencies. The scope of the HPAB includes vaccinations, screening, environmental threats to health, infectious disease prevention and control, antimicrobial resistance and healthcare associated infections. Members heard that the Board includes representation from local councils, the UK Health Security Agency, NHS England, Norfolk and Waveney Integrated Care Board and the Laboratory Medicine and Eastern Pathology Alliance. The importance of vaccinations, screening, and handwashing was highlighted to members It was noted about the low uptake of Whooping cough vaccinations across Norfolk and Waveney, and it was confirmed that women may not be aware of the vaccine and also that it was required to be had during every pregnancy. The system organisation was a factor, and that work was being done to make it easier to get vaccinations. Members discussed barriers to vaccinations generally and heard of the initiatives to encourage uptake. This included a recall contact system where people would be directly contacted to arrange a convenient time to have the vaccination. A greater focus on health inequalities is planned for the coming year. The Board agreed to receive annual reports from the HPAB. Integrated Care Partnership Driving Integration through Digital, Data and Technology including Digital Inclusion This was an update on the work that had progressed on the Electronic Patient Record (EPR) and Shared Care Record (ShCR) since the last update in June. It also provided an overview on how we are working collectively as a system to tackle digital inclusion.

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The ICS Digital Transformation Roadmap remains unchanged since last presented but is included here again for ease of reference

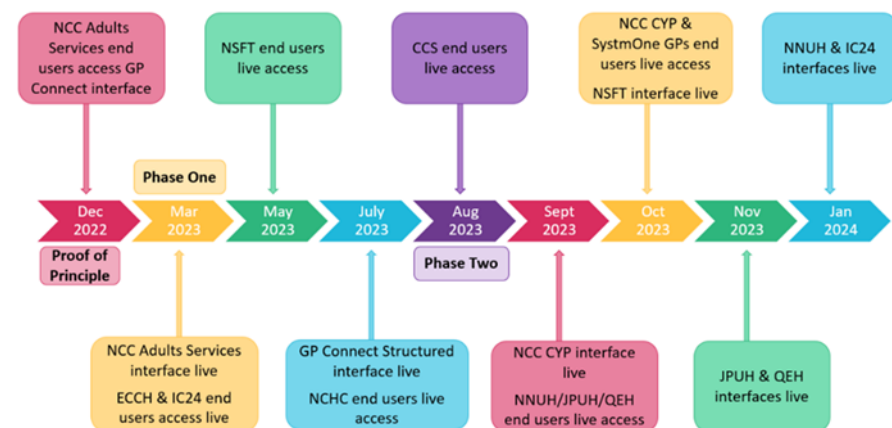
Digital Transformation Strategic Roadmap

Digital will enable transformation across all care settings, including outpatients.



The ShCR system has developed incrementally over time to include more partners providing data feeds and consuming the data.

ShCR Delivery Phases 1 and 2



The following organisations can access the ShCR:

- East Coast Community Services : Trust Wide
- Norfolk Community Health and Care: Trust Wide
- Cambridgeshire Community Services: All Norfolk and Waveney Services
- Norfolk and Suffolk Foundation Trust: Trust Wide
- Norfolk and Waveney Primary Care: All System One practices & All EMIS practices
- Norfolk and Norwich University Hospital: Trust Wide
- The Queen Elizabeth Hospital: Trust Wide

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	• James Paget Hospital: All front door services – full roll out in progress • Integrated Care 24: All Norfolk and Waveney Services • Norfolk County Council – Adults: All Norfolk and Waveney Services • Norfolk County Council – Children’s: All Norfolk and Waveney Services *Please note access is correct as of April 2024. We heard that the Full Business Case for the EPR has received Treasury approval. The new system, worth £88million, will benefit patients across Norfolk and Waveney. The EPR will enable the acute hospitals in Norfolk and Waveney to change the way they operate The new EPR’s (for both Acutes & MH) will grant health and care professionals instant and secure access to the information they need, precisely when and where they need it With this information we will have a greater level of data insights that we need to run an effective integrated care system and understand the needs of our citizens and move towards managing geographic, demographic and disease specific populations The new solution is planned to launch in 2026 and will transform acute hospital healthcare by storing patient information electronically and streamlining communication between patients and staff. It also provides an overview on how we are working collectively as a system to tackle digital inclusion. The Digital Inclusion programme has had many significant achievements since its launch including: ➤ Securing over £900,000 of external funding. ➤ Refurbishing and gifting over 2400 devices since 2022. ➤ Launching a successful laptop loaning scheme from our libraries with over 1300 loans since August 2023. ➤ 97.51% of properties now have access to Superfast broadband and 60.27% Gigabit capable broadband. ➤ 1500 plus residents supported with free or subsidised connectivity by way of SIM cards, mi-fi devices and refurbished smart phones.

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- Implemented a successful staff digital skills onboarding programme for new staff which is now mandatory with over 770 plus new staff members trained to date. Feedback from staff and managers has been excellent.
- Adult Learning have supported 5194 learners with digital skills course.
- 2200 plus young people have attended Digital Technology Events.
- 3400 small businesses and self-employed have been supported through Go Digital and our Business and Intellectual Property Centres based in our libraries.
- Our Silktime WCAG 2.1 AA compliance score now stands at 98.2%.
- Ongoing communications to staff, customers, residents, and partners about the digital switch in light of the UK's telephone network upgrade and potential impact on those who use technology that are reliant on analogue telephone connections.

Following a successful bid for funding in 2023 through the Norfolk Investment Fund, an innovative proof of concept pilot was launched. The pilot service was called Tech Skills for Life – West Norfolk. This was a place-based approach working with residents and partners in the local community to improve access to and use of technology. It has surpassed all targets and expectations as far as the metrics go

Since launching Tech Skills for Life we have been successful with a bid for funding to the Department of Health and Social Care Accelerating Reform Fund. This has enabled the pilot to continue and expand during 2024/25. We have doubled the team to eight community Tech Coaches and expanded to cover North Norfolk, Great Yarmouth and Waveney and some parts of Breckland such as Thetford and Swaffham. West Norfolk is still being covered.

There is an ambition to roll the Tech Skill for Life scheme across other areas of the county. The areas with the highest need for connectivity and skills would be prioritised. The rollout will be dependent on funding.

Members noted the difficulties that can occur when accessing websites on a mobile and suggested that we encourage website layouts across our system that are optimal for mobile usage.

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It was also confirmed that a lot of work was being carried out to understand the impact of the landline telephone digital switchover and that communications had gone out to raise awareness about the changes. There were data sharing agreements with telephony providers to share the details of vulnerable people to help with the switchover.

It was agreed to note the updates on the progress taken around the collaboration as a system and raise any potential gaps or priorities to further inform the plan; Review, comment, and advise on the potential impact and actions which are being taken to support digital inclusion in the county and consider how as a partnership we can continue to raise awareness of the digital switch for our vulnerable residents.

It was also agreed to give further consideration on how we can obtain permanent funding in order to make the Digital Inclusion offer into a business-as-usual service.

Health Inequalities Strategic Framework for Action

We received an overview of the proposed governance and oversight arrangements to implement the Health Inequalities Strategic Framework for Action (Health Inequalities Framework).

An Operational Coordination group has been established to support the implementation of the Strategic Steering Groups.

We were provided with the arrangements for the Strategic Steering Group to oversee implementation, as well as the leadership groups:-

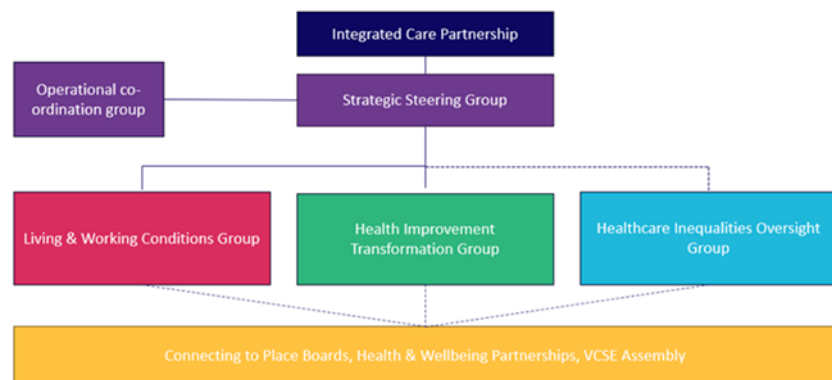
Living and Working Conditions Group - This is a new group, formed and developed as result of the Health Inequalities Framework. A workshop was held on Friday 2nd August which facilitated discussion around principles, roles and responsibilities, membership, and programme management and Senior Responsible Officer capacity.

Health Improvement Transformation Group (HITG) - This group existed prior to the development of the Health Inequalities Framework, having been formed to build collaboration around primary prevention activity. The Senior Responsible Officer for primary prevention and Chair of this group is the Director of Public Health, NCC. The ICB Clinical

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Lead for Healthcare Inequalities and Inclusion Health acts as Vice-Chair.

Healthcare Inequalities Oversight Group (HIOG) - This group existed prior to the development of the Health Inequalities Framework, having been formed to oversee and support the work in the system around healthcare inequalities, as well as initially oversee the development of the Framework itself. This group has agreed to take a leadership role for healthcare inequalities, with a particular emphasis on the implementation of the Core20plus5 health improvement frameworks and the five priority actions outlined in NHS operational planning guidance. The Senior Responsible Officer for healthcare inequalities has been agreed as the ICB Executive Director for Patients and Communities. Healthcare Inequalities Oversight Group (HIOG) is Chaired by the ICB Clinical Lead for Healthcare Inequalities and Inclusion Health, and Vice-Chaired by the joint Deputy Director of Public Health for NCC and Associate Director for Population Health Management for the ICB.



These groups will support and enable the system to agree priority outcomes and drive change in the agreed priority areas of:

- Living and Working Conditions (i.e. the wider determinants of health),
- Lifestyle Factors (i.e. primary prevention),
- Healthcare Inequalities (i.e. avoidable differences in access to care and outcomes) and
- Creating the Conditions for Success (i.e. underpinning structures to enable delivery).

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	October 2024. The system is not starting from scratch and the governance arrangements seek to coordinate the efforts of the system. It was agreed that there would be delegation to the Strategic Steering Group to approve proposed governance structures and Terms of Reference as they develop. The ICP is to receive regular progress updates from the new ICP Health Inequalities Strategic Steering Group and that representation from partner organisations within the governance structures will be determined with a view to having local council, Voluntary Community and Social Enterprise (VCSE) and NHS provider representation distributed across the structure Driving Integration through system wide training opportunities update Norfolk and Waveney ICS recognised the need to provide opportunities for system wide leadership and training programmes. This report provided an update on current activities taking place within the Integrated Care System (ICS) and highlighted progress on the Joint Learning, Leadership and Development/Education updates that were identified as further areas for development. Apprenticeships: Norfolk County Council (NCC) have put in place a procurement framework that can be accessed by NHS and other public sector organisations including district councils in Norfolk and Suffolk. There is also a portal that allows NHS organisations to share their levy with other providers in the system. In the future, joint training needs analysis/delivery of apprenticeships could be achieved. NCC, alongside Broadland and South Norfolk Councils, built on the success of the 2023 local government work experience pilot by delivering the scheme in 2024, with twenty Year 10 students from mainstream schools across Norfolk attending. The next steps will be to develop a proposal for a Norfolk Graduate Management Scheme as part of a wider Early Careers Strategy that is under development. Opportunities to engage with partners to identify potential for collaboration and alignment of strategies will form part of this development work. Social Care and Health Sector Skills Plan: The Social Care and Health Sector skills plan will ensure social care and health's needs are represented in the wider skills ecosystem

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in Norfolk and Suffolk. It has already enabled strategic links with initiatives such as the Local Skills Improvement Plan and DfE-funded Skills Boot Camps and will enable effective working with colleagues planning the anticipated devolution of the Adult Education Budget. It prepares Norfolk to work with the National Workforce Strategy for Adult Social Care (launched in July 2024) to leverage it for Norfolk's needs and to effectively roll out the new Adult Social Care and Development Fund, which replaces the Workforce Development Fund

The Health and Care Academy and careers pathways programme: Norfolk and Waveney Integrated Care Board (ICB) have convened the Norfolk and Waveney Careers Faculty to co-ordinate and allow system wide oversight of a range of initiatives that are designed to support the local population in Norfolk and Waveney to engage with employment and volunteering in the Health and Social Care sector

Care Workforce Pathway for Adult Social Care: Published in January 2024 the pathway sets out an incremental route to build skills and experience for the adult social care workforce. In conjunction with the Adult Social Care and Development Fund, it includes provision for hundreds of thousands of training places to be made available, and a new Care Certificate Level 2 qualification, with the aim to have this become the baseline standard for all new care and support workers. By spring 2025 a digital skills passport will be introduced and a website to support workforce with information on careers linked to the pathway being developed.

Norfolk and Waveney Primary Care Connect NoW: The ICB's new Primary Care intranet will launch in October 2024 and will aim to revolutionise the communication dynamics between the NWICB and Primary Care. This innovative solution is designed to combat the challenge of duplication and establish an efficient, centralised platform for swift access to all necessary information. The solution aims to enhance the visibility of crucial information and ensure that all important content is effectively highlighted and accessible for stakeholders to self-serve content anytime anywhere. This is currently being piloted for primary care providers, but the ambition will be to expand to other NHS and system partners where feasible.

A systemwide approach to leadership development: The work on leadership development which forms part of the

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“Improving Lives Together (ILT)” HR services programme in the ICS continues to progress to plan.

NHS Digital Skills passport: Initial conversations are taking place with the ICB innovation team and with the ICS clinical education forum about developing a skills passport between NHS organisations in the first instance, with a view to confirming a minimum viable product that can potentially be developed for third party users.

The Collective Resilience Programme: aims to develop a methodology and a set of resources to allow ICS partners to enhance their wellbeing approach.

Restorative Just Culture programme: A training programme for the Restorative Just Culture initiative has been designed in collaboration between NHS (corporate and clinical) Health and Social Care, Voluntary Community and Social Enterprise (VCSE) and County Councils. The training package will be linked with key programmes of work such as the NHS People Plan, the national Patient Safety agenda and the County Council Quality Programme and will be formally rolled out across ICS in late 2024

Oliver McGowan Training: the ICB-led Oliver McGowan Mandatory Training steering group have scoped the workforce numbers to be trained for tier 1 and tier 2 face to face training, with tier 1 due to commence in the Autumn

Cross Sector training platform (learning management system): some initial conversations have taken place with ICB colleagues in central Norfolk about the desirability of a multi-agency training platform, but funding, resource and capacity are formidable barriers. The challenge of working across organisations with broader workforce remits than health and social care also needs to be considered.

The ICP was also asked to consider the following challenges for our system:

- Work is focused on and shaped by NHS partners, with some social care and County Council input. This could be strengthened by input from VCSE, district or other stakeholder involvement, and would allow the development of a system forum for collaboration on OD initiatives in which all stakeholders are represented.
- There are several wide-ranging initiatives across the system, driven mainly through local, system or national requirements. The approach would be

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	strengthened by an overarching strategic plan that supports integration across all system partners. • Whilst some of the initiatives described above are currently funded through pre-existing arrangements, the financial challenges facing all partners mean that limited progress is likely for the foreseeable future on key strategic approaches. • Whilst there is an ambition to pool and share learning resources, it is proving challenging to put this into practice. It was noted that this was an opportunity to look at training in a new way and explore the different opportunities to provide training. Members considered the ongoing activities and the joint approaches being taken and to endorse the initial conversation to scope out the development of a system “skills passport.” Full copies of the all the Papers and Minutes can be found here Dates for your diaries: - The ICS Conference on 16th October 2024. Please respond to your invitations if you have not already done so. The next formal meeting of the Norfolk Health and Wellbeing Board and Integrated Care Partnership will be at 09:30 am Wednesday 4th December 2024, this meeting is livestreamed on YouTube on the Norfolk County Council channel, or you can watch from the public gallery if you are not a member. I look forward to seeing you all then.
Items for escalation to Board:	N/A
Items requiring approval:	N/A
Confirmation that the meeting was quorate:	Yes

Key Risks

Clinical and Quality:

N/A

Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	N/A
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A

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Agenda item: 11

Subject:	Report from the Commissioning & Performance Committee
Presented by:	Hein van den Wildenberg
Prepared by:	Liz Joyce, Head of System Transformation
Submitted to:	Integrated Care Board – Board Meeting
Date:	25 September 2024

Purpose of paper:

To provide the Board with an update on the work of the Commissioning and Performance Committee for the period 22 May to 25 September 2024.

Committee:	Commissioning and Performance
Committee Chair:	Dr Hilary Byrne, Deputy Chair Hein van den Wildenberg
Meetings since the previous update on 22 May 2024	Meeting held in private on 18th July 2024 0900 – 1130 via MS Teams. Meeting on 19th of September 2024 will be after ICB Board meeting papers are distributed. Key points from this meeting will be shared verbally at the Board meeting.
Overall objectives of the committee:	To make financial decisions / recommendations about business cases for commissioning and decommissioning, within the value of its delegated responsibilities as set out in the terms of reference. This forum is where decisions will be made about commissioning, other than for primary care which has its own committee. To consider and make decisions on clinical policies as recommended by the Clinical Policy Development Group.

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	To consider and make decisions on recommendations from the medicines optimisation programme board. To oversee and gain assurance on the operational arrangements that support the commissioning of services. Oversee the process of any further delegation of commissioning responsibilities from NHS to the ICB. Provide oversight to the Individual Funding Request panel. Conduct and lead the oversight of NHS system and commissioned provider performance, directing improvement resources and ensuring learning is implemented. This includes coordinating with regulators where formal improvement is required. Ensure that innovation, best practice, evidence and evaluation and the impact on health inequalities consistently informs our commissioning decisions. Approve the application of the Provider Selection Regime process for the procurement of any business cases that it approves under its delegation.
Main purpose of meeting:	The Committee exists to provide assurance and oversight and make decisions (within its delegations) on the commissioning and performance of services to ensure better outcomes for the population of Norfolk and Waveney. It will also consider the management of risk in all its work.
BAF and any significant risks relevant / aligned to this Committee:	The following risks are the responsibility of this Committee, which will be making commissioning decisions and managing performance: BAF05 – Barriers to full delivery of the Mental Health Transformation Programme BAF07 – System Urgent & Emergency Care (UEC) pressures BAF08 - Elective Recovery These are the risks that are part of the reviewed BAF, signed off by the ICB public Board in July, and aligned to the 8 ambitions in the Joint Forward Plan. The risk rating has reduced for BAF05 and the Committee wanted to understand why. This will be picked up at the next meeting.

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Key items for assurance/noting:

1. The Committee further reviewed its' ToR's and they are brought here today to the ICB Board for sign off. The changes are summarised at the front of the ToR template but the main changes are to the membership and to reflect the development of a Scheduled Care Board which will directly feed into this Committee and streamline the flow of reporting. The ToR will be reviewed again in March 2025, when a new NHS 10-year plan is expected to be published (tbc).
2. The Performance Dashboard was reviewed for the second time but was not significantly different to previous in terms of the data. The focus is on key metrics for urgent care, elective care, cancer, and mental health with the development of a supporting a narrative ready for the next Committee meeting. The feeder groups have a role to monitor the detail and escalate as required. In terms of escalation and highlight reporting the following key areas were discussed:
 - **Elective:** against the target of zero patients waiting more than 78 weeks by end of June QEH achieved this, JPUH missed it by 18 patients and NNUH by c200. Industrial action during June has had an impact.
 - **Cancer:** performance has been mixed across different types of cancer pathways at the three hospitals. Performance against the Faster Diagnosis Standard (FDS) was not consistent at the NNUH for the breast cancer pathway, but it has stabilised now. The national FDS was introduced to speed up cancer diagnosis and improve patient experience.
 - **Mental health:** concerns were raised around using our crisis houses more effectively and the ADHD and neurodevelopment pathway.
 - **Autism:** the Committee heard about the new service purchased from The Owl Centre to reduce the current waiting list for adult autism assessments in central Norfolk. The Centre will support circa 170 assessments within the next few months which will make a good inroad into the size of the overall waiting list, but with circa 1,000 patients waiting more than 18 weeks we need to do more. The autism pathway is being reviewed N&W wide and will be recommissioned from April 2025.
 - **Urgent & Emergency Care (UEC):** we remain in tier 1 and UEC is still a challenge for our system. The number of walk-in patients to the A&E

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	departments is higher than forecast. Length of Stay in acute hospitals is improving but once patients move into an acute or MH setting the length of stay seems to be relatively high so this will be a focus. The work being undertaken in the central Urgent Care Co-ordination Centre was commended, and the improved take up of virtual wards. N&W UEC team is working with the regional team on the New Models of Care workstream that is focussed on Urgent Care Co-ordination Hubs. 3. The internal audit report on Performance was brought to the Committee for information and five key areas highlighted. These suggestions will be taken forward with the support of the new VSM Commissioning Manager and team. 4. The NHSE Head of Acute Specialised Commissioning attended the meeting and presented a report on N&W specialised services. Whilst not a new risk, mechanical thrombectomy is a regional risk and the challenges of setting up a service at NNUH were discussed – both capital and staffing. The Aseptic paper was approved by the Committee which supports the development of a business case to have a new aseptic unit at QEH, one of two across the eastern region. 5. The decommissioning process and checklist was tabled. The ICB will be looking well ahead, reviewing contracts at least 6 months in advance of their expiry. The June prioritisation outcome report was tabled which generated further discussion about several specific projects on the Red, Amber, and Green lists as to why they scored what they did and where they interrelate to other Groups / Boards and decisions being made so we join the discussions up. 6. There were several updates from feeder groups and some escalation: ➤ A termination of pregnancy service re-procurement is underway. ➤ The sustainability of Covid medicines for clinically vulnerable patients remains a concern, with the requirement to make this business as usual but with no additional funding. ➤ The development of an integrated dermatology service across the three hospitals was noted and there was a request to ramp up the pace on this if possible.

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	➤ Cataract providers are not adhering to the service specification and the Committee was asked to note this and support the ICB with improving adherence. ➤ Weight management and lack of a tier 3 service was discussed, as this precludes referral to a tier 4 service. This is a high-risk area and work is being undertaken to mitigate this. ➤ A report from the Medicines Management Group highlighted financial challenges in relation to obesity and diabetes drugs. ➤ Provider funding matters were raised which would need to be part of commissioning intentions next year. 7. The New Models of Care work was referenced, and the Committee was asked to consider the strategic alignment and fit of this to other work, and how to influence this at a regional level, noting that N&W is involved in the UEC workstream of this already.
Items for escalation to Board:	None
Items requiring approval:	None
Confirmation that the meeting was quorate:	Yes. The Deputy Chair chaired this meeting.

Key Risks	
Clinical and Quality:	None
Finance and Performance:	None
Impact Assessment (environmental and equalities):	Not completed
Reputation:	None
Legal:	None
Information Governance:	None
Resource Required:	Not discussed
Reference document(s):	N/A
NHS Constitution:	None
Conflicts of Interest:	None

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Agenda item: 12

Subject:	Annual Report and Accounts for NHS Norfolk and Waveney ICB 2023/24
Presented by:	Tracey Bleakley, Chief Executive Officer
Prepared by:	Amanda Brown, Head of Corporate Governance
Submitted to:	ICB Board
Date:	25 September 2024

Purpose of paper:

To present the second Annual Report and Accounts for the NHS Norfolk and Waveney Integrated Care Board for the period 1 April 2023 to 31 March 2024

Executive Summary:

In accordance with the national timetable the ICB is pleased to present the first Annual Report and Accounts for the NHS Norfolk and Waveney Integrated Care Board (ICB) for the period 1 April 2023 to 31 March 2024.

The Annual Report and Accounts is a key document for the organisation. It sets out the objectives and achievements as well as how the organisation has complied with regulatory requirements and guidance. The document also reports on how money has been spent.

The ICB's external auditors audited the financial statements and confirmed that they gave a true and fair view of the respective financial positions. The external audit reports can be found at the end of the Annual Report and Accounts.

The document was submitted to NHS England to meet the national deadline of 28 June 2024.

The Annual Report and Accounts can be found on the ICB's website [here](#) from 23 September 2024 when the document is formally published. This meets the requirement to hold a public meeting to present the ICB Annual Report and Accounts.

A Summary Annual Report of the ICB document has also been produced and is also available on the Website.

David
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Recommendation to the Board:

The Board is asked to note the Annual Report and Accounts for NHS Norfolk and Waveney Integrated Care Board for the period 1 April 2023 to 31 March 2024.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	The Annual Report and Accounts is a key document setting out the work and responsibilities of the organisation. It is audited by external auditors.
Legal:	Production of an Annual Report and Accounts is a statutory requirement. The document is prepared in accordance with the Department of Health and Social Care Group Accounting Manual guidance.
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	Reviewed by the Audit and Risk Committee 20 June 2024 and approved by the Board on 26 June 2024 for CEO signature.

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NHS Norfolk and Waveney Annual Report

1 April - 31 March 2023-24

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PERFORMANCE REPORT

Performance overview

The purpose of this overview is to provide sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives, and how it has performed during the year.

There is further detail in the Performance Analysis, Accountability Report, and Accounts sections.

Chief Executive Officer and Chair's statement

Welcome to our Annual Report and Accounts for 2023/24. This report sets-out our achievements and the performance of the organisation over the past year, as well as the challenges we've faced and what we need to focus on next.

Of course, in an Integrated Care System, our achievements belong to the whole health and care system, and the challenges we face can and will only be tackled by us working collaboratively with partner organisations.

The way the system has worked together over the past year has been very positive, however we have always said that our success should be judged on whether we are making a real difference to people's lives, and over the past year we have had some important successes. For example:

We have worked as a system to improve ambulance handovers and response times: As a result of changes introduced at our hospitals, patients are now spending much less time waiting in ambulances when they arrive at one of our hospitals. This in turn is enabling our ambulances to quickly get back on the road and to the next person who needs help.

We have made changes to help ensure people are getting the right care, at the right time and by the right person: RightCareNoW is a programme of work that has helped improve the way people are discharged from hospital back into the community, and reduced the number of people in our hospitals who have no medical reason to be there and could be better cared for in their own home or another setting.

We have made it easier for people to get support for their mental health and wellbeing in their community: There are now seven family hubs in place to support parents and children, as well as ten mental health support teams working in our schools. To support adults, we now have five wellbeing hubs across Norfolk and Waveney, and mental health practitioners and recovery workers working alongside GPs so people can be seen and get help quicker.

We have taken action to keep people healthier, to prevent problems and to treat conditions early: For example, we have increased the number of people receiving targeted lung health checks, to help identify and treat lung cancer earlier. We have also increased support and set-up a new service at our three hospitals to reduce smoking during pregnancy, as this helps to reduce the chance of miscarriage, stillbirth, low birthweight and other conditions.

We are making a difference and there are many more examples of where we have made progress described in the annual report. Our progress is being recognised by others too, including by NHS England, as demonstrated by their decision to move Norfolk and Waveney into segment three of the National Oversight Framework and out of the Recovery Support Programme, or what was formerly known as "special measures".



While this is of course positive, we know we have a lot to do as a system to ensure we are consistently providing the right the level of care. The next year will have its own challenges, there's more we need and will be doing to improve the quality of and access to care, to prevent people getting ill and to intervene early when they do, and to support and grow our workforce, all of which we will need to do while living within our means.

We want to thank everyone who works for the ICB for everything they have done over the past twelve months to improve the health, wellbeing and care of local people. We know it has been a challenging year with our organisational review and restructure; we appreciate the professionalism and continued dedication that colleagues have shown throughout.

More widely, we wish to extend our gratitude to health and care staff and our voluntary sector colleagues across Norfolk and Waveney for their hard work and resilience over the past year, particularly during periods of industrial action and heightened demand for services.

We look forward to the year ahead and to continuing to make progress against our mission: to help the people of Norfolk and Waveney to lead longer, healthier and happier lives.

Rt Hon. Patricia Hewitt

Chair of NHS Norfolk and Waveney

Tracey Bleakley

Chief Executive Officer
NHS Norfolk and Waveney

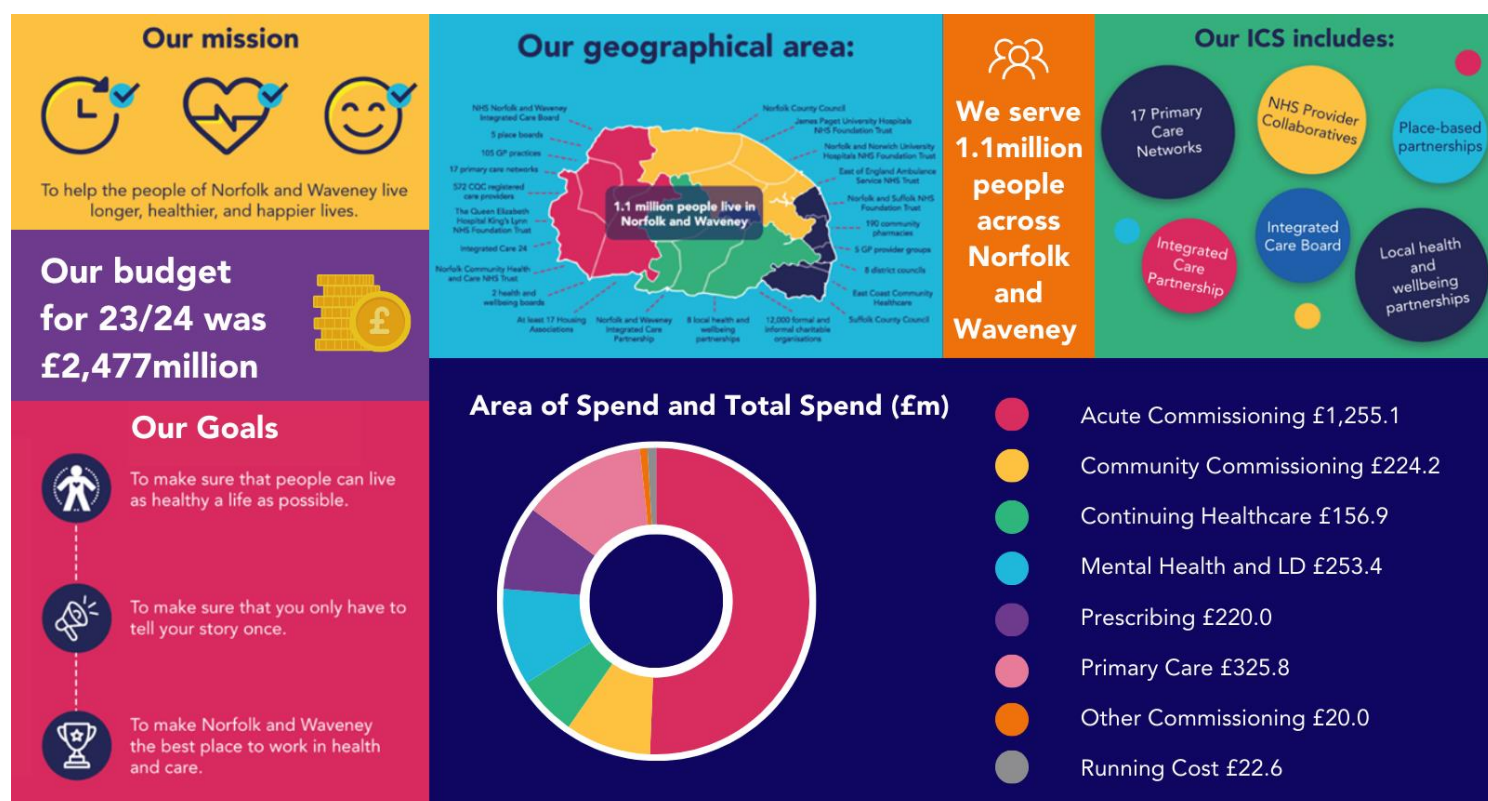
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Purpose and activities of the organisation

[NHS Norfolk and Waveney](#) is responsible for planning and buying safe, high quality health services. NHS Norfolk and Waveney agreed and administers contracts with hospitals, community services, the mental health trust, GP practices, dentistry, pharmacy, optometry, the ambulance trust, and other organisations who provide care and treatment services, and monitored the performance of the delivery of these services.

As a result of the Health and Care Act 2022, NHS Norfolk and Waveney is responsible for the budget for the whole of the NHS landscape across Norfolk and Waveney.

2023-24 At a glance



Structure of NHS Norfolk and Waveney

NHS Norfolk and Waveney plans and buys healthcare services for local people and communities. We are accountable for the performance and finances of the NHS across Norfolk and Waveney – a total budget of £2 billion a year. We work with local people, health and care professionals, and partner organisations to improve the health and wellbeing of our population.

The organisation is part of the Norfolk and Waveney Integrated Care System. A system dedicated to working with partners in local government, the voluntary sector and others and helping the NHS to support broader social and economic development and to tackle inequalities in health outcomes.

There are four pillars of our ICS which broadly bring organisations together:

- NHS
- Local Government
- Social Care Providers and Voluntary, Community and Social Enterprise (VCSE)
- Our staff, people and communities

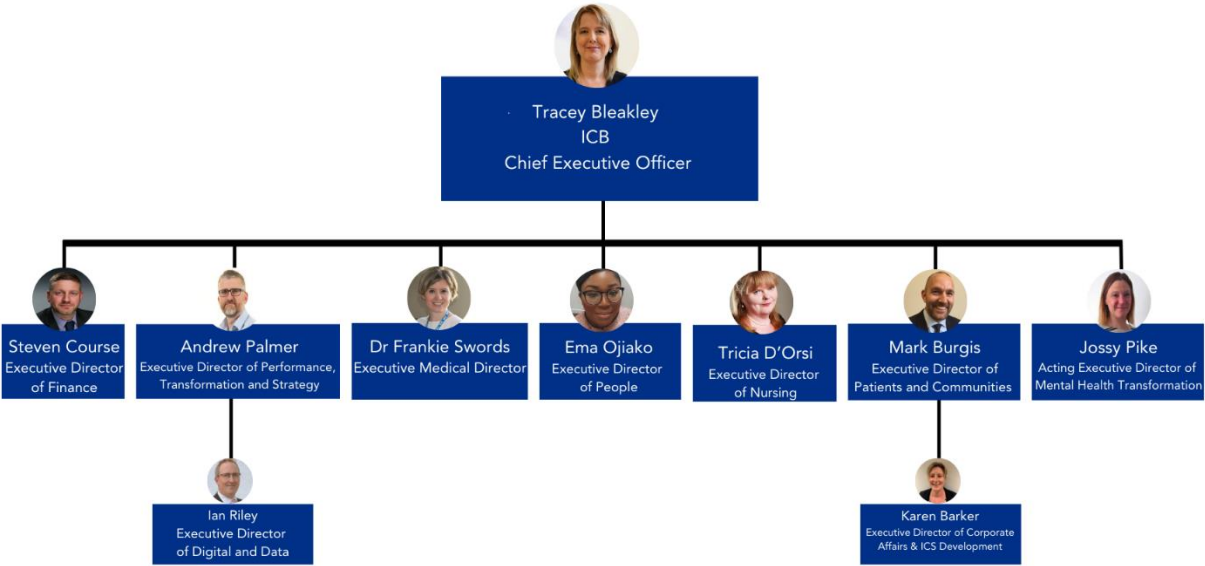
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Integrated care is about giving people the support they need, joined up across local councils, the NHS, and other partners including social care providers, voluntary and community groups, social enterprises, charities and local communities. Integrated care involves partnerships of organisations that come together to plan and deliver joined up health and care services to improve the lives of people in their area.

NHS Norfolk and Waveney also supports 105 Member Practices, grouped into Primary Care Networks (PCNs) (see map above), and more information on PCNs is available at [Primary Care Networks - Norfolk and Waveney](#).

Operationally, NHS Norfolk and Waveney is led by the Chief Executive Officer and a team of Executive Directors who, along with other senior colleagues, meet regularly as an Executive Management Team.

A [diagram of the Executive Management Team](#) is below. The organisation is also supported by a number of other colleagues, officers and Non-Executive Members (NEMs) who support decision making across our organisation. These roles can be found on in the Accountability Report.



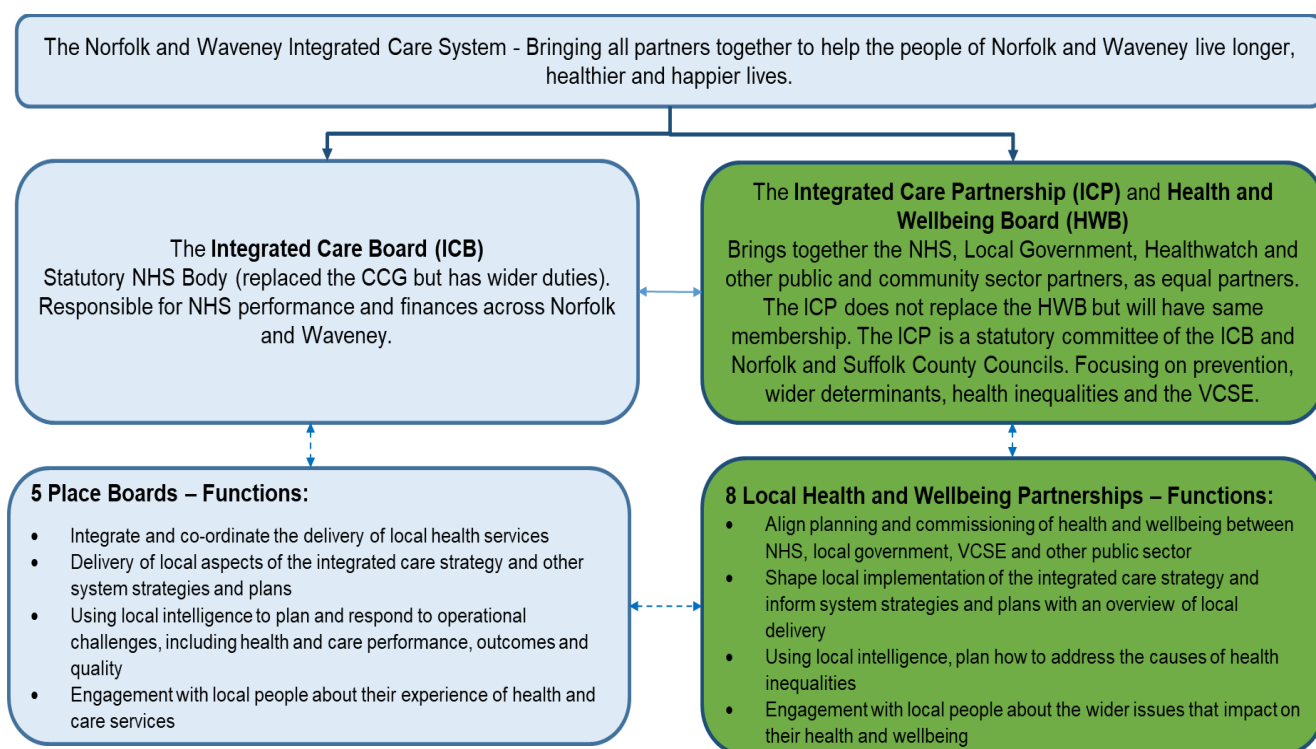
Integrated Care Partnerships. Locally these two elements perform the following core functions:

- The [Integrated Care Board \(ICB\)](#) is responsible for the strategic development, funding, and health commissioning activities for the partnership.
- The [Integrated Care Partnership \(ICP\)](#) is responsible for integrating the care system with the wider public and charitable sector and has statutory responsibility for developing the strategy to address health inequalities. An overview of the ICP and links to the early Integrated Care Strategy can be found later in this report.

NHS Norfolk and Waveney, along with its wider system partners have a clear vision and set of common goals for improving the health, wellbeing and care of people living locally, and has developed the right relationships between the different parts of the health and care system to enable the ambitions of the ICS to be realised.

More information can be found at [Norfolk and Waveney Integrated Care System \(ICS\)](#).

The diagram below provides an overview of the Norfolk and Waveney ICS and describes how each component links and works together.



The goals of the Norfolk and Waveney ICS

The ICS has three overarching goals:

- 1. To make sure that people can live as healthy a life as possible** - Preventing avoidable illness and tackling the root causes of poor health to reduce health inequalities across our area.
- 2. To make sure that you only have to tell your story once** - Services must work better together so that key information doesn't have to be repeated to every health and care professional.
- 3. To make Norfolk and Waveney the best place to work in health and care** – Supporting staff development and wellbeing will improve the working lives of our staff, and mean people get high quality, personalised and compassionate care.

The ICS vision is to help ensure that our staff, people and communities across Norfolk and Waveney can lead longer, healthier and happier lives.

To help drive this vision, in November 2022, the Norfolk and Waveney Integrated Care Partnership agreed its [first Integrated Care Strategy](#). The strategy is an important high-level framework for the system and has four themes: Driving integration, prioritising prevention, addressing inequalities and enabling resilient communities.

It sets out the challenges and opportunities which can best be overseen by the [Integrated Care System](#) and looks beyond traditional organisational boundaries at complex, long-term issues which need collaborative approaches to succeed.

The strategy is designed to influence the strategies in our Health and Care system, including the [Integrated Care Board five-year Joint Forward Plan](#) as well as [Place Boards](#) and [Health and Wellbeing Partnerships](#).

Also embedded within our decision making and a fundamentally important part of our ICS is working with our VCSE sector. Norfolk and Waveney has an established VCSE Assembly, which is Chaired by Emma Ratzer. Emma sits on the Board of NHS Norfolk and Waveney and works with us and the wider VCSE sector to ensure we work together at every opportunity.

Linked to the goals and ambitions of the Norfolk and Waveney Integrated Care System are eight ambitions, which can be found in the Performance Analysis section of this report.

In summary, our system goals, themes and ambitions are interlinked as follows:



Key Risks and Issues

NHS Norfolk and Waveney was proactive in identifying and managing risks and issues that might adversely affect its plans or business.

Key risks to performance were formally logged on the NHS Norfolk and Waveney Board Assurance Framework (BAF) document, which was reviewed by the NHS Norfolk and Waveney management teams and committees and was reported to The Board of NHS Norfolk and Waveney at each meeting. The latest BAF can be found on page 367 of the [March 2024 NHS Norfolk and Waveney Board papers](#).

For each risk identified there are mitigating actions identified and provided to the Board of NHS Norfolk and Waveney with assurance that they are being managed.

During 2023-24, several key issues and risks recorded on the Board Assurance Framework (BAF). These included:

- System Urgent and Emergency Care pressures risk impacting on patient assessment and care, timely discharge from hospital and ambulance congestion.
- The risk that East of England Ambulance Trust (EEAST) response times could potentially lead to significant risk of patient harm.
- Potential structural (RAAC roof and wall plank) failure at the Queen Elizabeth Hospital (King's Lynn) and James Paget Hospital (Great Yarmouth).
- Financial pressures risk impacting on ability to deliver current levels of service in 2023-24.
- The risk that mental health services provided by Norfolk and Suffolk NHS Foundation Trust (NSFT) do not meet the required standards, leading to risk of poor patient experience, delays in treatment or services, and clinical harm.
- The impact of the pandemic and cost of living crisis has created unprecedented demand for mental health services with current system capacity and models of care being very challenged.
- Risks linked to timely cancer diagnosis and treatment.

Performance summary

The following section provides a summary of the Performance Analysis. Further details about performance and a more detailed look at the work of NHS Norfolk and Waveney can be found from page 8.

NHS England announced in March 2024 that the Norfolk and Waveney ICB is no longer under the oversight of the NHS Oversight Framework (NOF) segment 4 and has been successfully removed from the Recovery Support Programme (RSP), previously known as "special measures".

The Norfolk and Waveney ICB was placed into the national RSP in August 2021 due to challenges in quality, performance, and finances. This programme offers a collaborative, system-focused approach to support providers and systems facing significant difficulties.

Following a sustained period of improvement, NHS England has endorsed the decision to transition the ICB from segment 4 (mandated intensive support) to segment 3 (mandated regional support). This transition reflects notable progress in quality, urgent and emergency care (UEC) performance, and financial stability. However, it's acknowledged that there remains ongoing work to embed these advancements and ensure their sustainability.

The following performance analysis provides a snapshot of some of the key issues, challenges and achievements that have been made, along with a summary of programmes of work that will continue into 2024-25.

Performance analysis

NHS England has a legal duty, as set out in the Health and Care Act 2022, to undertake an annual assessment of Integrated Care Board (ICB) performance. NHS Norfolk and Waveney ICB's Annual Assessment for 2022/23 noted significant evidence of the ICB having put in place the foundations of leadership, partnership working, governance and delivery focus to deliver against its core functions with substantial progress already being made across many responsibilities.

This annual report goes into detail about the issues and challenges NHS Norfolk and Waveney, along with the wider ICS face, but also, a great deal of progress that has been made over the last 12 months.

Performance of NHS services

Information about the overall performance of services is contained in the table and information below.

The table below shows an overall RAG (Red / Amber / Green) performance against constitutional targets, based on an average summary of monthly performance during 2023/24.

Green indicates that all targets were achieved, Amber that some targets were achieved, and Red that no targets were achieved.

Davey Heidi
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A detailed summary of performance of these indicators is provided under each ambition area of this report.

Constitutional Area	23/24 Performance RAG	Unknown Metrics * See Detailed tab
Cancer Waiting Times	0 / 3	
Diagnostics Waiting Times	0 / 1	
Referral to Treatment Waiting Times	0 / 3	
A&E Waits	0 / 2	
Ambulance Response Times	0 / 6	
Ambulance Handovers	0 / 3	1
Mixed Sex Accommodation	0 / 1	
Cancelled Operations	0 / 1	1
Mental Health	4 / 6	
Patient Safety	0 / 3	3
Community	1 / 1	

NHS Norfolk and Waveney, along with ICS partners is working to deliver eight core Ambitions which are those that are in our published Joint Forward Plan.

Services within NHS Norfolk and Waveney are grouped under these ambitions. The performance analysis for NHS Norfolk and Waveney aims to showcase how services performed in alignment with the priorities.

Ambition one – Population Health Management, Reducing Inequalities and Supporting Prevention

Population Health Management

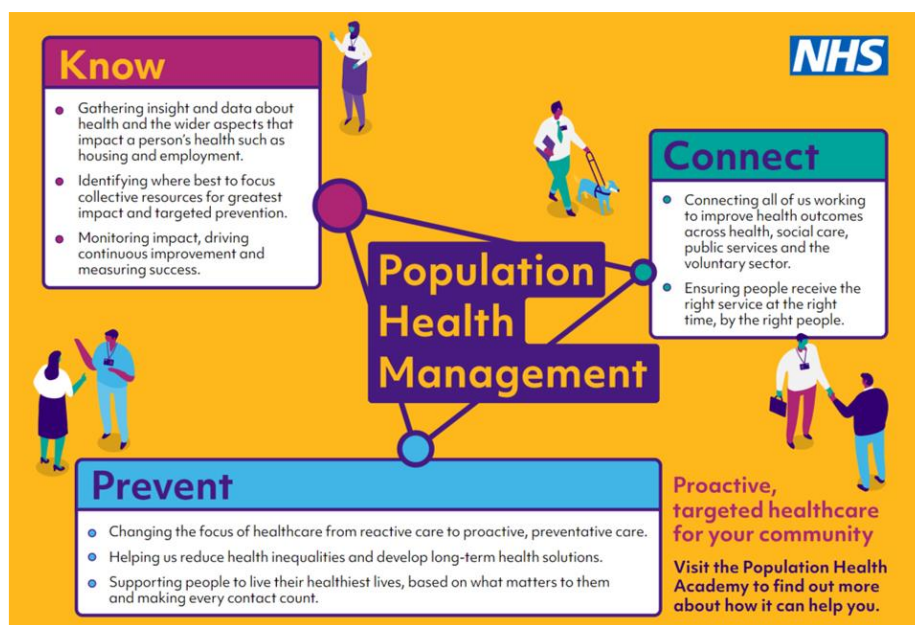
In 2023/24 NHS Norfolk and Waveney developed a new Population Health Management (PHM) Strategy, informed through a series of stakeholder engagement events. This document can be found on our ICS website [here](#).

This strategy sets out our approach to use joined-up data and information to identify and understand the health and care needs of our population. This approach will lead to opportunities for improvements and establish targeted interventions to support these.

Through a prevention lens, the strategy prioritises health inequalities and collaborative working to improve health outcomes and empower professionals to help people live well.

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Figure 1: Population Health Management – Know, Connect, Prevent
Source: [FutureNHS. HM messaging framework 2023](#)



Over the past year, the PHM team have supported several improvements as part of the Protect NoW programme of work. Protect NoW is a collaboration between NHS organisations, local authorities, the voluntary sector and independent partners. It comprises of a growing number of projects, each focused on proactively optimising physical and/or mental health and wellbeing.

Key PHM projects for 2023/24 have included:

Priority Patient Review

The Priority Patient Review initiative aimed to address rising unplanned hospital admissions and pressure on primary care by targeting patients with the highest reversible risk of admission. Implemented from November 2022 to March 2024, the pilot project collaborated with multiple General Practices. Three clinical pathways were identified based on high-risk data, utilising primary care information and risk stratification techniques to identify patients who would benefit from specific tests or care processes. General Practices received regular reports on their most at-risk patients to facilitate proactive reviews and action plans aimed at improving patient care and reducing adverse outcomes. Evaluation of the pilot project is ongoing.

Diabetes Digital Structured Education

Working with the ICB Planned Care diabetes team, this pilot project commenced in January 2024 in the Great Yarmouth and Waveney area. It involved reaching out to people diagnosed with type 2 diabetes via an SMS text message. Patients were given the offer of a digital pathway where they can self-manage their condition and reduce the risk of future complications. Due to the success of this initial pilot, which demonstrated significant uptake in engagement with digital education, this pilot is now being rolled out across Norfolk and Waveney and will be extended to include people with type 1 diabetes.

Diabetes Digital Weight Management Programme

The Diabetes Digital Weight Management Programme (DWMP) offered support to adults living with obesity who also have diabetes and/or hypertension, to manage their weight and improve their health. Commissioned by NHSE and working with the ICB Planned Care team, 32 General Practices took part in the project between June 2023 and March 2024. The Protect NoW team promoted the DWMP initiative to eligible patients via letter, SMS text messages and motivational interviewing via phone. This work resulted in an eight-fold increase in people participating in the DWMP and, in terms of national benchmarking, has seen NHS Norfolk and Waveney moving from the bottom quartile to the highest performing ICS by a considerable margin.

Other PHM projects supported in 2023/24 included:

- **Active NoW Phase 2 – West Norfolk**- a project to increase physical activity for patients at risk of diabetes and hypertension through referral to the Active NoW programme.
- **Dementia - North Norfolk** – supporting people affected by dementia, raising awareness of services they can access, including offering contact with authority partners relating to Housing support, benefits and finance advice, equipment, social activities, mental and physical health support, and carers support.
- **Warm Homes - Great Yarmouth and Waveney**- to reduce the impact of cold homes and fuel poverty on vulnerable people (60 plus or under 10) who have chronic respiratory ill-health.
- **NHS Talking Therapies (IAPT) Phase 2** – proactively identifying people who would benefit from this support, including people aged over 65 years and people vulnerable to falls.
- **Lowestoft PCN** - proactively identifying people with mental health and other health conditions to increase resilience and self-care, involving health and wellbeing coaches/care coordinators.

More information about these projects and others are available on the [NHS Norfolk and Waveney website](#).

The development of the new PHM strategy and the ongoing programme of work has been led by a Clinical Steering Group and overseen by the PHM Oversight Group (PHMOG), reporting to the Population Health and Inequalities (PHI) Board. The multi-agency membership of these groups is overseeing the implementation of the PHM strategy and the establishment of the infrastructure needed to deliver it.

Reducing Health Inequalities

NHS Norfolk and Waveney is committed to reducing health inequalities and supporting equality and inclusion. It recognises and has implemented all legislation relevant to its role and functions including the Equality Act 2010, meeting statutory Human Rights legislation; the Equality Delivery System (EDS); the Workplace Race Equality Standard (WRES); the Modern Day Slavery Act; and the Equality Impact Assessments (EIAs) and Equality Analysis.

In November 2023 NHS England's statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006) was published. You can read the statement [here](#).

Good progress has been made towards publication of key information on health inequalities and we are developing a Norfolk & Waveney Health Inequalities Dashboard that aligns with the statement data requirements and our Health Inequalities Strategic Framework for Action. This has been undertaken with support from our colleagues in Business Intelligence and Population Health Management, using our extensive data hub which provides an excellent range of resources. We have worked closely with NHSE and other ICB's in our region when developing our response to the statement. This is to ensure that we are aligned with the data NHSE will request to enable the ICB's to look at regional patterns and trends, together with data that is bespoke to Norfolk and Waveney and important for our local decision making, especially at Place level. Oversight of the statement will be through the Population Health and Health Inequalities Board and through the programme of work in collaboration with all our NHS providers in Norfolk and Waveney that will come together in our Health Care Inequalities actions as we implement our Health Inequalities Strategic Framework for Action.

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Health Inequalities Strategic Framework for Action

In 2023/24 the whole system worked together to develop our [ICS Health Inequalities Strategic Framework for Action](#). An extensive engagement programme was developed and implemented which ensured over 100 organisations across the system were part of our 'Health Inequalities Conversation' and had the opportunity to input and help shape the Framework.

Through attendance at Place Boards, Health and Wellbeing Partnerships and numerous VCSE forums, as well as via a number of system workshops and engagement events, the Framework was co-developed with local government, VCSE and NHS partners. The Community Voices programme, which works with trusted communicators in our VCSE sector, also asked some of our most vulnerable and underserved communities what matters to them, and we engaged with people with lived experience.

The vision for the Health Inequalities Strategic Framework is that the system will come together to tackle unfair and avoidable differences in health outcomes between residents. We will do this by listening to communities, prioritising prevention, and taking action together, making health inequalities everybody's business.

It will adhere to the following guiding principles:

- ✓ Everyone needs something, some people need more.
- ✓ Enabling communities to have a voice is key and requires creativity and persistence.
- ✓ We will work as close to people and communities as possible.
- ✓ We want to achieve the right person, the right action, at the right time.
- ✓ We strive for accessible services for those in greatest need.
- ✓ We know we can make a difference, and this is a long-term commitment.
- ✓ Leading for change requires shared responsibility and enduring focus.
- ✓ Understanding who is accessing our services, who isn't and why in order to act.
- ✓ Recognising the building blocks for good health and wellbeing are not just in health services.
- ✓ Building fairer services means supporting change in our organisations.

The Framework will act as a catalyst for change; it includes a clear call to action to come together and take collaborative, as well as organisational level action. It also includes actions that can support and empower communities to take action themselves. These actions include considerations around community voice and coproduction, taking intelligence and data led action, and ensuring we have the policies, processes and procedures in place to tackle health inequalities in everything that we do. the Framework requires a whole-system commitment, we must continue our Health Inequalities Conversation, and drive further action.

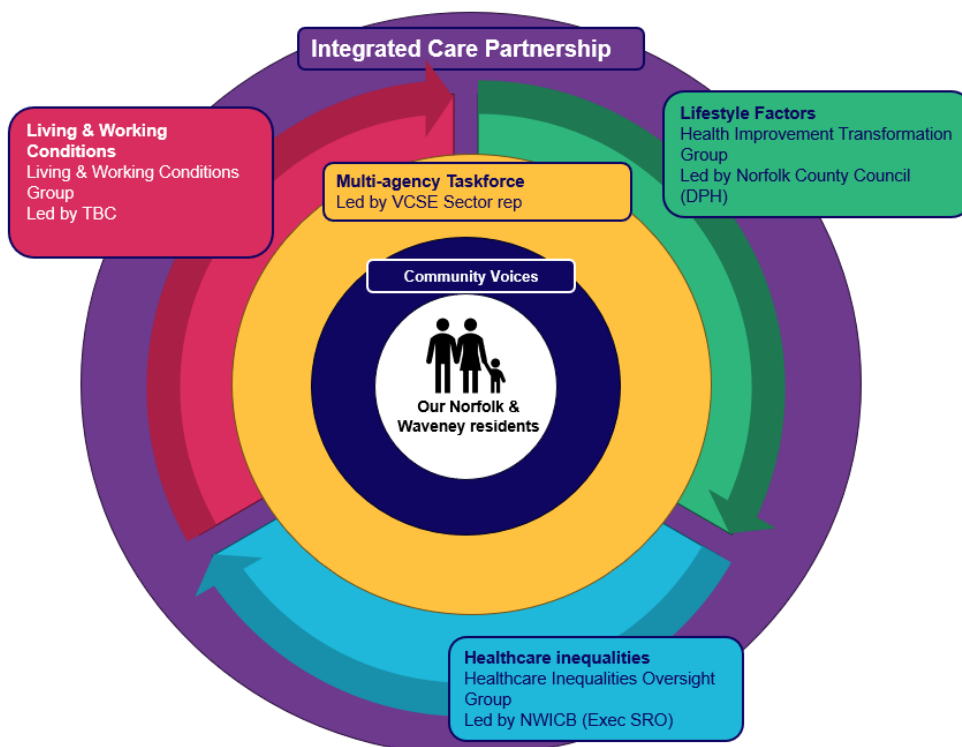
In order to develop the Framework we defined a clear scope, recognising the wider determinants of health, and have defined the Core20plus population groups for Norfolk and Waveney.

The Framework commits the ICS to a focus on **3 building blocks for action** as well as strengthening our foundation to **create the conditions for success**, as described in the image below.

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An initial 10 actions have been identified in the Framework, which will be overseen by a multi-agency Taskforce. Each building block has its own governance arrangements, with the ICB leading the action around Healthcare Inequalities via the Health Inequalities Oversight Group (HIOG) reporting to the PHI Board.



HIOG continues to meet and has overseen the development of the Framework, as well as continuing to oversee existing work programmes that seek to deliver on key local and national strategic objectives, such as Core20plus5, the NHSE five urgent actions, and ensuring compliance with the NHSE Statement on Information on Health Inequalities.

Some examples of health inequalities work are included below:

Community Voices

The Community Voices programme works with trusted communicators in the VCSE sector and local government organisations to engage communities that experience health inequalities. Initiated during the pandemic, this programme seeks to improve access to services with a focus on the 5 clinical priorities of the Core20plus5 health improvement frameworks. Through training of trusted communicators, we improve health literacy in communities, and we record and analyse the insights gathered around barriers and enablers to influence and support future service design and strategic decision making via a central insight bank. In the last 12 months Community Voices has:

- Delivered 8 projects, including bowel cancer screening, smoking cessation, refugee and asylum seeker health, asthma in children and young people, healthy hearts (CVD) and on focusing on diversity in research participation aligned with the Research Engagement Network (REN) programme).
- Gained insights from over 1,500 residents that experience significant health inequalities and recorded these on the central insight bank.
- Worked in partnership with 40+ VCSE and local government organisations.
- Provided training to 52 trusted communicators, such as Making Every Contact Count (MECC) and behaviour change, COM-B and smoking, asthma risk and management, CVD and cancer signs, symptoms and screening.
- Read a [Community Voices case study](#)

Wellness on Wheels (WoW)

Access to vaccination was identified as a barrier to increasing uptake in areas of deprivation and for inclusion health groups. Therefore, the WoW bus operates across Norfolk and Waveney supporting underserved communities and Core20plus populations access health interventions/screening. This is supported via access and inequalities funding by the vaccine team.

The bus provides services such as Stop Smoking support, sexual health self-testing kits, seasonal vaccinations, NHS Health checks and much more.

The WoW programme works in partnership with the voluntary sector and district councils in all places/localities to meet the needs of the local population, taking a Population Health Management (PHM) approach and making every contact count.

Partnering was essential to increase engagement and trust with communities that have a historical mistrust of the NHS and other governmental organisations. This bus provides an opportunity to reach into those communities that do not access health and care in more traditional ways or who are underserved by fixed delivery models. Sites have included local supermarkets, market events and other local community events. There have been Winter wellness neighbourhood events in Norwich and in coastal towns such as Great Yarmouth there have been family themed events.

Inclusion Health

Inclusion Health is a priority for Norfolk and Waveney ICB as these communities are a key part of the Core20plus NHS England approach to reduce Health Inequalities. Over the last year the number of asylum seekers and refugee communities in the ICS has increased due to the number of contingency hotels and growing number of dispersal properties, the majority of which are within the Norwich boundary. These asylum seekers and refugees are all registered at a local GP surgery, but also receive support from a number of other organisations and projects such as the Asylum Seeker Healthcare team and offer of Measles, Mumps and Rubella (MMR) vaccinations on the Wellness on Wheels bus.

Since the beginning of 2024, the ICS has been working with statutory organisations supporting Gypsy, Roma and Traveller communities to bring the WoW bus to a number of sites across Norfolk

and Waveney. There have been a range of identified areas of need such as access to MMR vaccinations, Mental Wellbeing support and will be developing the variety of services offered as the knowledge of the community requirements improves. This is an ongoing project which is recognised that it will take time to fully engage with these groups but there is a longer-term agenda to build a trusted relationship whilst improving outcomes for these communities.

Wellness Hubs development

Castle Quarter Wellness Hub has been part of the National Complete Care Community Programme (CCCP) which is a national learning programme. There has been engagement with the Norwich PCN and Norwich Health and Wellbeing Partnership to build an integrated offer to the local community. Initially the hub offered COVID-19 vaccinations providing over 32,000 vaccines and has also been offering a range of services to support access to wider health support, lifestyle, and wellbeing advice along with welfare support which also includes NHS Health Checks and MMR vaccinations.

A second Wellness Hub has been established in partnership with ICB Immunisation Team and the Queen Elizabeth Hospital based in Conduit Street Kings Lynn. This was launched November 2023 and has given over 24,000 COVID Vaccines. They also offer a range of services to support access to wider health support, lifestyle, and wellbeing advice as well as welfare support including NHS Health Checks

Place-based approaches to reducing health inequalities

In **Great Yarmouth** the Warm Homes project identified clinically and socially vulnerable residents that may be eligible for welfare and financial support through the Household Support fund. Its aim was to positively impact on exacerbations of chronic respiratory ill health caused by living in cold homes and fuel poverty. The ICB Protect NoW team proactively sent out 720 letters and followed up with telephone calls. They signposted to key links on wider welfare and health support and made appropriate referrals to the Community Hub at Great Yarmouth Borough Council (GYBC). 115 referrals made to GYBC Community Hub for Household Support fund and welfare support.

In **West Norfolk** a place has been secured on the Marmot Place Programme. A 'Marmot Place' is a place which has a significant commitment to tackle health inequalities through action on the social determinants of health. The Institute of Health Equity^[1], established by Professor Sir Michael Marmot, has supported over 40 Local Authorities to become 'Marmot Places', through a process of analysis, reporting and implementing recommendations, that typically runs over a two-year period. Being part of the programme enables access to expert advice and guidance, mentoring and facilitation in developing partnerships that are better equipped to face the complex challenges associated with tackling health inequalities, supporting a culture shift that means that health inequalities is part of everybody's business and learning from an ever-growing network of Marmot Places that provide peer support.

In **Norwich**, as part of seasonal planning, a Winter Wellness on Wheels campaign took place visiting GP surgeries, community venues and schools in our most deprived neighbourhoods between Nov 2023 and March 2024 offering a range of advice and support to help people impacted by the cost-of-living crisis. With its focus on reducing inequalities, the INTERACT service continues to provide integrated support for people whose housing or home environment is negatively impacting on their health and wellbeing alongside Safe and Habitable Homes, the tenure neutral offer for people who are experiencing hoarding and/or self-neglect. Hosted by Norwich City Council, both projects are delivered by cross-sector, multi-agency teams including housing, health, social care and VCSE partners.

In **North Norfolk** a partnership programme is underway to further understand the impact of coastal erosion on health and wellbeing. RIPPLE, which is funded by UEA Health and Social Care Partners,

^[1] Institute of Health Equity information accessible [here](#)

works alongside the Community Voices programme and Community Connectors in North Norfolk district council to engage communities and give voice to coastal communities, one of our Core20plus population groups. These insights will be utilised to support the development of future intervention.

Supporting prevention

Active NoW

Active NoW is a multi-agency partnership programme that works with partners in the Active Partnerships (Active Norfolk and Active Suffolk), Public Health, all 8 district councils and the VCSE sector to provide a single point of access to physical activity for health professionals.

The programme is targeted at Core20 plus populations who are inactive and at risk of, or living with, long term conditions. Initially focus has been on integrating the programme into diabetes, CVD, falls and SMI pathways with work now underway to align with Musculoskeletal (MSK) transformation.

Launching in January 2023 the programme has received over 4000 referrals in its first year, a quarter of which reside in our Core20 most deprived populations and 27% of participants reporting to have a disability. Main reasons for referral include MSK, hypertension, diabetes, obesity and mental health. Of those who took up physical activity (70%) a total of 69% report an increase in physical activity levels after 6 months. 92% reported increases in fitness, 86% increases in health, 78% increases in condition management, 80% increases in wellbeing and 44% increase in socialising.

Vaccines

NHS Norfolk and Waveney Immunisation Team has continued to lead the roll out of the vaccination programme across the health and care system during 2023-24, working with partner organisations across the Norfolk and Waveney ICS, there has continued to be a focus on vaccine inequalities with a population health management approach to improve take up in our most underserved communities.

The NHS COVID-19 vaccination programme facilitated a local transformative approach whilst engaging with communities. The ICB and the wider health and care system have continued to deliver holistic, person-centred, preventative care, via flexible teams that span primary, community, pharmacy, hospital hubs and wellness centres. This approach has enabled our system to meet the needs of our whole populations, including adults and children that may be underserved by current services, and use vaccination to help address health inequalities and inclusion health.

As of 11 March 2024, more than 3.26 million vaccinations have been given across Norfolk and Waveney since the beginning of and since the pandemic.

Norfolk and Waveney have continued to excel in the delivery of this COVID-19 programme with some of the highest vaccine uptake figures in the country, remaining first within the East of England and third nationally, receiving regional and national recognition for the performance of the vaccination programme. Indeed, the vaccination programme and the development of the Wellness on Wheels (WoW) bus was presented as a success story in the NHSE national strategy 'Shaping the Future Delivery of NHS vaccination service December 2023.

In 2023/24 we have delivered over 432,000 COVID-19 vaccines. This has included partners across the system:

- 106 GP Practices
- 33 Community Pharmacies
- 17 Primary Care Networks
- 2 large scale vaccination sites
- 5 Hospital Sites
- 1 Wellness on Wheels (WOW) bus
- 1 ICB Immunisation Team

The ICB continues to have oversight and maintain a record of clinical incidents reported by PCN and community pharmacy sites. Since April 2023, a new Clinical Assurance Dashboard has been available from NHSE. This highlights vaccination instances which appear to deviate from agreed guidelines. The Vaccination Team have taken a proactive approach to the use of this dashboard with every instance being investigated. Most instances have been recording errors, which are then corrected by the sites- ensuring accurate patient records. The ICBs work in this area has been recognised by the regional team and was presented as an exemplar, to the other systems in the region.

A supportive, team approach has been deployed with sites which has resulted in a positive culture whereby sites are open and honest and keen to engage with the ICB to establish the root cause of any incidents and put steps in place to prevent reoccurrence. Quality assurance site visits have been undertaken to provide support.

The recent Autumn/Winter campaign despite delivering the largest number of vaccinations in the region, Norfolk and Waveney had the lowest number of instances on the dashboard - indicative of the governance and oversight which has been put in place.

Listening to 'Quieter Voices' in Norfolk and Waveney - How we think working with people and communities can tackle health inequalities

We're working to draw together the various sources of data available within the system. Building on existing [Public Health guidance](#), this will drive much of the ICS activity and will go a long way towards identifying need. Through working with people and communities we want to use the people's voice to test and assure the data is reflecting what matters to local people. This will enable us to move beyond information about treatment and services to hear people's whole lived experience.

Ambition two – Primary Care Resilience and Transformation

Primary Care (Community Pharmacy, Dentistry, General Practice, Optometry)

In Norfolk and Waveney, General Practice is at the forefront of a transformative journey to improve healthcare accessibility and quality for everyone. Guided by the NHSE plan, we have embarked on a comprehensive strategy to improve access to services, enhance the overall patient experience, and gain a deeper understanding of healthcare demand within our communities.

Central to our approach is collaboration, with practices across the region uniting as Primary Care Networks. Through this collective effort, we have extended services beyond traditional working hours, offering over 1,000 additional hours of appointments every week, including weekday evenings and Saturdays. This initiative helps services to be readily available to our population, which stands at 1,124,979 as of 1 January 2024. The result is over 67,440 minutes of Enhanced Access Hours appointments provided weekly, demonstrating our commitment to timely access for essential healthcare services.

Our dedication to education and training remains paramount, with 86% of General Practices approved as training grounds for medical students in primary care settings. This commitment to nurturing the next generation of healthcare professionals has been further underscored by our recognition nationally for retaining young General Practitioners (GPs). Through targeted workforce retention programmes, we have successfully secured 25 ST3 placements within our region, ensuring a steady pipeline of skilled healthcare professionals for the future. Additionally, we have witnessed a 20% increase in the number of Tier 3 Educators for ST1-3 placements, highlighting our ongoing efforts to strengthen our educational infrastructure and support the development of future healthcare leaders.

In recognition of our commitment to addressing local health inequalities, we were honoured to receive the prestigious ENHANCE Generalist Programme and the Coastal and Rural Programme. These initiatives aim to bolster educational resources and support sustainable workforce planning, which helps pave the way for a more equitable and inclusive healthcare system. By focusing on community-centric care, we are not only addressing the unique healthcare challenges faced by underserved populations, but also developing a culture of collaboration and inclusivity within our healthcare system.

Within dentistry, we have undertaken a comprehensive short-term plan aimed at improving access to dental services and enhancing oral health outcomes across the region. This multifaceted approach encompasses various strategies, including the mobilisation of urgent treatment services, recruitment of 18 new dentists, and expansion of training practices. Additionally, our community pharmacy sector has experienced significant growth, with dedicated teams working hard to enhance accessibility and quality.

Data from our urgent dental treatment pilot scheme shows progress, with 1,779 appointments offered per month and 5,300 patients seen in the first three months alone. Moreover, the scheme has achieved a 'did not attend' rate of 0.02%, highlighting its demand and effectiveness in addressing unmet dental needs within the area.

Within primary care workforce, Norfolk and Waveney participated in the inaugural General Practice NHS Staff Survey, marking a milestone as the sole ICB in the East of England to engage in this endeavour.

Highlights of our participation include:

- A commendable return rate of 45.9%, surpassing the national average of 40.2%.
- Noteworthy performance in several areas such as working flexibility, health and safety, and recognition and rewards.
- Identified areas for improvement include fostering a culture of voice, compassion, and inclusivity within our team.

In response to the findings, we have taken proactive steps to welcome a Health and Wellbeing Fellow for Primary Care to our team, and we are currently seeking applicants for an Equality and Diversity Fellow position.

Furthermore, we have initiated a 12-month 'Working Well' programme aimed at supporting all primary care staff in areas such as stress management, harassment prevention, work-life balance, and leadership development.

Looking ahead, we acknowledge that significant challenges remain, particularly around ongoing workforce shortages and funding constraints.

Ambition three – Improving services for Babies, Children and Young People (BCYP) and developing our Local Maternity and Neonatal System (LMNS)

Commissioning and Transformation

Over the past year in the Commissioning and Transformation team have focused efforts on enhancing communication within our community. We have devised and distributed a comprehensive reasonable adjustment resource pack for families navigating lengthy pathways, emphasising inclusivity and support. Collaborating with the all-age stakeholder group for neurodiversity, our team has tailored advice and guidance to assist parents/carers seeking independent assessments for their children. Our widely circulated Children and Young People (CYP) newsletter continues to serve as a beacon, illuminating key priorities, information, and avenues for support across the system.

We are proud of a variety of achievements which demonstrate our commitment to actionable change and inclusive practices. We secured a successful expression of interest for Wave 4 of the Core20plus5 Community Connectors Programme, fostering a network of community influencers dedicated to health improvement and equity. Notable initiatives include the commissioning of Sensory Training for Special Educational Needs Coordinators (SENCOs) to bolster sensory processing and well-being in schools, and Sensory Profiling for Transforming Care (TC) Navigator teams to cater to the needs of the most vulnerable. Our procurement endeavours, such as the Neurodevelopmental Disorder (NDD) provider framework, further exemplify our strategic investments in comprehensive care pathways.

Service enhancements are evident across various domains, from the Children's Community Nursing Team (CCNT) service review to the establishment of recognised pathways for CYP utilising special medical devices (SMDs). We have also initiated vital training programmes, including ventilator competencies and calibration sessions, fortifying our system's clinical skills.

Collaborative efforts extend beyond service provision to strategic alignment, as demonstrated by the joint commissioning strategy with Norfolk County Council (NCC) defining our approach to Occupational Therapy (OT) commissioning. The distribution of an OT handbook to educational settings and the launch of an OT digital library show our commitment to resource accessibility and knowledge dissemination. Additionally, our engagement with families through initiatives like the Mental Health Navigators service and the creation of neurodiversity (NDS) fact sheets highlights our increased focus on holistic support and empowering people and families.

Engagement with patients, people, and communities remains central to our principles, with ongoing co-production efforts shaping programme implementations. Face-to-face interactions with parents, carers, and young people have been instrumental in refining our initiatives, ensuring they resonate with diverse needs and experiences. Our involvement in professional networks continues to yield tangible outcomes, informing priority areas such as Palliative and End of Life Care (PEoLC) and asthma management.

Despite our achievements, challenges persist, especially concerning workforce shortages and the continued impact of COVID-19 on service delivery. Limited investment funding poses additional hurdles, necessitating careful resource allocation and strategic planning in the coming months.

In assessing our targets, we are proud of our achievements such as the successful implementation of the TC Navigator and Mental Health Navigator programmes, along with the launch of OT universal services. However, we acknowledge areas where further progress is needed, including post-diagnostic support for autistic individuals and the optimisation of critical pathways amid resource constraints.

Maternity

Significant progress has been made in enhancing maternity and neonatal services in Norfolk and Waveney. This progress is deeply rooted in the Three-Year Delivery Plan for Maternity and Neonatal services, which was created to address critical areas identified through safety reports, input from maternity staff, and the voices of women and pregnant individuals. This plan, unveiled in March 2023, outlines four main themes:

1. Listening to Women and Families with Compassion:

Maternity and Neonatal Voice Partnerships (MNVPs) have been established to ensure active engagement with service users. National guidance aligns with the MNVP model in Norfolk and Waveney, with a robust governance structure in place. The Perinatal Pelvic Health Service (PPHS) was mainstreamed in April 2024 following a successful two-year pilot. This service addresses pelvic floor dysfunction, a prevalent issue among women and birthing individuals.

2. Growing, Retaining, and Supporting the Workforce:

Recruitment efforts, including the integration of student midwives, have contributed to a reduction in midwifery vacancies. Training initiatives, such as the implementation of the national core competency training framework and Neonatal Life Support Training, have bolstered staff competencies.

3. Developing and Sustaining a Culture of Safety, Learning, and Support:

Pre-hospital Obstetric Emergency Training (POET) sessions have empowered staff with essential skills, leading to increased confidence in handling emergency situations. Regular Local Learning Events (LLEs) have facilitated knowledge sharing and continuous improvement across the system, addressing various topics relevant to maternity and neonatal care.

4. Standards and Structures Underpinning Safer, More Personalised, and More Equitable Care:

Personalised Care and Support Plans (PCSPs) have been introduced to ensure individualised care for pregnant individuals, supported by a systemwide project involving key stakeholders. Efforts to promote breastfeeding and achieve UNICEF Baby Friendly Initiative (BFI) accreditation by 2027 have been supported through investments in breastfeeding mentoring services.

Despite achievements, there remain persistent challenges in the realm of maternity healthcare that demand ongoing attention and concerted efforts.

CQC Inspections revealed a mixed landscape across Norfolk and Waveney's healthcare providers. While the Norfolk and Norwich University Hospital (NNUH) and Queen Elizabeth Hospital (QEH) garnered favourable ratings, the James Paget University Hospital (JPUH) faced challenges. Consequently, a comprehensive Maternity Improvement Plan has been initiated to address areas of concern within JPUH's maternity services.

Tobacco Dependency and Health Inequalities continue to pose significant hurdles in the region's healthcare landscape. Smoking remains a prevalent risk factor during pregnancy, with 11.6% of the birthing population in Norfolk and Waveney being smokers at delivery. Initiatives, such as the introduction of a Maternity Tobacco Dependence Treatment Service, aim to mitigate this issue. Additionally, health inequalities, particularly affecting communities in areas of high deprivation, exert profound impacts on maternal and neonatal outcomes. Consequently, targeted interventions and support programmes are necessary to address these disparities.

Digital Access and Transformation present both opportunities and challenges in the delivery of maternity care. While advancements in digital technology hold promise for enhancing healthcare delivery, digital exclusion remains a significant barrier, particularly for marginalised communities often associated with deprivation. Efforts to mitigate this issue are underway, exemplified by initiatives like the Maternity Digital Hub project, which seek to bridge the digital divide and ensure equitable access to healthcare services.

Despite these challenges, the LMNS remains committed to its corporate priorities and targets outlined in the Three-Year Delivery Plan, ensuring the continuous improvement of maternity and neonatal services in Norfolk and Waveney.

Special Educational Needs and/or Disabilities (SEND)

The Designated Clinical Officer's (DCO) team for SEND has actively engaged in regular meetings, both virtual and face to face, with education, health, and care plan (EHCP) teams in Norfolk and Suffolk. This collaborative effort has led to heightened awareness and strengthened relationships, facilitating increased knowledge in NHS provision and enhancements in EHCPs. EHCP panels have undergone thorough review and improvements, resulting in clearer identification and streamlined sharing of information. A SEND training platform, hosted on Just One Norfolk (JON), was co-produced with stakeholders and launched in October 2023, providing a centralised resource for SEND training accessible to individuals working with CYP with SEND. Additionally, content related to SEND and associated services/resources on JON and SEND Local Offer websites in Norfolk and Suffolk has been enhanced.

Efforts to improve oversight of SEND tribunals have been bolstered by established systems with both Norfolk and Suffolk local authorities. Strong connections with CYP and their parents in Norfolk have been forged, evidenced by improvements made to the Norfolk SEND survey and increased response rates. Furthermore, Norfolk has advanced its SEND quality assurance framework with the DCO playing a pivotal role. Working links have been re-established between EHCP teams and Children's Continuing Care (CC) teams in Norfolk, aligning EHCPs and CC CYP reviews and assessments. Suffolk has followed Norfolk's lead in adopting an electronic/web-based approach to early identification and notification processes as of January 2024.

The DCO team now receives working draft EHCPs from coordinators in Suffolk, including NHS health needs and provisions, which are subsequently endorsed as needed by the DCO team on behalf of the ICB. Regular meetings have been initiated with both Norfolk and Suffolk teams for CYP with EHCP transfers into the ICB area, facilitating access to required health services through advice and coordination with key health services.

In Norfolk, the DCO and Senior SEND Advisor have developed SEND multi-agency writing good advice training, which has received positive evaluations following sessions held across the system. The SEND Training Working Group collaboratively produced the SEND training platform for professionals on the JON platform, consolidating access to SEND e-learning training in one location. The successful transfer of CYP with EHCPs in and out of the area has been achieved.

Regular meetings are held with stakeholders and parent/carers groups, alongside active participation in SEND forums, local events, and conferences attended by CYP with SEND and their parents across Norfolk and Suffolk. The DCO chairs the SENDIASS steering group, facilitating the incorporation of key information and reporting from parents, carers, and young people with SEND into the system.

Following the Suffolk SEND area inspection in November 2023, further challenges have emerged, necessitating the development of a priority action plan to address identified systemic concerns. There is an ongoing effort to shift towards a needs-led approach rather than one driven solely by medical and diagnostic considerations. The aim is to build confidence in available services and resources by embracing diversity and individuality.

Challenges persist regarding the consistent reporting of SEND health data outcomes and performance dashboards within the wider system, exacerbated by the volume of work and time pressures on statutory responsibilities in both Norfolk and Suffolk. Addressing competing demands and streamlining agendas remain essential, considering the overarching nature of SEND across various domains such as TC, LDA, mental health, medical needs, physical health, safeguarding, MCA, and DOL.

Quality assurance of EHCP health advice for needs assessment has shown improvement, albeit with inconsistent progress in effectively incorporating the voices of CYP. Efforts to enhance workforce awareness and build trusting professional relationships have had positive outcomes, although challenges remain in obtaining consistent reporting evidence on statutory health advice from providers.

Learning Disabilities and Autism (LDA)

Significant progress has been made within Learning Disabilities and Autism (LDA). The Transforming Care (TC) Navigator team is now operating at full capacity, a significant milestone in our efforts. Work on prescribing guidance and the ongoing refresh of the Stopping Over Medication of People with a learning disability, autism or both (STOMP) guidance are in progress, ensuring that best practices are consistently updated and applied.

Another notable achievement is the establishment of a section 117 (S117) register, with plans for further development in the coming year. A dedicated working group, inclusive of parent/carers

representation, has initiated a review of processes post a working diagnosis of Global Developmental Delay (GDD), aided by the development of a diagnostic tool.

Key achievements over the past year include the positive movement observed in the dynamic support register (DSR), with a notable decrease in the number of CYP on the register from 30 in April 2023 to 14 in February 2024. Efforts in admission avoidance are evident through various initiatives such as community care, education, and treatment reviews (CETRs), local area emergency protocols (LAEPs), and participation in NHSE England (NHSE) inpatient CETRs.

The sixth Learning from Lives and Deaths – People with a Learning Disability and People with Autism (LeDeR) Annual Report was published in Norfolk and Waveney and the ICB continues to ensure that people living with learning disabilities and/or autism live well. We recognise that this work must be informed by the learning identified within the report, using lived experiences to help identify opportunities to improve services and support.

The acquisition of the Wellness on Wheels (WOW) bus for SENDFest 2024 marks a significant step forward in community engagement. Additionally, robust engagement in neurodevelopmental stakeholder meetings and the inclusion of Norfolk and Waveney ICB services in the Suffolk autistic spectrum disorder (ASD) strategy highlight our commitment to collaborative efforts.

Engagement with patients, individuals, and communities remains a priority, with regular feedback mechanisms in place and active participation observed across all working groups. Highlights include the creation of training materials co-produced with individuals who have lived experience, and the filming of a reasonable adjustments video.

There are challenges ahead, particularly within a busy system experiencing financial and workforce constraints. However, progress has been made in implementing policies related to DSR and CETR, with ongoing work to meet Annual Health Check targets and maintain consistency in mental health inpatient numbers.

In summary, while this area has many challenges, the dedication and collaborative spirit within the LDA sector have paved the way for significant progress and promising initiatives in the year ahead.

Continuing Care (CC)

Over the past year, Continuing Care (CC) has made improvements within its services. Since April 2023, the team has processed 48 new referrals, with 30 of these undergoing full assessments. Currently, there are 76 children on the caseload, with 62 in Norfolk and 14 in Waveney. Notably, the evolving complexity of needs, especially concerning challenging behaviours among BCYP, has been a focal point. The team has been adept at identifying cases meeting CC criteria, particularly in psychological and emotional domains.

Efforts to address gaps in training regarding personal health budgets (PHBs) have been underway, with bespoke arrangements tailored through various providers. Collaboration with school transport staff has enabled safe travel for young people on ventilators. Moreover, joint funding initiatives with Norfolk and Suffolk County Councils have ensured comprehensive support packages.

Key achievements include maintaining holistic support for families, facilitating smooth transitions into adult services, and securing funding for additional Specialist Nurses to cater to complex care requirements. Successful transitions into out-of-county placements have also been facilitated, resulting in positive outcomes for individuals. Furthermore, close collaboration with the Clinical Mental Capacity Act (MCA) Lead has enabled the identification of children requiring community deprivation of liberty (DOL).

Engagement efforts have been robust, including feedback collection from families receiving care, monthly meetings with parent partnerships, and active participation in regional CC groups.

Collaboration with NHSE and educational initiatives regarding the role of CC have also been highlighted.

Challenges persist, including a rising number of new referrals, a national shortage of paediatric nurses affecting care delivery, and sourcing appropriate care packages for individuals with extreme challenging behaviour. Addressing complex safeguarding issues and ensuring smooth transitions into and out of hospitals remain priorities. Alignment of CC reviews with Education, Health and Care Plans (EHCPs) is an ongoing effort to streamline processes for families.

While targets regarding new assessments and annual reviews align with national guidance, challenges remain in meeting the increasing demand for services and addressing staffing shortages.

Designated Safeguarding Children Team (DSCT)

NHS Norfolk and Waveney ICB has followed the statutory assurance processes set out in the Safeguarding Accountability and Assurance Framework. Over the past year, our Designated Safeguarding Children Team (DSCT) has been committed to highlighting the importance of safeguarding within the ICB and across the ICS. Ensuring that safeguarding remains woven into the fabric of our processes, from procurement to quality assessment, and commissioning for the ICB, has been a primary focus. Additionally, the DSCT has taken proactive steps in establishing partnerships and initiatives aimed at tackling serious youth violence and transitional safeguarding, particularly within our ICS.

One significant development has been the formation of the Serious Youth Violence and Transitional Safeguarding group, spearheaded by the DSCT on behalf of the ICS. This collaborative effort is instrumental in addressing exploitation issues within our county. Moreover, our involvement in leading the Family Community and Network priority for the [Norfolk Safeguarding Children Partnership \(NSCP\)](#) underscores our commitment to holistic safeguarding measures, including initiatives targeting family dynamics and the involvement of invisible fathers. The NSCP's Local Plan for Multi-Agency Safeguarding Arrangements can be found [here](#).

In response to health-related school absences, our team has played a pivotal role in the system's management, highlighting our focus on safeguarding children across various contexts. Furthermore, the establishment of an all-age safeguarding team emphasises our comprehensive approach to safeguarding efforts.

Among our key achievements, the DSCT has embarked on the critical task of reviewing smaller contracts on behalf of the ICB, in collaboration with our Adult Safeguarding Team. This ensures that safeguarding considerations are embedded in all aspects of service provision. Additionally, our joint efforts with Adult Safeguarding Team in overseeing podiatry, optometry, and dentistry services within Norfolk reflect our commitment to safeguarding across the lifespan.

We've also been actively engaged in broader community initiatives, such as our partnership membership with the NSCP, further amplifying collaborative safeguarding efforts.

Looking ahead, safeguarding children and maintaining a family-centric approach will continue to be the guiding principles for the ICB. Challenges exist in ensuring the rapid review of all deaths requiring a joint agency response and providing timely feedback to families.

More information about how we work with our ICS partners to safeguard children can be found on our [website](#). The latest copy of NSCP's annual report can also be found [here](#).

Looked After Children

Progress over the past year has seen the reintroduction of peer audit reviews for initial and review health assessments, ensuring consistently high quality amidst staff turnover. The Designated Looked After Children (LAC) team's multi-agency efforts have refined the Strengths and Difficulties

Questionnaire pathway, enhancing emotional support for LAC. Annual audits identify areas for improvement.

Key achievements include the resolution of backlogs in initial and review health assessments, facilitated by collaboration between the Designated LAC Team and providers. Workshops conducted over the Summer showcased best practices, elevating the profile of the ICB nationally.

Engagement efforts involve the Designated Nurse for LAC gathering input from children in care and care leavers to shape future assessment protocols. Bi-monthly joint focus group meetings allow providers to address feedback from LAC and carers, driving actionable plans. Positive feedback from care leavers underscores the value of extended services.

Challenges persist, notably the rising numbers of LAC aged 15 and above, often with complex needs requiring tailored placements. High volumes of Unaccompanied Asylum-Seeking Children (UASC) strain local resources, complicating timely service delivery. Fluctuating caseloads hinder consistent appointment availability for statutory health assessments. Sustaining the Care Leavers Nursing Service remains uncertain due to resource constraints, compounded by vacancies within the Designated LAC Team affecting strategic planning.

Child Death Review Team

The Child Death Review Teams (CDRT) in Norfolk and Suffolk stand as pillars of support and improvement in child welfare. Since their inception, they've been instrumental in enhancing the quality and effectiveness of our practices.

The CDRTs play a pivotal role in the review process, ensuring that families' concerns are heard and addressed. They facilitate open and frank discussions among staff regarding the care provided to each child. Moreover, they provide support to families in need, acting as key workers when no other support is available.

Similarly, the Child Death Overview Panels (CDOP) serve a fundamental function in identifying actionable steps to mitigate modifiable risk factors contributing to child deaths. From local initiatives to national advocacy, CDOP utilise collaboration to promote change and save lives. As detailed in their latest [annual report](#), recurring themes in child welfare emphasised the importance of clear communication, information sharing and record-keeping, which have been areas of focus for the team over this period.

The report noted challenges arise from lack of shared records and a reluctance to share information, while parental behaviours such as smoking and neglect can impact a child's well-being. Other key notes included the importance of safe sleep environments, staff training and dedication to listening to parents and carers.

Using this information, the CDRT in Norfolk focused their work in these area over the past year. Efforts were made to enhance communication with tertiary units, deliver comprehensive training to partner agencies, and emphasise the importance of face-to-face meetings between families and medical teams. Additionally, the development of feedback mechanisms ensures ongoing refinement of services.

Every family receives dedicated support, ensuring that the bereaved child remains at the heart of the process. Collaborative efforts have led to tangible improvements in service delivery within the acute sector. Comprehensive training packages have been developed and disseminated, fostering a culture of awareness and competence among staff. Importantly, feedback from families continues to drive service improvement initiatives, ensuring that their voices are heard and valued.

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Ambition four – Transforming Mental Health services

Adult Mental Health

Detailed summary of performance indicators – referred to on page 9.

Mental Health							
Metric ID	Short Description	Values	Target	Mar-24	AVG 23/24	Trend (Most Recent vs AVG 23/24)	Mar-23
EBS3	Inpatients followed up within 72 hours of discharge	%	80%	94.9%	91.1%	↑	88.9%
EH4	MH - EIP 2 week treatment	%	60%	73.7%	74.5%	→	67.3%
EH1	MH - IAPT 6 week waits (entered treatment in month)	%	75%	98.7%	97.9%	↑	96.4%
EH2	MH - IAPT 18week waits (entered treatment in month)	%	95%	100.0%	100.0%	↑	100.0%
EH10	MH - CYP ED Routine 4 weeks	%	95%	87.5%	82.4%	↑	88.9%
EH11	MH - CYP ED Urgent 1 week	%	95%	71.4%	80.4%	↓	77.8%

Financial Years	2022-23	2023-24
Mental Health Spend	£182.0m*	£199.4m**
ICB Programme Allocation	£2,209.9m	£2,455.4m
ICB Programme Allocation (net of Pharmacy, Ophthalmology and Dentistry introduced in 2023-24)***		£2,355.3m
Mental Health Spend as a proportion of ICB Programme Allocation	8.2%	8.5%

*Figure from audited Mental Health Investment Standard Compliance Statement 2022-23

**Figure to be audited for 2023-24

*** First year of delegation in 2023-24, therefore removed to provide normalised comparator

NHS Norfolk and Waveney set [ambitions](#) for mental health, requiring partners to work together to enable:

- Greater focus on prevention and early support, aiming to prevent crisis where possible.
- A network of services that work together and are responsive to need, ensuring people reach the right service first time.
- More accessible community-based services that support the management of mental health issues closer to home, such as in GP surgeries and well-being hubs.

Since April 1, 2023, progress has been made in these areas:

- Mental Health Collaborative: A new setup where providers team up to improve mental health care quality, efficiency, and sustainability. Year one focused on Dementia, Delirium, and Depression in older people, continuing with a partnership through the Ageing Well programme. More improvements are planned from April 2024.
- Support for Mental Health Crises: More short stay recovery houses have been set up, increasing from 1 to 3, covering Central, East, and West areas, to support people during acute mental health crises.
- Working Well Service: Collaborative efforts with Norfolk County Council resulted in launching the Working Well service, which integrates with other programmes supporting employment for people with mental health challenges.

Early Psychosis Support: A new service will be fully operational in 2024 to support those showing early signs of psychosis, allowing for prompt intervention and better chances of recovery.

- Support for Rough Sleepers: A pilot service launched in Great Yarmouth aims to support rough sleepers with severe mental health needs or at risk of homelessness.
- Recovery Centre for Complex Emotional Needs: A new recovery centre has opened to provide community-based interventions for those with Complex Emotional Needs, in collaboration with Norfolk and Waveney Mind and Norfolk and Suffolk Foundation Trust.

Key achievements in 2023/24:

- There are two national targets that act as warning signs, usually signalling capacity problems in the crisis pathway; work has focused on a number of initiatives that reduced in year both the number of people waiting longer than 12 hours in AandE, as well as the number of people being treated in hospital wards outside of Norfolk and Waveney (called out of area placements) which has halved from July 2023 to March 2024.
- The number of people with a diagnosis of dementia recorded in their GP records has increased from 59.7% in July 2023 to 61.4% in January 2024. This is an additional 400 people on registers, moving our system closer to the national standard of 66.7%.
- More people than ever before have accessed treatment in the NHS Talking Therapies service, with (on average) an additional 350 people every month accessing the service compared to last year. This has been accompanied by a consistent decline in the 'in-service' waiting time, which achieved national targets in December 2023.
- The Primary Care Mental Health model in Norfolk and Waveney was short-listed for an award in the 2023 General Practice awards for '*Clinical Improvement; Mental Health*'.
- 460 people have so far been referred (as of January 2024) to a new specialist service to support people living with severe mental illness to quit smoking tobacco (national early adopter site for this initiative).
- 15% more people supported by the specialist employment support service for people living with severe mental illness (Individual Placement Support) compared to the previous year. This service supports people with severe mental illness to remain in or access employment.
- The Mental Health Joint Response Car is run in partnership by the ambulance service and mental health services; more than 75% of people supported by this service do not need to attend the Accident and Emergency department.
- The Admission Prevention Service, provided by Julian Support (a VCSE partner), has been expanded county-wide and succeeded in supporting more than 80% of people to avoid a hospital admission.
- The response time to calls made to the 111 Mental Health option service (support for people experiencing crisis) has improved and is now an average of 6 minutes.
- Norfolk and Waveney ICB continue to champion work that joins up services and enables people to recover from mental ill-health in a way that considers all areas of life, including promoting physical health. One example of this is investing in the Active NoW programme, supporting people living with mental ill-health to access physical activity that meets their needs.

In terms of engagement, the Adult Mental Health Team conducted extensive public and stakeholder engagement throughout 2023 to revamp the delivery of NHS Talking Therapies, a service aimed at individuals with depression and anxiety-based needs. This effort resulted in the publication of a [summary document](#) by the ICB.

Experts by experience, engaged through a partnership with Rethink Mental Illness, played a pivotal role in leading the reference group for mental health transformation, aiding in the development of the ICS prevention and wellbeing programme, and contributing to projects focused on urgent and emergency mental health care.

A partnership with Rethink Mental Illness also led to the formation of an ICS-wide working group, supported by the Norfolk and Waveney Mental Health Provider Forum. This collaboration facilitated the development of a draft Integrated Care System Mental Health Coproduction Strategy and an associated online coproduction toolkit, scheduled for publication by March 31, 2024.

System-wide workshops were also held in alignment with commitments outlined in the Joint Forward Plan, focusing on further developing pathways for individuals with dual diagnosis (mental health needs alongside substance misuse) and those with complex emotional needs.

Looking ahead, several challenges remain within the Norfolk and Waveney mental health landscape. Ensuring a stable and resilient workforce is in place is paramount to delivering timely and effective services, yet recruitment and retention hurdles persist locally, regionally, and nationally. Collaborative efforts with service providers and workforce leaders are ongoing to tackle this issue. Moreover, the rising prevalence and complexity of mental health presentations pose a continuous strain on the system's capacity to meet growing demands.

Additionally, an increasing number of individuals seeking assistance with neurodiversity-related issues adds further complexity, demanding workforce support for diagnosis and ongoing care.

Addressing these challenges will be important for mental health services to effectively serve the population's mental health needs in the coming year.

Children and Young People's Mental Health

The launch of the CYP System Collaborative in April 2023 signalled a further development in the way partners across the system are committed to working together. Building on the CYP Strategic Alliance, the System Collaborative is led by five key system partners (NSFT, ICB, Norfolk County Council, CCS and NCHC) and is striving to improve integrated working practices for CYP and their families. Initially, two priorities will be emotional wellbeing and mental health, and neurodiversity, with key working groups established to lead projects. For mental health key considerations include a focus on 'place-based provision' around school and community offers, the alignment of integrated front doors, and a new way of working for CYP with the most complex needs (known as the integrated practice model).

Prevention/Wellbeing and Community Transformation

- Implemented 10 Mental Health Support Teams across Norfolk and Waveney, with plans for an 11th team by 2024/25, covering 55% of the area.
- Conducted 'Flourish Schools Survey' in partnership with local authority to understand needs of school-aged children.
- Expanded pilot training for pastoral staff to provide parent-led CBT (Working on Worries) in 114 primary schools.
- Recognised the need for single session interventions in therapeutic pathways, with trainer identified.
- Provided trauma-informed training across the system at three levels.
- Commissioned MAP for community youth work in four Primary Care Network sites, with plans for expansion.
- Established primary care integration group to support those under 18 years.
- Sustained TALK Centre and MH Champion Training to train staff working with CYP.
- Progressed Family Hub programme focusing on perinatal mental health, parent-infant relationships, and parenting support.
- Procured NHS Talking Therapies service considering needs of the 16-25 age group.
- Continued funding for Better Sleep Programme and other adaptation projects.
- The Professional Therapeutic Pathway accepted 185 requests for support for CYP.
- Extended VCSE provision to support MH system waiting lists.
- Integrated Front Door for CYP MH processed over 3800 requests with 98% processed within 5 days.
- Developed CYP MH Charter Implementation Toolkit for commissioned providers.
- Procured an all-age gender identity service for support and advice.

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CYP Mental Health Urgent and Emergency Care

- The alternative to admission team (CATAT) has successfully supported CYP at home instead of inpatient admission.
- Embedded Senior Mental Health and Assistant Mental Health Practitioners in paediatric wards for crisis support and early discharge, reducing lengths of stay.
- Increased clinical leadership roles in CAIST to handle complex cases and improve recruitment.
- Progressing Castle Green proposal for Intensive Day Service and 72-hour respite for CYP in mental health crisis.
- Launched Integrated Practice Model to support CYP with complex Health and Social Care needs during mental health crisis.
- Recruited a project manager and team manager for Mental Health Navigator service, set to begin in July 2024, to support CYP and families with complex MH needs and reduce crisis presentations and admissions.

Eating Disorders

- Established 'The Lighthouse' intensive day treatment service for CYP with severe eating disorders, offering admission avoidance and education.
- Commissioned counselling service for CYP with mild to moderate disordered eating to prevent the development of diagnosable eating disorders.
- Learning from Cambridgeshire and Peterborough, establishing parent/carer peer support group in Norfolk as a commissioned service.
- Established Avoidant Restrictive Food Intake Disorder (ARFID) service in July 2023, with approximately 50% of users being neurodiverse.

Key achievements and outcomes of the 2023/24 period:

MHSTs Project Management:

- Achieved full establishment recruitment despite national challenges.
- Quadrupled referrals in Q4 of 2023/24 compared to Q3.
- On track to meet the goal of supporting 500 CYP per team per year.

Integrated Front Door (IFD):

- Processed 3800 requests for support with 98% within 5 working days.
- Positive feedback received for service quality.
- 40% of requests closed with advice only, reducing repeat referrals.
- Improved relationships and triage process enhancing support accessibility.

16+ Wellbeing Service Enhancements:

- Increased referrals and improved engagement for young people.
- Enhanced recovery outcomes for this age group.

Professional Therapeutic Pathway:

- Praised by partners for increased support capacity.
- Supported 185 CYP and families with complex mental health needs.

Perinatal Mental Health and Parent-Infant Relationship Workstream:

- Recognised nationally for innovative practices.
- Engaged various partners for comprehensive support.

Service Specifications and Procurement:

- Developed specifications and completed eight successful procurement exercises.
- Focused on mild-moderate mental health pathways and awarded to voluntary sector organisations.

Building Relationships in Primary Care:

- Embedded youth work roles across four PCN sites.
- Primary care teams engaged in expanding support roles.

Reduction in VCSE Provider Waiting Lists:

- Reduced waiting lists, particularly for child and families and CBT-informed therapeutic contracts.
- Aiming for 18-week referral to treatment standard.

CYP Crisis Team (CAIST) Support:

- Transitioned CAIST team into Integrated Practice Model with Social Care and Care.
- Maintained core services while developing new models.

All-age Eating Disorder Strategy Implementation:

- Established Intensive Day Service as an alternative to admission.
- Recognised regionally and being replicated in East of England.
- ARFID pathway addressing previously unmet needs.

Gender Identity Service Expansion:

- Commissioned an all-age service with positive feedback.
- Reduced mental health needs in supported individuals.

Effective Management of Contracts:

- Managed contracts efficiently, redirecting underspend to increase capacity and pilot new services.

In our ongoing efforts to transform mental health services for CYP and their families, we have prioritised their voices and experiences by undertaking many engagement opportunities over the past year.

The 'Youth in Mind' initiative, a systemwide 0-25 Participation model, reflects our commitment to incorporating the perspectives of CYP and their families. Through this model, we have focused on addressing unmet needs, particularly among under 11s and those with physical health requirements. This approach has been instrumental in shaping our recruitment processes, service specifications, and key procurements.

Steering groups, inclusive of school staff, parents/carers, and local service representatives, have provided valuable feedback on Mental Health Support Teams (MHSTs). We use this insight to adapt and tailor services according to local needs, ensuring inclusivity and effectiveness.

In other areas of engagement, young people have actively contributed to the development of the Integrated Front Door (IFD) through focus groups and surveys. Their input has influenced the refinement of support request processes and the creation of digital platforms like the 'FYI' website, enhancing accessibility and relevance.

Although significant progress has been made across CYP mental health, challenges persist, particularly regarding workforce recruitment and retention, leading to extended waiting times. Despite improvements in the VCSE sector, long waits for specialist therapeutic support remain a concern.

Our transformation agenda aligns with broader mental health priorities, emphasising early intervention and equitable provision across age groups. Efforts are underway to further embed MHSTs in schools, strengthen partnerships with primary care, and enhance the IFD to streamline access and improve outcomes.

Key milestones such as the implementation of MHSTs across the region and surpassing planned access targets for mental health support are good news. However, challenges remain in meeting intervention targets due to workforce constraints, though quality improvement initiatives are underway.

Efforts are directed towards addressing specific service gaps, such as eating disorder referrals, with improvements noted in treatment timelines. Despite challenges, the crisis support team is transitioning to full operational capacity, ensuring 24/7 coverage.

While providers are still adjusting to new information systems, efforts are being made to demonstrate improved outcomes through the Mental Health Services Data Set (MHSDS), with workshops facilitating knowledge sharing and best practices.

Despite challenges, our commitment to transforming mental health services for CYP remains strong, prioritising inclusivity, early intervention, and partnership working.

Ambition five – Transforming care in Later Life

Within Transforming Care in Later Life, one of the most notable developments has been the establishment of the Ageing Well Programme Board, which convenes every two months with representation from various sectors including Trusts, providers, and VCSE organisations. The Board has outlined five primary workstreams to concentrate on Frailty Attuned Acute Care, Dementia, Prevention, Care Homes and Housing with Care, and Education.

Additionally, an [Ageing Well Strategic Framework](#) has been drafted, finalised, and made publicly available. A supporting strategic framework matrix outlining the ICS 9 key objectives across the three ageing well life phases was also approved. In tandem with this framework, a Dementia Charter has been developed and disseminated to all providers, emphasising a commitment to addressing dementia-related challenges comprehensively.

Furthermore, the establishment of the Norfolk and Waveney Clinical Ageing Network stands as a significant milestone which draws clinical experts from across the system. The network has committed to convene bi-monthly, with an initial focus on standardising a frailty tool across the system, marking a crucial step toward enhancing care delivery.

Among the achievements since April 2023, the collaborative approach to the Ageing Well Programme at a system-wide level stands out. This concerted effort emphasises our commitment to addressing the multifaceted challenges associated with ageing populations.

In terms of engaging with patients, individuals, and communities, the Transforming Care in Later Life team has actively sought input and feedback to shape and refine services. This engagement was particularly evident in the development of the Ageing Well Strategic Framework and strategic matrix, where patient representatives were integral in providing insights, intelligence, and valuable feedback to ensure that services are tailored to meet the diverse needs of our communities.

Ambition six – Improving Urgent and Emergency Care (UEC)

Detailed summary of performance indicators – referred to on page 9.

Emergency

Metric ID	Short Description	Values	Target	Mar-24	AVG 23/24	Trend (Most Recent vs AVG 23/24)	Mar-23
EB5	A&E attendance seen <4 hrs	%	76%	77.0%	72.6%	↑	70.9%
EBS5	Proportion of Service Users attending A&E who wait more than 12 hours from arrival to discharge, admission or transfer	%	2%	5.3%	6.0%	↓	7.7%
	Ambulance - Cat 1 7min mean	Min	7	10	10	→	11
	Ambulance - Cat 1 15min 90th centile	Min	15	18	19	↓	21
	Ambulance - Cat 2 30min mean	Min	30	41	47	↓	66
	Ambulance - Cat 2 40min 90th centile	Min	40	91	105	↓	152
	Ambulance - Cat 3 120min 90th centile	Min	120	269	301	↓	386
	Ambulance - Cat 4 180min 90th centile	Min	180	225	424	↓	605
EBS7a	Ambulance - Arrival to handover <15mins	%	65%	37.5%	30.1%	↓	14.5%
EBS7b	Ambulance - Arrival to handover <30mins	%	95%	63.1%	53.7%	↓	33.5%
EBS7c	Ambulance - Arrival to handover <60mins	%	100%	78.9%	69.7%	↓	49.9%
EBS8a	Ambulance - Handover to Clear >30mins	#	0			→	

Summary of performance

- AandE <4hrs performance has seen moderate improvement over the course of the year because of all the work done by system partners to improve ambulance handover, prioritise admissions avoidance and increase Virtual Ward capacity.
- Ambulance Response times across Norfolk and Waveney have been challenged, in part due to rurality of Norfolk and Waveney, but they have also been impacted by delays in ambulance handover at our acute hospitals.

- Operational flow pressure remained within the ICS during 2023-24, driven by the need to balance UEC activity and elective recovery against an increasing length of stay within hospitals (including an increase in patients with no criteria to reside) and the impact of Industrial Action.
- Discharge pathway capacity reduced in line with the non-recurrent seasonal funding allocation as we exited Winter 2022-23. This created a reduction in capacity as a longer-term plan for intermediate care is developed.
- Norfolk and Waveney has been in the Tier 1 national UEC recovery programme and this has also identified other areas impacting patient flow and performance. These areas are admissions avoidance, front door operating practices, effective use of data and leadership/culture.
- Through the annual planning process the ICS is developing programmes of work to improve flow that are aligned to the National UEC Recovery Plan.

Community urgent response

Community							
Metric ID	Short Description	Values	Target	Mar-24	AVG 23/24	Trend (Most Recent vs AVG 23/24)	Mar-23
	Community health services two hour urgent response standard	%	70%	68.9%	74.7%		70.2%

Summary of performance

- Activity within the service has seen a notable increase, with year-to-date referrals rising by 10% compared to 2022/23. However, this surge has placed strain on the service's ability to maintain its targeted 70% performance rate, as capacity hasn't expanded proportionately to meet the heightened demand.
- This uptick in activity stems from a concerted effort to ensure individuals receive timely and suitable care, aligning with the principle of 'right care, right place, right time.' Consequently, more individuals who might have traditionally sought care in Emergency Departments are now being directed to more appropriate services. We are working to bolster alternative urgent care services within the community, which will cater to patients whose needs are better suited to community-based care rather than emergency services.

Despite targets not being achieved, over the past 12 months urgent and emergency care in Norfolk and Waveney has continued to make considerable progress to improve patient flow, reduce ambulance handover delays and continue with important work, communications and engagement activity to help signpost alternative services.

Progress has been made in the following areas:

- Ambulance handovers: Significant reductions in delays have been achieved across our three acute hospitals through rapid triage, enabling ambulance crews to quickly respond to critical cases in the community.
- Virtual Ward: A community ‘step up’ virtual ward has been established, using remote monitoring technology to facilitate seamless transitions between acute and community care, allowing for earlier discharges and safe home care.
- Care Coordination: The establishment of a Norfolk and Waveney-wide ‘Care Coordination Hub’ supports complex elderly patients, directing them away from Emergency Departments towards community-based alternatives for better outcomes.
- Same Day Emergency Care (SDEC): Expansion of direct referrals to SDEC units via 111 pathways and increased support for ambulance crews to divert patients to more appropriate care services.

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Mary's story below is a good example of how the system is working together:

Mary's story

Mary's husband, Jim, a palliative care patient on chemotherapy, fell and broke his femur, affecting his mobility. Their main concern was Jim's ongoing abdominal pain, which had persisted for three days. After contacting the Acute Oncology Service (AOS), they were advised to call 111.

A telephone assessment with the UCCH GP determined the need for an in-person evaluation to decide if Jim could stay home or needed direct admission to AOS, bypassing long ED waits. An Urgent Care ACP from EEAST was dispatched to assess Jim, and a video assessment was conducted with the GP.

A plan was agreed upon by the paramedic, family, and GP, allowing Jim to stay home.

The GP prescribed remotely, and a secondary care appointment was scheduled for that afternoon, with the family arranging transportation.



The landscape of urgent healthcare is slowly evolving, with shifts in how and where urgent activity manifests. However, hospitals remain a bottleneck in the system due to high occupancy levels, prolonged lengths of stay, and delays in discharge transitions. These bottlenecks affect the ambulance service's ability to promptly reach critically ill patients in the community.

Efforts to enhance community-based capacity and capabilities have yielded successes in reducing dispatched ambulances and conveyances to hospitals. Consequently, the growth in ED attendances and hospital admissions has been slower than expected, especially considering population and demographic trends, indicating more effective community management of patients.

Despite these improvements, hospitals continue to experience congestion and lengthy stays, highlighting the ongoing need to enhance in-hospital flow and discharge processes. Although new Virtual Ward capabilities have been introduced in the community, current capacity remains limited. However, with ongoing workforce recruitment and training throughout 2024/25, fewer patients will require hospital conveyance, as more can be safely managed in the community.

Our urgent and emergency care priorities for 2024-25 are to:

- Reduce length of stay across all care settings (hospital and community beds).
- Expand and integrate our Virtual Ward capacity.
- Build on the work we have done in care coordination - ensuring our patients 'get the right care, in the right place, whenever they need it'.
- Increase the number of patients who can access SDEC services where the skills and capability of our EDs are not needed. This will help us protect the EDs for our sickest patients who are experiencing life threatening and/or life changing emergencies.
- Recover ambulance category 2 response times by reducing, and then eradicating avoidable handover delays at our hospitals. Through support to crews and better care coordination, we will reduce the time they spend on scene when a conveyance to hospital is not required.

These priorities align with the national asks set out in the NHS England Urgent and Emergency Care Recovery Plan and the 2024/25 Planning guidance.

Central Norfolk Intermediate Care Bed (ICB) Model

In response to the demand for reablement and recovery services, the Central Norfolk Intermediate Care Bed (ICB) Model has been instrumental in addressing the needs of people with varying levels of cognitive impairment, including Dementia. Commissioned with non-recurrent funding, up to 42 ICB beds were distributed across seven residential homes for the Winter of 2023/24. This initiative aimed to bridge the capacity gap and facilitate discharges from NNUH.

A hallmark of the ICB Model is the integrated approach involving a multidisciplinary team (MDT) providing in-reaching support. This team comprises of Primary Care professionals, physiotherapists, occupational therapists, social workers, and exercise instructors, ensuring comprehensive care for clients. Weekly MDT meetings, overseen by designated heads, foster collaboration and facilitate effective decision-making.

Several key achievements and outcomes have been attained with this area of work. The rapid mobilisation of schemes was realised through robust collaborative relationships with system partners. The consistent Multi-Disciplinary Team (MDT) resource has transitioned into a cohesive unit, contributing significantly to a marked reduction in the length of stay. Additionally, the implementation of the HomeFirst Therapy model has provided resilience and a governance structure, facilitating successful recruitment and retention of temporary staff. Despite recruitment challenges for agency social care staff, a rolling recruitment program and supportive management approach have resulted in successful retention and applications for substantive positions. Ring-fenced social worker resources and discharge-to-assess pathways have enabled a reduction in the length of stay for clients, including those with complex needs. Moreover, seamless integration with existing contracts for equipment delivery and transport has optimised service delivery.

Residential home providers have expressed appreciation for the integrated MDT approach, citing timely issue resolution and visible progress in discharge plans, encouraging a sense of inclusion and collaboration.

Challenges ahead include the issue of funding sustainability as the current non-recurrent funding model is scheduled to conclude by March 2024. Efforts are imperative to secure recurrent funding and seamlessly integrate the model into broader bedded capacity oversight. Additionally, ongoing optimisation of the Multi-Disciplinary Team (MDT) offer remains important to maximise patient outcomes in bedded discharge capacity. Lastly, effective planning for Winter resilience is essential, encompassing timely fund allocation and staff recruitment to ensure the smooth mobilisation of schemes during the challenging months.

Ambition seven – Elective Recovery and Improvement

Detailed summary of performance indicators – referred to on page 9.

Waiting Times						
Metric ID	Short Description	Values	Target	Mar-24	AVG 23/24	Trend (Most Recent vs AVG 23/24)
EB4	Diagnostics completed <6 weeks	%	99%	71.4%	66.1%	⬆️
EB3	RTT - Incomplete Pathways	%	92%	51.4%	52.5%	➡️
EBS4	RTT - Incomplete pathways > 78 weeks	#	0	531	670	⬆️
EBS4	RTT - Incomplete pathways > 65 weeks	#	0	3,385	4,013	⬆️
Mar-23						
						67.4%
						52.9%
						328
						3,531
Cancelled Operations						
Metric ID	Short Description	Values	Target	Mar-24	AVG 23/24	Trend (Most Recent vs AVG 23/24)
EBS2	Number of patients not treated within 28 days of last minute ele	#	0	85	88.5	⬆️
EBS6	No urgent operation should be cancelled for a second time	#	0			➡️
Mar-23						
						87

Planned Care

Key progress and milestones achieved during 2023/24 include:

- The start of construction on the Diagnostic Assessment Centres (DACs) based at the three acute hospitals in Norfolk and Waveney.
- Approval received to build a Community Diagnostic Centre in East Norfolk.
- A new paediatric theatre complex opened at NNUH in December 2023 releasing theatre capacity for gynaecology and urology cases.
- The second phase of the new orthopaedic elective hub at the NNUH (NaNOC) was approved in February 2024. The centre, due to open Summer 2024, will provide capacity for an additional 2,500 cases per year with 2 additional theatres and 21 beds.
- Building work started in March 2024 for the new orthopaedic elective hub at JPUH. The hub is due to open in October 2024 and will operate 7-days per week with an additional 1400 theatre sessions per year.
- Significant steps were taken towards achieving zero 78-week and 65-week wait patients by the end of March 2024, however delivery was impacted by the industrial action in January and February 2024.

Within Elective Recovery, significant progress has been made to enhance accessibility and quality of care. This includes commissioning new services from both NHS and Independent Sector Providers (ISP), with over 1000 patients successfully transferred to these new ISP facilities since April 2023. Vigilant management of ISP performance remains a priority, alongside active participation in the national Patient Initiated Digital Mutual Aid System (PIDMAS) programme and the implementation of Women's Health Hubs.

Within the Clinical Policy Development Group, a comprehensive review and approval process for Individual Funding requests has been established. This group also spearheads the development of new policies, ensuring all are up-to-date and accurate, while also engaging in horizon scanning initiatives and overseeing the Clinical Threshold Policy.

Referral Management efforts have been robust, focusing on supporting primary care staff in utilising e-Referral Systems effectively, optimising referrals, designing new referral forms and clinical pathways, and championing the Patient Choice agenda. The diligent management of patient complaints and queries regarding waiting times remains a priority.

Reflecting on challenges, industrial action by clinical staff severely impacted elective recovery and looking ahead, it remains the biggest risk to performance as we move into the new financial year.

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National Clinical Programmes:

NHS Diabetes Prevention Programme

Under the NHS Diabetes Prevention Programme, remarkable achievements have been reached, surpassing NHSE targets with a 144% increase in referrals and a 175% increase in new starters. Noteworthy improvements have also been observed in diabetes management processes and treatment targets. Over the past year, a range of actions have taken place to enhance diabetes care including pilot programs, technological advancements, and educational outreach efforts.

Respiratory Disease

Efforts in respiratory care have resulted in the delivery of 10,000 additional appointments for acute respiratory infections via local hubs, with ongoing improvements in service models and care pathways. In particular, the Pulmonary Rehabilitation service has witnessed substantial enhancement, with a significant reduction in waiting lists observed. Moreover, progress has been made in improving access to accurate standardised respiratory diagnostics.

Cardiology / Stroke

Investments in heart failure projects and stroke community catalyst projects demonstrate a commitment to enhancing cardiovascular health across our communities. Notable actions include the development of integrated community stroke service models, and the rollout of Personal Stroke Records across acute facilities in collaboration with the Stroke Association.

System Clinical Programmes:

Initiatives such as Women's Health Hubs aim to improve access to crucial services while enhancing staff training and patient education. In Eye Care, the implementation of standardised pathways and service specifications across providers reflects a commitment to quality and regulatory compliance. Similarly, efforts in MSK care emphasise pathway standardisation and optimisation of referral processes.

In Palliative and End of Life Care, a rigorous review process has informed the development of an operational plan to address key priorities, ensuring alignment with statutory duties. The Dermatology domain sees proactive steps in refining pathways and piloting innovative teledermatology solutions to enhance service delivery.

By focusing on these core areas, we continue to advance accessibility, quality, and efficiency across our healthcare system, ensuring the well-being of our communities remains paramount.

Cancer

Detailed summary of performance indicators – referred to on page 9.

Cancer

Metric ID	Short Description	Values	Target	Trend (Most Recent vs AVG 22/23)		Mar-23
				Mar-24	AVG 23/24	
EB27	Cancer - 28 days Faster Diagnosis Standard	%	75%	73.9%	60.8%	69.8%
EB8	Cancer - 31 days	%	96%	86.0%	87.5%	90.9%
EB12	Cancer - 62 days	%	85%	60.9%	55.3%	61.9%

* Cancer metrics updated to new standards issued October 2023

The Cancer Service Area, housed within the ICB, facilitates the System Cancer Transformation Team. This team is dedicated to realising the objectives outlined in the System Cancer Transformation Programme, delivered in collaboration with the ICS. The goals set from April 2023 were aligned with national directives, focusing on reducing cancer backlogs and meeting long-term cancer plan objectives.

Over the past year, progress towards these aims has been significant but partial. Efforts have been concentrated on reducing patient waiting times, with advancements in clearing backlogs. However, two Trusts are enrolled in the National Tiering programme for their Cancer Waiting Time (CWT) performance, indicating room for improvement. While improvements have been made in implementing nationally defined best practice pathways and personalised care, full integration across all cancer tumour site pathways remains incomplete due to diagnostic delays.

In terms of Long-Term Plan Objectives for Cancer, data from Norfolk and Waveney demonstrates improvements in survival rates over the past decade. Notably, 74% of individuals diagnosed with cancer in this region survive more than one year, with 56% surviving beyond five years. Furthermore, staging data analysis indicates a rise in early-stage diagnoses, from 53.4% to 57% since the inception of the transformation programme.

During the 2023/24 period, several nationally led cancer innovations have been successfully piloted in Norfolk and Waveney, including the Targeted Lung Health Checks programme, teledermatology, colon capsule, capsule sponge, and the National GRAIL trial. These initiatives aim to enhance early detection and streamline diagnostic processes, ultimately improving patient outcomes.

The programme actively engages patients and communities through various projects and partnerships, such as initiatives with Opening Doors to address barriers faced by the learning disability community, collaborations with the Academic Health Science Network (AHSN) to raise awareness of bowel screening, and partnerships with the Big C Cancer Charity to promote cancer awareness.

Despite progress, challenges remain in meeting Cancer Waiting Time targets. Trusts have not yet achieved agreed performance metrics for the Faster Diagnosis Standard (FDS), indicating the need for continued efforts amidst operational pressures and workforce challenges.

While there have been achievements, ongoing dedication is essential to address remaining challenges and meet targets within the Cancer Service Area. Additional funding and collaborative efforts will further support service recovery and ensure the delivery of quality care to cancer patients within Norfolk and Waveney.

Ambition eight – Improving Productivity and Efficiency

System Transformation

For NHS Norfolk and Waveney and the wider ICS, health and care transformation is vital.

The role of the Transformation Board during 2023/24 has been to co-ordinate the delivery of strategic transformation at system level, acknowledging that moving forward, more of the transformation may happen locally and within provider collaboratives.

Some of the remit and responsibilities of the Transformation Board will migrate into the Commissioning and Performance Committee in May 2024 as part of the ICB governance review, and the Transformation Board met for the last time in February 2024. This will support decision making as close to patients as possible, and the new Committee has the authority to make financial decisions.

Our key areas of transformation focus have been in the following areas:

a) Joint Forward Plan 2023/24

Our [first Joint Forward Plan \(JFP\)](#) was published on 30 June 2023.

The JFP is one of delivery mechanisms for the Health and Wellbeing Strategies for Norfolk and Suffolk and aims to describe the key work that can only be achieved by working in partnership together. It is not a work plan for all our deliverables, or a response to the NHS Long Term Plan.

[Part two](#) of the Joint Forward Plan sets out the ICB's response to our legal duties and Financial Duties are set out on page 9.

Within this section we explain how capital and revenue sources are assigned and managed. The transformation described within the JFP is aligned to our medium-term financial plan and capital plan and the 21 objectives within the eight Ambitions each have a bespoke section describing 'How are we going to afford to do this?'.

The Transformation Board has been monitoring implementation of the 2023/24 JFP and has had a role to support, escalate and unblock any emerging issues. Reports were received in October 2023 and January 2024, supported by the ICB PMO team, with a year-end report due in April 2024. A summary of 2023/24 JFP achievements will be published on the [JFP webpage](#) during April/May 2024.

The reporting format was piloted before being rolled out and aligns with the published JFP. It reports on what we are going to do, how we are going to do it, how we are going to afford it, key dates for delivery, and how we will know we are achieving our objectives.

The eight ambitions and the 21 underpinning objectives are tracked according to what has been completed, is in progress and delayed.

Summary to the end of January 2024:

There were no specific escalations in January in terms of entire Ambitions or Objectives being at risk of non-delivery or withdrawn, but some delays against the original timescales were reported for Ambition 2 Primary Care Resilience and Transformation, Ambition 4 Transforming Mental Health Services, Ambition 6 Improving Urgent and Emergency Care and Ambition 7 Elective Recovery and Improvement.

Within the context of the ICB restructure and Industrial Action this is a fair appraisal of realistic and achievable progress, particularly in relation to Ambitions 6 and 7 which are linked. The elective programme of work is affected when the demand for urgent and emergency care increases, and procedures have been postponed as a result of the industrial action. All eight Ambitions reported a number of measures of success and evidenced progress within the most recent quarter.

The 2023/24 JFP was the first to be published so a number of the Ambitions focused on co-ordinating the efforts at system level so there was a clear common purpose and ensuring we had a plan of action. As a result of this there were four plans:

- Health Inequalities Strategic Framework for Action
- [Population Health Strategy](#)
- [Ageing Well Strategic Framework](#)
- [Short Term Plan for Dentistry](#)

The other seventeen objectives are delivering projects or specific workstreams and include prevention work such as targeted lung checks to detect cancer early, smoking cessation work with the hospitals to support pregnant women, and initiatives in primary care to detect and prevent cardiovascular disease.

There is specific and joint work in both mental health and with CYP, including implementing the Norfolk Start for Life initiative, and an Integrated Front Door to ensure people are not passed between organisations and that they only have to tell their story once. The Children's Occupational Therapy (OT) work (Objective 3d) has been concluded and will become part of business as usual from now on, with the publication of a school's OT handbook and an OT digital library resource. These resources are designed to empower families, care givers and educators with the knowledge and tools

to best support children and young people. This has been welcomed by schools and paediatric matrons.

Work continues to stabilise dental services but there is still much to do, and there is a focus on Integrated Neighbourhood teams, with services being accessible through one route and in one place.

We have worked as a system to improve ambulance handovers and response times. As a result of changes introduced at our hospitals, patients are now spending less time waiting in ambulances when they arrive at one of our hospitals. This in turn is enabling our ambulances to quickly get back on the road and to the next person who needs help. We have also made changes to help ensure people are getting the right care, at the right time and by the right person. RightCareNoW is a programme of work that has helped improve the way people are discharged from hospital back into the community, and reduced the number of people in our hospitals that have no medical reason to be there and who could be better cared for in their own home or another setting.

Patients waiting for operations are supported while they wait. Hospitals share their waiting lists with each other, and patients are asked if they are able to be seen at different locations if the wait would be shorter for them.

A lot of work is being undertaken to progress the Transforming Care in Later Life Ambition and there is a clear drive to make change so that patients can be supported if they need to be in hospital but that the wrap around services are developed.

2024/25 JFP Guidance was received on 22 December 2023 and can be found [here](#). It was very similar to 2023/24, noting that revised plans are expected to reflect a continuation of the priorities set out in the previous year's JFP. The revised 2024/25 JFP was approved by the ICB Board in March 2024 and is available to view on our [website](#).

b) Clinical Strategy alignment

Linked to the JFP is a parallel workstream of system strategy alignment.

In particular the Transformation Board has been coordinating the delivery of the ICS Clinical Strategy.

The clinical strategy outlined six key objectives, which was that my NHS in Norfolk and Waveney would:

- Tackle health inequalities
- See me as a whole person
- Be one service
- Reduce long waiting times
- Act early to improve health
- To be reliable.

We [published a progress report against Year 1 in July 2023](#). We undertook a huge array of work in Year 1, with 34 actions overall. The six themes within the Clinical Strategy remain current, but the learning from Year 1 was that this was overly complicated. Our ambitions for Year 2 were agreed through the Transformation Board and we have been explicit about which of the Year 1 actions have now been completed, are no longer relevant, have been built into business as usual for our teams or have been carried over into Year 2. Each of the six Objectives will also have a specific focus for Year 2, which includes 10 actions carried over from Year 1 and aligned with overlapping work already being monitored through the JFP.

This approach has been supported by our Clinical and Care Professional Assembly and by Norfolk and Suffolk Healthwatch.

The six areas of focus for Year 2 are:

Objective	Year two proposed focus
1 See me as a Whole Person	People with MH needs
2 Be one high quality resilient service	Primary care, including dentistry, and clinical care for CYP
3 Reduce Long Waiting Times	Elective care including cancer care and care closer to home
4 Act Early to Improve Health	PHM, prevention and care for older people
5 Be reliable	Emergency care
6 Tackle Health Inequalities	Health Inequalities

Within the six themes are 19 new actions and 22 that are already part of our JFP. We will publish progress updates at six-monthly intervals.

c) Improving Lives Together (ILT) programme

This is the System's principal joint transformation workstream and is referred to within Ambitions 6 and 8 in the JFP. The Transformation Board was involved in the determination of the three priority areas, driven by data, and these are Human Resources (HR), Digital Services and Improving Discharge from Hospital (RightCareNoW). Three Cases for Change have been received into the System, and now formally passed on to the individual Programme Delivery Groups to take forward.

There is an expectation of releasing savings and increasing productivity from these workstreams. *In summary the scale of the opportunity (including both cash releasing and non-cash releasing savings) was identified as:*

	£ million
HR	6.6
RightCareNoW	10-17
Digital	3.1

The governance for the ILT programme has now progressed from a single system project team overseeing the diagnostic phase and production of the Cases for Change, to three workstreams that will lead each programme. Each is being led operationally via the three existing local delivery groups which are the system's HR Directors, Digital Strategy Steering Group (DSSG), and the Discharge Board, respectively. This is our most challenging piece of work, interlinked with our change culture and appetite for risk.

Each delivery group will need to consider with partners whether formal business cases requiring internal sign off by a partner are necessary.

Delivery of these workstreams will remain challenging in the context of other work, but the three individual projects remain agreed as a priority by the system.

d) Transition of the commissioning of specialised services from NHSE to the ICB

From April 2024 the six ICB's in the East of England are coming together to commission what are called 'specialised services', legally taking on the delegated responsibility for these from NHS England with support from the existing staff. The rationale for delegating the commissioning is to enable population based, end-to-end commissioning of services with decisions made closer to communities, and care provision is better joined up for the benefit of the local population.

Specialised services are typically (but not exclusively) those that fewer numbers of the population need to access as they are for more complex care. Some of them are provided locally but some are in specialist hospitals such as Great Ormond Street, Papworth or Moorfields for example. The ICB took on responsibility for commissioning pharmaceutical, ophthalmic and dentistry services in 2023 and these additional 59 specialised services follow the roadmap of delegation, with more services expected to follow in future years. 2024/25 will be a transition year but the six ICB's and partners are working together to develop a work plan and longer-term strategy for the eastern region which is consistent.

In the short term the Transformation Board has overseen what needs to be in place for the safe transition of the services and strategy development on day one. Post transition this work would move into the proposed new commissioning team at the ICB, but NHSE resource will be available for all the functions as it is now, through the hosted team.

BLMK ICB will be the lead/host ICB for the NHSE Commissioning Team but all six ICB's are working closely together to develop principles of collaboration which are reflected in a signed a Collaboration Agreement, setting out how we will plan services together and make collective decisions for example about budgets and prioritisation of transformation work.

Strategic Transformation (Community Services Transformation)

A review of Community Services was undertaken to identify the optimal model needed to meet current and future need across Norfolk and Waveney.

An engagement process was undertaken involving:

- Resident engagement
- >50 individual and group interviews with key leaders
- 2 dedicated system workshops, and attendance at numerous system meetings.

Good practice from the King's Fund and activity and financial data from comparable CCGs was reviewed, testing and challenging models and assumptions.

The result of the engagement process was the creation of a framework to guide future planning, commissioning, and the delivery infrastructure of community health services in Norfolk and Waveney.

This framework revolves around four Strategic Impacts:

1. Proactive and personalised support from integrated teams
2. Delivering more specialist care in the community
3. Enabling healthy communities
4. Meeting local urgent and emergency care needs.

The engagement process included a series of five online workshops to share progress about the Community Services Review with residents and communities and gather their views about the vision and areas requiring service improvement.

An online survey was conducted which mirrored the content of the sessions with residents. Both activities were promoted heavily by partner organisations and as part of the community outreach undertaken by staff onboard the Wellness on Wheels (WOW) bus.

73 people who either live or work in the region registered for the five workshops and 92 people completed the online survey.

The workshops and survey complemented wider engagement with residents – Joint Forward Plan and Community Voices Project.

We now enter the implementation phase. This is planned through learning from a series of agreed 'prototypes' testing new ways of working and in some cases, new models of care.

We are developing new collaborative approaches to Community Service transformation in the East, West and Central parts of the ICS building on existing arrangements to give greater focus on delivering our four Strategic Impacts. The first task for these Community Services Alliances will be to develop clarity on their purpose, ways of working and their priorities and plans for delivering our new community service model.

Our community services model has integrated teams at all levels of Norfolk and Waveney at its heart. Integrated Neighbourhood Teams provide the essential foundation for supporting primary care resilience and delivering community care across Norfolk and Waveney.

Integrated Neighbourhood Teams bring together people to meet the needs of the local neighbourhood populations, usually based around 30-50,000 people. Their aim is to provide personalised and proactive care as close to people's homes as possible and to enable people to look after their own health. There is a gradual integrating of how GP practice and community staff work on a day-to-day basis. Other services can be added as relationships and trust develops. Integrated Neighbourhood Teams will look different as they seek to meet the diverse needs of local populations they serve.

The transformation of community health services can make an important operational and strategic contribution to delivery of the Joint Forward Plan, system outcomes and a much desired 'left shift'. This means strategically focusing on 'downstream' prevention and integrated local primary and community care to reduce unnecessary hospital referrals and enhance continuity of care. This moves the overall burden of care out of hospitals and residential care. By doing so, this approach promotes system productivity, better patient outcomes, and improved well-being.

Digital Transformation

A wave of digital transformation continues to revolutionise the way we care for people and communities across Norfolk and Waveney.

The [Shared Care Record](#) has united the three acute hospitals, community services, the Mental Health Trust, Norfolk County Council, and GP Practices under one digital umbrella. Over 5,000 dedicated health and care professionals have embraced this tool, impacting the lives of 150,000 patients. The days of repetitive storytelling are fading as the Shared Care Record gives health and care staff a holistic view of important records, meaning people receive better and quicker care.

Over 80% of Norfolk and Waveney's social care providers have embraced the Digital Social Care Record, bringing newfound efficiency and effectiveness to their services. This digital leap forward not only benefits service users and staff, but promises greater synergy once integrated with the Shared Care Record.

Progress has been made with remote monitoring as 40 care homes in the region now have real-time access to critical patient information, enabling individuals to receive care in the comfort of their own homes. Furthermore, the introduction of community-based Virtual Wards has encouraged people to live well independently yet safely.

The Norfolk and Waveney Acute Hospital Collaborative's [Electronic Patient Record \(EPR\) Programme](#) has continued to evolve over the past year. After a rigorous procurement process during the Summer, MEDITECH, a world leader in integrated digital systems, was selected as the supplier for the new EPR system. The new EPR for the collaborative, formed of NNUH, JPUH, and QEH, is poised to elevate staff and patient experiences, transforming acute hospital healthcare by storing patient information electronically and streamlining communication between patients and staff. The EPR will introduce time-saving features and facilitate safer, more personalised care, ultimately enhancing the overall quality of care provided by the three Trusts. The EPR Full Business Case is currently in its final approval processes with implementation scheduled to start in Autumn 2024 and a final go-live in 2026.

More people are using the NHS App where they can easily connect with their health information, receive messages from their GP Practice, and even manage prescriptions with a barcode scan. With information about appointments readily available, the ability to manage their own health is in reach via a smartphone.

Full-fibre connections, cloud technology, and ubiquitous Wi-Fi are transforming GP practices into hubs of modernity and efficiency. This new infrastructure not only enhances connectivity but also paves the way for seamless information exchange, ensuring that healthcare professionals have the data they need, precisely when they need it.

Progress has been made with cloud-based telephony and GP practices. Improved signposting, call-back functions, and enhanced queue details have helped interactions become more streamlined and efficient. Furthermore, the exploration of automation in GP practices promises to unlock new capacities, from patient registrations to prescription processing, freeing up valuable time for caregivers to focus providing the best care.

Looking ahead, engaging with patients, communities, and stakeholders remains paramount. Through direct engagement events, partnerships with Healthwatch, and ongoing feedback mechanisms, we strive to bridge the gap and ensure that every voice is heard. Challenges persist, from increasing NHS App adoption in hard-to-reach community groups, to enhancing information flow across the system.

Research, Evaluation and Innovation

The ICB Research and Evaluation Team plays a crucial role in spearheading research, evidence utilisation, evaluation, and innovation within the realms of primary and community care across Norfolk and Waveney. Our mission is centred on enhancing the quality and safety of services accessible to our local population. Through collaborations and partnerships, we aim to catalyse advancements that positively impact the healthcare landscape.

In May 2023, we released the comprehensive Norfolk and Waveney ICS Research and Innovation Strategy, a strategic blueprint designed to guide our collective efforts. Embracing four foundational principles – a community-centric approach, fostering a confident and capable workforce, promoting collaboration and coordination, and integrating research and innovation seamlessly into our operational framework – this strategy serves as a roadmap for initiatives.

To ensure the effective execution of the strategy, a leadership forum has been established, comprising of system partners dedicated to driving its implementation forward. Acknowledging our statutory obligation to nurture innovation, we've appointed a Head of Innovation, jointly funded with [Health Innovation East \(HIE\)](#). This pivotal role is instrumental in steering innovation initiatives and aligning them with our Joint Forward Plan objectives.

Our collaborative working extends beyond organisational boundaries, encompassing partnerships with higher education institutions and key National Institute for Health Research (NIHR) teams.

As part of our plan to embed research and innovation principles, we've initiated a monthly programme of lunchtime learning sessions since May 2023. Delivered by the Evidence and Evaluation (EE) Hub, these sessions offer a platform for ICB colleagues to deepen their understanding of evidence-based practices, and explore avenues for incorporating research and evaluation into service design and delivery.

In terms of research funding, we've secured 11 NIHR research grants totalling nearly £18 million, addressing diverse areas such as the impact of diet on long-term health, and the development of tailored care plans for individuals with dementia. Additionally, for 2023-24 we received £535,047 in Research Capability Funding (RCF), aimed at fortifying our research capacity through project grants, early career fellowships, and primary care network awards.

Commercial research activities serve as another avenue for innovation and revenue generation within the healthcare sector. Recognising the benefits of such initiatives, we actively explore opportunities for collaboration and knowledge sharing, with the aim of growing a culture of innovation across the system.

Our involvement in national initiatives, such as the [Clinical Entrepreneurship Innovation Sites \(InSites\)](#), demonstrate our commitment to an innovation-driven health and care system. We have been chosen as a 2024 InSite receiving £200,000 in funding, which will jumpstart our efforts to enhance our innovation culture, readiness, selection, implementation, spread, and sustainability.

With this support, we've developed an initial system-wide innovation vision and principles. Collaborating with ICS partners, we're refining objectives and have created draft innovation and governance processes to identify, match, and select innovations in partnership with various organisations.

Amidst our progress within research, challenges persist. We're keenly aware of the need to instil a deeper appreciation for research and innovation within healthcare organisations. Looking ahead, we hope to expand the reach and inclusivity of research activities, ensuring that all members of our community have equitable access to opportunities for participation and engagement.

Services which support delivery of all priorities

Adult Safeguarding

As an organisation, we are designated by the government to address serious violence issues, working closely with the Norfolk and Suffolk Serious Violence partnerships. Our main responsibilities include assessing health needs, developing strategies, and implementing action plans to combat violence and ultimately help people live longer and healthier lives.

We regularly meet with safeguarding teams at the Police Commissioner's Office and collaborate with various services to ensure effective coordination. Attending safeguarding meetings and promoting our new internal website for safeguarding information are some of the activities we have taken part in this year.

Chairing the Norfolk Safeguarding Adults Board is an important commitment for us, as is ongoing work to secure funds to support victims of domestic abuse. We are dedicated to promoting awareness through initiatives like the [White Ribbon](#) accreditation.

Over the past year, we have actively participated in workshops and events aimed at improving safeguarding practices, such as Safeguarding Week. By merging safeguarding teams to cover all ages, we aim to engage with diverse groups, including universities and family networks, to raise awareness of safeguarding issues. A highlight has been working with the University of East Anglia Allied Health Practitioners and medics to support their professional development and compliance with the requirements of the Mental Capacity Act (MCA)

Our team have worked with various Carers and family networks raising awareness of MCA including presentations at a Local Family Justice Board and the Palliative Care and End of Life conference. This work led to engagement with young people who have experienced care and we gathered insightful feedback from these activities.

Following a number of audits/surveys of MCA knowledge, confidence and application in practice the ICB were invited to coproduce and deliver a number of programmes alongside the NSAB regarding MCA improvement work across Norfolk system, including the creation of discussion groups for small providers and members of the VCSE.

As a team, we've observed an increase in adult reviews, which helps us identify areas for improvement in services. Ensuring that recommendations from these reviews are acted upon and regularly revisited is a priority for us.

Supporting health services in meeting their safeguarding duties is fundamental. We've expanded our reach to include pharmacy, optometry, and dentistry services, and have supported new initiatives like Right Care, Right Person in Suffolk.

Lastly, we're proud to report that we have consistently met deadlines for reports and reviews related to safeguarding, including Domestic Homicide Reviews and Safeguarding Adult Reviews.

Estates

In our ongoing efforts to enhance healthcare infrastructure and services, we are proud to announce the merger of two dedicated teams: ICS Strategic Estates and Primary Care Estates. Together, we have formed a unified Estates team, aimed at bolstering the provision of estate and infrastructure to facilitate collaborative healthcare delivery.

Our Estates team is intricately linked to corporate priorities, serving as a backbone for transformation, integration, and the facilitation of 'out of hospital care'. We also support the relocation of service activities and develop infrastructure to enable effective commissioning.

We've secured national approval for business cases for four Wave 4b Primary Care Hubs, representing a significant £25.2 million investment in the primary care estate. The implementation of the PCN Service and Estates Toolkit Programme has been successful, resulting in the generation of Estate Strategies for the majority of PCNs. These strategies highlight the opportunities and challenges facing primary care estates.

We secured £1,283,000 in Community Infrastructure Levy funding to support premises extension and improvements at Bungay Medical Centre. Land has been secured through Section 106 to support the construction of a new Bridge Road Surgery in Oulton. Additional funding of £508,540 via Breckland District Council and £157,550 via North Norfolk District Council has been secured to support infrastructure expansion and improvements at various medical practices. Our collaboration with Local Authority colleagues has been effective, with ongoing discussions to scope new healthcare premises in Taverham, Hethersett, and Diss.

Two landlord-funded schemes have been approved, paving the way for extensions to surgery premises in Long Stratton and Drayton.

Over the past year our service has actively engaged with patients, people, and communities through various initiatives. Steering and Engagement Groups, inclusive of patient representatives and community groups, have provided invaluable support to the Wave 4b Primary Care Hubs. Their input has been instrumental in the options appraisal for each scheme and continues to guide ongoing developments.

We recognise the challenges faced by many primary care colleagues in accommodating a growing workforce and increased registration list demand due to population growth. National policies and funding for investment in primary care estate are crucial in addressing these challenges and ensuring quality healthcare services for all.

Local Commissioning

Catheters Quality Improvement Project

In collaboration with the ICB Quality team, the catheters improvement project aimed to decrease the unnecessary use of urinary catheters across community and acute healthcare settings within the ICS.

The primary objective was to mitigate catheter-associated urinary tract infections (CAUTIs) and minimise patient harm, such as bloodstream infections and prolonged hospital stays.

Our focus was on fostering a culture of StopThink: No Catheter, ensuring consistent implementation of best practices across the system. We have engaged Heads of Quality Improvement from Trusts and nursing colleagues, emphasising collaboration.

Through extensive fact-finding and discussions, we gathered insights to inform the project. A system-wide audit of catheters in situ was conducted, with providers testing audit tools in both inpatient and community settings. Continuous engagement with all providers has been maintained, offering support and gaining enthusiasm throughout the project.

As of January 2024, audits have been conducted, leading to the identification of quality initiatives and the development of action plans by some Trusts. Knowledge-sharing sessions have been organised, and inappropriate catheters have been successfully removed, showcasing tangible progress. New workstreams, including catheter home packs and policy development, have been identified.

Primary Care In-Reach Services for Intermediate Care Beds

The seamless transfer of Primary Care In-Reach Services from One Norwich Practices to another GP Practice ensured uninterrupted care for patients in Intermediate Care Beds. Under the new provider's oversight, patients now benefit from a comprehensive Multi-Disciplinary Team (MDT) approach, optimising outcomes and facilitating their return home.

Looking ahead, while historically reliant on short-term Winter payments from NHS England, a sustainable, long-term commissioning strategy is needed to ensure continued provision of Intermediate Care Beds and associated services. This strategic approach is important for meeting the ongoing healthcare needs of our community effectively.

Lymphoedema

Following the closure of One Norwich Practices, the Lymphoedema service they previously offered transitioned to a new provider, Norfolk Community Health and Care (NCHC). Our priority throughout the transition was to ensure minimal disruption to patients and this goal successfully achieved.

Under the management of NCHC, the Lymphoedema service now operates from a new, purpose-built clinic space, ensuring that patients continue to receive high-quality care in a comfortable environment.

Looking ahead, the next 12 months present opportunities for further enhancement of the Central Norfolk service in collaboration with NCHC's existing services in West Norfolk. Additionally, we are exploring possibilities for optimising our prescribing formulary, which could lead to increased efficiencies and potential cost savings.

Wound Care

In response to updated wound care guidelines, this year we launched a pioneering project prioritising early intervention. Key achievements include developing two clinical pathways and a training video to standardise practices.

Over 100 staff members from NCHC and East Coast Community Healthcare (ECCH) have received specialised training. Contracts and specifications have been updated to integrate the new pathways, now accessible on the Knowledge NoW website.

Noteworthy progress has been made in wound care data recording, addressing national shortcomings. The project has drastically reduced waiting times for non-ambulatory patients from 140 to 25 days.

Previously unmet CQUIN targets have been surpassed, with ECCH achieving a remarkable increase from 1.7% to 31.25%. The accessible early intervention video has been widely distributed, benefiting staff across care settings. This initiative not only fortifies primary and community care but also alleviates pressure on urgent care facilities.

Learning Disabilities and Autism (LDandA)

In the past year, our Transforming Care Partnership has made significant progress in our mission to provide exemplary care for individuals with learning disabilities and autism in Norfolk and Waveney. Our efforts have produced tangible results, with inpatient discharges from hospitals increasing to 14 individuals, including those who have experienced hospital stays exceeding 3 years. This uptick in discharges not only reflects our commitment to facilitating smoother transitions from inpatient care, but also signifies our dedication to ensuring individuals receive appropriate care in the most suitable setting.

One of the cornerstones of our success has been our investment in training for local staff. By expanding the qualifications and skills of the workforce in LDandA care, we have bolstered our capacity to meet the diverse needs of service users. Through comprehensive training initiatives, we have equipped health and social care staff with the necessary tools and knowledge to provide compassionate and effective support.

Moreover, our LDandA Dashboard has proven to be an invaluable tool in our efforts to monitor and enhance the quality of care. This dashboard tracks vital metrics, including inpatient admissions and discharge rates, autism diagnostic waiting lists, annual health checks, and more. By analysing this data, we can identify trends, pinpoint areas for improvement, and take prompt action to address any quality issues that may arise.

Despite these achievements, we recognise there is still work to be done. We are currently outside the NHSE trajectory for the number of people in inpatient beds, with 31 individuals compared to the trajectory of 23. Additionally, we are striving to meet the 18-week target for adult autism assessments in Norfolk, a mission that requires concerted effort and strategic planning.

To address these challenges head-on, we have implemented a series of targeted initiatives aimed at driving meaningful change. We are introducing a new Autism community service in collaboration with NSFT which will provide psychological interventions tailored to the unique needs of autistic individuals, with the overarching goal of reducing admissions and re-admissions to inpatient services.

Furthermore, we have commissioned an Autism Diagnostic pathway in Waveney, which has already demonstrated success in meeting the 18-week target. Building on this achievement, we are extending similar efforts to reduce waiting lists for autism assessments in Norfolk, ensuring timely access to essential services for individuals in need.

Looking ahead, we remain steadfast in our commitment to transformative action. By April 2025, we aim to redevelop LD health services in line with NHSE service models, fostering a more integrated and person-centred approach to care delivery. Additionally, we are enhancing our Dynamic Support Register (DSR) and Care and treatment Review (CTR) processes to reduce inpatient numbers and improve the overall quality of care provided.

In conclusion, while our journey towards comprehensive and inclusive care is ongoing, our progress so far is encouraging. Together with our partners, we will continue to strive towards our shared goal of delivering high-quality care for individuals with learning disabilities and autism, ensuring they are supported to live fulfilling and meaningful lives within our communities.

Pharmacy and Medicines Optimisation

Over the past year there has been a particular focus in this area to develop strong collaborative relationships with stakeholders across the ICS, Associate Commissioners, and Interagency Clinical Boards. Regular meetings with local Trusts have been established to address interface prescribing challenges, facilitate resolutions, and effectively manage the introduction of new medications within the local health economy.

Active participation in clinical working groups has been instrumental in advancing various projects and supporting pathway development, particularly focusing on adopting a best value approach to treatment options within Trust directorates. Additionally, the development of a Therapeutic Advisory Group has taken place, aimed at promoting engagement from all system partners.

Progress has been made towards standardising prescribing and medicines optimisation practices across the region, with a focus on encouraging the utilisation of biosimilar drugs in local Trusts to align with NHSE priorities and ensure effective management of long-term conditions.

Key achievements during 2023/24 include transitioning from Knowledge Anglia to the new Knowledge NoW platform, a move that involved the review and update of over 200 documents. Furthermore, timely commissioning of National Institute for Health and Care Excellence (NICE) Technology Appraisals (TAs) has facilitated access to a broader range of treatment options for patients with complex needs.

Implementation of Blueteq automation has significantly reduced administrative burdens for consultants in secondary care, thereby enhancing capacity for patient consultations. Notably, initiatives such as the opioid de-prescribing project have provided essential tools and resources to support practices in optimising patient pain management.

A key focus of the Medicines Optimisation Team is to ensure that the local health economy gets the best value from our spend on medicines and devices. A collection of tools for GPs has been produced to help reduce demand and spend on items of low value to the NHS, such as medicines that are available over the counter or with little evidence of benefit.

A prescribing quality scheme and a suite of low risk and cost-effective switches have also supported financial recovery through reduced spend and increased quality in prescribing.

The team continue to support practices with CQC preparation around medicines management processes and procedures. They also support practices needing support around medicines following CQC visits.

Additionally, collaborative efforts have led to the production of documents aimed at supporting prescribers in both primary and secondary care settings, such as guidance on Methadone in pain management.

Looking ahead, challenges remain in ensuring adequate staff allocation to prioritise key commissioning areas for the benefit of patients in the local health economy. Additionally, maintaining focus on national medicines optimisation opportunities identified by NHSE beyond 2023/24 is crucial for achieving the [overarching objectives](#), which include improving outcomes in population health and healthcare, addressing inequalities, enhancing productivity, and supporting broader social and economic development.

Place Development

Place Boards, in West Norfolk, North Norfolk, South Norfolk, Norwich and Great Yarmouth and Waveney, have progressed and continue to recognise and influence local arrangements for local people. Bringing together colleagues from health and care to integrate services with a focus on effective operational delivery and improving people's care.

The work of the Boards, include:

- a) Identifying local health and care priorities and deliverables, using data and intelligence, that focus on addressing the health and wellbeing needs of the Place population together with local Health and Wellbeing Partnerships.
- b) Using a system-wide perspective when considering how to integrate health and care services.
- c) Providing oversight and assurance to the ICB; developing a shared Place Plan made up of the ICS strategic objectives/ICS strategy and local need.
- d) Ensuring effective operational delivery within existing local resources to improve people's care at Place.
- e) Supporting the delivery of national and system priorities and commitments.

Specific examples of work are outlined below:

West Norfolk

In West Norfolk, the Place Board has fostered strong relationships with local system partners, focusing on Urgent and Emergency Care (UEC) and System Integration. A notable achievement is the successful implementation of the 2023/24 Winter Plan, supported by significant investment. This included the establishment of an Acute Respiratory Infection Hub and improvements in Non-Emergency Patient Transport. Additionally, community services have been bolstered, such as the Out of Hours Palliative Care Response, reducing unnecessary hospital admissions and receiving positive patient feedback. Challenges ahead include further workforce development and ensuring sustainability of initiatives.

North Norfolk

The North Norfolk Place Board has prioritised better collaboration to meet population needs, exemplified by initiatives like the Integrated Neighbourhood Teams and the Dementia Working Group. Significant milestones include successful delivery of objectives within the Dementia Working Group and ongoing support for Health and Wellbeing Partnerships. Challenges include managing demand versus capacity and enhancing community engagement to address mental health challenges in coastal communities.

South Norfolk

South Norfolk Place Board has forged trusted partnerships to deliver innovative services, such as the deployment of Community Health and Wellbeing Workers addressing health inequalities in the CORE20 area. Achievements include generating numerous referrals for health and welfare interventions, indicating hidden needs in the community. Challenges ahead involve further integration of services and sustaining positive engagement with residents.

Norwich

Norwich's Place Board has focused on building local foundations for integrated care, exemplified by initiatives like CHESS, offering complex health and social support. Notably, consultation with stakeholders led to the decision to keep the Norwich Walk-in Centre open, reflecting community desires. Challenges include adapting to changing health and care landscapes and ensuring equitable access to services.

Great Yarmouth and Waveney

Health Connect, a partnership initiative, has provided targeted support to residents, aiding in faster recovery and avoiding hospital admissions. Notable achievements include extending service reach

and collaboration with Public Health Suffolk to address respiratory conditions. Challenges include managing increasing demand and ensuring sustained funding for vital services.

Each Place Board has actively engaged with stakeholders, utilising feedback to shape services. Examples include falls prevention projects in West Norfolk, mental health initiatives in North Norfolk, stroke survivor support in South Norfolk, consultation on service provision in Norwich, and community feedback initiatives in Great Yarmouth and Waveney.

Key achievements include successful delivery of various initiatives, such as the Winter Plan in West Norfolk, Dementia Working Group in North Norfolk, Community Health and Wellbeing Workers in South Norfolk, CHESS in Norwich, and Health Connect in Great Yarmouth and Waveney. Challenges ahead include further workforce development, sustaining initiatives, and managing increasing demand.

Common challenges across the regions include managing demand, workforce issues, and patient understanding of evolving health services. The work of Place Boards aligns with corporate priorities, contributing to Primary Care, Urgent and Emergency Care, Mental Health Transformation, Planned and Elective Recovery, and Financial Recovery initiatives.

Environmental matters

NHS Norfolk & Waveney has a vital role to play in relation to environmental matters and sustainable development. Whilst utilising public funds for the delivery of health and care services NHS Norfolk and Waveney also has the opportunity, and obligation, to spend public funds in ways that generate positive effects on the natural environment we all reside in.

Sustainability in this context means spending public money efficiently on our services but also minimising the impact on the natural world with our use of resources. By making the most of social, environmental, and economic assets we can improve population health.

Spending money well and considering the social and environmental impacts is enshrined in the Public Services (Social Value) Act (2012).

Climate change presents a profound and growing threat to people's health. Taking action to reduce harmful carbon emissions will save lives and improve health now, and for future generations. As one of the top ten largest employers in the world, contributing almost 5% of UK carbon emissions, the NHS has a real opportunity, responsibility, and interest in tackling this threat head on.

In October 2020 the NHS set the ambition to be the first 'net zero' health service in the world, in recognition of the global 'climate emergency which is also a health emergency'. It committed to two challenging targets:

- To reach net-zero by 2040, for the carbon emissions we control directly (the NHS Carbon Footprint), and
- To reach net-zero by 2045 for the broader emissions we can influence.

NHS Norfolk and Waveney acknowledged this responsibility to our patients, local communities, and the environment by working hard to minimise our carbon footprint.

Working together, the ICS Green Plan Delivery Group worked developed and [published an ICS Green Plan](#) for 2022-2025. The first three-year phase of the ICS Green Plan was developed with National Greener NHS guidance, with a focus on coordinating and enabling health and care providers and commissioners to assess their Net Zero maturity and outlining plans to reduce carbon emissions over directly commissioned health and care services.

Building on the progress made in 2022/23, 2023/24 has been a year of creating structures and process to enable our system partners to work together in a more systematic and integrated way.

Work is ongoing across the Norfolk and Waveney ICS to reduce our carbon footprint, examples of which are extending the use of virtual outpatient appointments to minimise patient journeys, and enhancing the virtual ward.

Specific actions from the ICB include the Digital Team's 'Think Green, Go Digital' initiative which encourages all staff to rethink how they use existing and emerging digital technologies to benefit the environment.

Task force on climate-related financial disclosures (TCFD)

The Group Accounting Manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025-26 financial year. Local NHS bodies are not required to disclose 1,2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

The phased approach incorporates the disclosure requirements of the governance pillar 2023-24. These disclosures have not been provided because these are still in the early stages of identifying requirements.

Improve quality

Detailed summary of performance indicators – referred to on page 9.

Mixed Sex Accommodation Breaches							
Metric ID	Short Description	Values	Target	Jan-24	AVG 23/24	Trend (Most Recent vs AVG 23/24)	Mar-23
EBS1	Mixed-sex accommodation breach	#	0	7	14	↑	16

Patient Safety							
Metric ID	Short Description	Values	Target	Mar-24	AVG 23/24	Trend (Most Recent vs AVG 23/24)	Mar-23
EAS4	MRSA	#	0	1	0.5	↓	1
EAS5	CDiff	#	27	28	29	↑	30
	Minimise rates of gram-negative bloodstream infections (NHS TI)	#	79	111	93	↓	85
	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE	%	95%			⇒	
	Proportion of Service Users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	%	90%			⇒	
	Proportion of Service User inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	%	90%			⇒	

A number of important projects have taken place to improve patient experience and increase our focus specifically on improving quality, both internally in the NHS Norfolk and Waveney and across the health and care system.

Priority projects and programmes are highlighted below:

Supporting and improving Urgent and Emergency Care

- The NHS Norfolk and Waveney Nursing and Quality Team continue to facilitate the System UEC Serious Incident Tactical Group, which brings together Norfolk and Waveney providers

to share and review learning from adverse incidents and, where appropriate, make shared recommendations, that inform system resilience and transformation plans, as well as broader quality improvement work around patient flow, including pre-hospital community-based interventions and discharge to assess. The group, which started in March 2022, has noted a positive downturn in harms occurring as a result of ambulance delays.

- The team has provided operational support to our three Acute Hospitals, with focussed periods of on-site input. This has provided additional operational support to provider colleagues as well as enabling NHS Norfolk and Waveney to actively reflect on the impact that quality improvement and transformation work is having on the delivery of frontline care.
- The team continues to work closely with provider organisations to identify and support the planning and implementation of quality improvement opportunities that will support pathways and improve patient experience, including actively partaking in supportive quality visits as a critical friend and at the invitation of provider organisations.

System Infection Prevention and Control (IPC) Partnership

- The NHS Norfolk and Waveney IPC Team has embedded a system workstream focusing on reducing the inappropriate use of gloves within healthcare settings. This reinforces good hand hygiene practice and feeds into the wider 'green' sustainability agenda. This is now being implemented in primary care, dentistry, and social care settings.
- The UK Health Security Agency (UKHSA) declared a national incident for Measles in January 2024 and called for immediate action to boost the uptake of the MMR vaccine in areas where the uptake was low. In response, we set up a system wide preparedness meeting, chaired by the Deputy Director of Public Health, with attendance from a wide and representative group of stakeholders across the ICS. There has been ongoing work to increase vaccine uptake and raise awareness of Measles locally.
- IPC Leads across the system are engaged in implementing recommendations from the national Tuberculosis Action Plan (2021-2026) published jointly by UKHSA and NHS England, with key priorities around prevention, detection, and control of active disease and transmission. The ICB IPC Team is supporting the commissioning of a new children's BCG vaccination service, a review of Occupational Health TB screening for new healthcare staff and working with provider teams to ensure there is resilience within teams. We are also currently exploring new commissioning options for Directly Observed and Video Observed Therapies.

Right Care NoW

- The Norfolk and Waveney System remains committed to supporting patients out of hospital as quickly as possible once they have recovered enough to leave. We are working collaboratively with our system partners in Local Authorities and community providers to ensure that once patients are discharged we have appropriate provisions of care that offer the individual the best opportunities for recovery and reablement and to promote independence as much as possible.
- We continue to develop our discharge to assess models in conjunction with National Discharge Guidance and aligned to legal frameworks and legislation. We are committed as a system that no patient will be assessed for their long-term needs in an acute hospital and as a system are striving to support same day/next day discharges where at all possible. There has and continues to be significant investment and efforts into the discharge workspace and as a local system have seen significant improvements in collaborative working right across Norfolk and Waveney.

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Patient Safety Incident Response Framework

- The ICB Patient Safety Specialist has led local roll out of key elements of the national NHS Patient Safety Strategy, coordinating implementation of the new Patient Safety Incident Response Framework (PSIRF), linking with regional and national teams, and working closely with provider organisation Patient Safety Specialists to deliver key milestones.
- NHS Norfolk and Waveney continues to develop its risk management procedures internally, to ensure that mitigations, controls and assurances are in place to manage risk and identify improvement opportunities. System Quality Group provides a forum to bring partners together and identify and share risks early, as a collective, and develop system solutions.

Learning from Deaths

- The NHS Norfolk and Waveney Nursing and Quality Team continues to work closely with the Executive Medical Director to embed the bi-monthly Learning from Deaths Forum which commenced in February 2023 with representation from system partners. The Forum collates information and learning from a system-wide view of mortality in Norfolk and Waveney and provides a forum to discuss the multiple strands of mortality with the aim of supporting improvement and sharing learning.
- This includes learning from Medical Examiner findings, Safeguarding Practice Reviews, Child Death Overview Panel and learning from the lives and deaths of people with a learning disability and autistic people (LeDeR).

Resilience in Primary Care

- Ensuring we support a resilient integrated model across place and primary care is key. We continue to provide support to practices 'at risk' or experiencing resilience issues. This involves senior clinical input to help practice teams to develop and strengthen their clinical and operational governance processes and support staff wellbeing and development. We have developed our team this year to include dedicated roles to lead the quality assurance of community pharmacy, optometry and dentistry, following delegation of commissioning from NHS England.

Supporting and improving Mental Health Services

- The ICB Nursing and Quality Team continues to play a key role in supporting Norfolk and Suffolk NHS Foundation Trust in their improvement journey, with senior NHS Norfolk and Waveney clinicians providing external check and challenge via Trust internal Governance forums, supporting the Trust to review their quality assurance, and working with teams to identify quality improvement opportunities that will support transformation and improve patient experience.
- The ICB Nursing and Quality Team plays an integral part in the quality and safety review (QSR) schedule of visits, both to internal teams and out of area placements. These visits fulfil the 'critical friend' role to identify improvements and areas for further development via an action plan. Links are maintained with Norfolk County Council regarding local authority commissioned services and public health suicide surveillance data. This information is triangulated with the new mortality and learning from deaths processes in NSFT. Work continues to utilise learning from deaths and incidents to inform pathway redesign as part of mental health transformation. Further information on mental health transformation can be found in the mental health section of this report.

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ICS Quality Strategy

- Development of the first systemwide ICS Quality Strategy and its approach to measuring and monitoring improvement, has been an extensive piece of work over the last year. Engagement from staff across teams and organisations has been invaluable and every contribution has counted and helped steer the plan.
- We still have more work to do to ensure that the way we measure impact of the strategy reflects patient and staff voices and what matters most to people living and working in Norfolk and Waveney. This will also include collaborative work with the local authorities to develop shared metrics around social care quality and Flourish outcomes for children, young people, and families. As we move forward with delivering the strategy, across the system, there will be lots of opportunities for people to get involved and be part of quality improvement.
- This Strategy does not replace existing quality assurance and improvement strategies developed by partners, including provider organisations and local authorities, but highlights the importance of quality within our wider system working and how we can more seamlessly ensure a robust approach to quality and safety across all our services.

Key achievements and outcomes for 2023/34 include:

- **Supporting and improving Urgent and Emergency Care**
The System UEC Serious Incident Tactical Group has provided a forum to collectively identify and take forward actions to improve safety and resilience within the local urgent and emergency care system, including work to align and optimise processes across the three Acute Hospitals and ambulance service, around ambulance handover, cohort care, interfacility transfers and the Norfolk and Waveney combined approach to Recommended Summary Plan for Emergency Care and Treatment ReSPECT documentation, feeding in to the appropriate groups to take this work forward at a system level. We continue to champion staff wellbeing and raise awareness of the impact of moral injury on staff working within sustained periods of high pressure. Recently, we have had support from Tricordent with a system collective resilience offer which was trialled with the group.
- **Clinical Harm Review Group**
A new system clinical harm review group has been established to share learning and reduce variation in clinical harm review processes across the ICS. Initially this will focus on the elective waiting lists within the acute trusts, then expand out to other providers once more established. The principles of this group are to share learning across the system, achieve consistency with clinical harm processes, review and implement National guidance and identify trending themes in relation to clinical harm. The group will also highlight specific pathways to the Elective Recovery Board for review when themes of harm or an increasing trend of harm is identified, so that provider organisations can review those pathways collectively to mitigate risk for future patients.
- **System Infection Prevention and Control Partnership**
We were successful in receiving national funding to represent the East of England region to deliver a hydration pilot in eight Care Homes in Norfolk over the last year. The aim of the pilot was to monitor the impact of hydration interventions on urinary tract infection (UTI) and subsequent hospital admissions for UTI and falls. The ICB Evidence and Evaluation Team undertook a local evaluation on the pilot using a range of qualitative and quantitative data. The data showed improved hydration practices, increased staff awareness, and enhanced resident and staff wellbeing. However, it did not indicate significant clinical impact during the 12-month intervention period. Data will continue to be collected for the first 6 months of the post intervention period to allow learning to embed in practice and look for impact over a longer timeframe. A final report and findings will be published April 2024.

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- **NHS Patient Safety Strategy Implementation**

The NHS Norfolk and Waveney Nursing and Quality Team and the ICB's Patient Safety Specialist continues to embed the national NHS Patient Safety Strategy (2019). This has included implementing the new Patient Safety Incident Response Framework (PSIRF) across the Integrated Care System commencing 01 September 2023. The PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety and prioritises compassionate engagement with those affected by patient safety incidents.

- **Supporting a resilient and integrated model of Primary Care**

This year we have extended the expertise and skills within our team to build a primary care quality assurance team that covers general practice, community pharmacy, optometry and dentistry, following delegation of commissioning from NHS England. Sector leads are focussing on risk stratification so that a risk-based approach can be taken to quality assurance and support and coproducing a quality approach with local committees and ICB Commissioning Teams.

We have also launched a health inclusion quality improvement initiative, that supports seldom heard service users, predominantly homeless people, to access primary care by developing a digital tool that can help communicate individuals' stories to health and care professionals. By working in partnership with Norwich Vulnerable Adult Service and a local housing trust, this initiative will enable opportunities for individuals to have an audible voice and to develop trusting relationships with GPs and primary care teams, to return for health interventions and monitor and promote wellbeing.

- **Acute Hospital Surge and Decompression**

In November 2023 Norfolk and Waveney moved to a new process across the three acute hospital sites, to minimise waiting times and reduce the risk of harm to patients within the community. Significant improvements have been noted; however, this has increased the need for escalation areas and additional patients cared for in ward areas, moving some of the risk to patient experience and quality of care into hospitals. The Nursing and Quality Team continue to support the acute Trusts, carrying out regular quality assurance visits, monitoring risk and providing recommendations to maintain patient safety and quality of care whilst recognising the challenging conditions that both patients and staff are experiencing.

- **Delegation of Specialist Commissioning**

Specialist services have historically been commissioned centrally by NHS England for people with rare and highly specialised conditions that require cutting-edge care and treatment, including rare cancers, genetic disorders and complex medical or surgical conditions. From 1 April 2024, the responsibility for commissioning fifty-nine of these service lines will delegate from NHS England to local Integrated Care Boards. This is a significant delegation of commissioning responsibilities, with longer term opportunities to develop specialised care pathways, both locally and across the country. We will work closely with Bedfordshire, Luton and Milton Keynes (BLMK) ICB as the host organisation in the East of England, to deliver quality oversight, assurance, and improvement within existing resources at a local level. The current Specialised Commissioning Team will transfer to BLMK ICB, to continue to support the commissioning and quality oversight of the delegated services in conjunction with the local ICBs, whilst continuing to work with NHS England for those services which will be retained nationally.

- **Independent Providers and Small Contracts**

The NHS Norfolk and Waveney Nursing and Quality Team continue to support our third sector providers attending both contract and quality meetings to ensure the provision of services is of a good quality and is safe. This methodology also enables us to support our providers to optimise delivery of services and offer alternative provision to support with current waiting lists by providing alternative referral routes. There has been significant progress with the

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introduction of Patient Safety Incident Response Framework (PSIRF) with several independent providers engaging in the implementation of this new framework.

Norfolk and Waveney ICB commission the British Pregnancy Advisory Service to deliver termination of pregnancy services. During the last year the organisation has gone through considerable changes to strengthen its governance and operational structure and processes. We are engaged with this national project and supporting the provider's local site.

Over the last 12 months, the nursing and quality team has engaged with partners, stakeholders, staff, people and communities in its work to improve nursing and quality.

Despite progress and a shift forward in many areas, several challenges remain. In particular, the recovery of local elective care pathway performance, community and hospital flow and decompression and continued mitigation of harm to patients is an area of intense scrutiny.

NHS Continuing Healthcare

The NHS Continuing Healthcare (CHC) function for NHS Norfolk and Waveney continues to be delivered by an in-housed model. The team have delivered 87% of assessing new referrals for CHC to conclusion within 28 days during 2023-24. This surpasses the target which is set nationally at 80%. During the last financial year, no individuals were assessed for CHC in an acute hospital setting.

There remains a challenge in staff recruitment for clinicians across the NHS, no less in CHC, where the ICB is recruiting to vacant positions and, following the organisational restructure in 2023/24, there are some posts still to be filled. The revised structure will give the ICB the improved capacity to deliver CHC services to patients and families across Norfolk and Waveney.

Three month and annual reviews are in focus. We continue to work with Liaison Care, an independent CHC provider, who will complete reviews over an annual period through to October 2024 whilst newly recruited staff become competent in roles. There is an ambition for us to deliver both assessments and review within our team as recruitment allows.

We continue to work closely with Norfolk County Council with an integrated post supplied by them. This role provides the essential component of linking social and health led joint assessments.

A revised, robust programme of work is in place for all staff to participate in during 2024/25 to ensure they have the necessary skills in place to deliver the NHSE framework for CHC.

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Engaging our staff, people and communities

NHS National Staff Survey

NHS Norfolk and Waveney is committed to improving staff experiences across the NHS and takes part in the National Staff Survey (NSS) annually. NHS Norfolk and Waveney participated in the annual NHS National Staff Survey. This opened for responses in October 2023 and closed December 2023.

The response rate for NHS Norfolk and Waveney was 67% (489 responses) which was slightly lower than our comparator average of 72%. Nationally in 2023 the overall results for the NHS declined for a third year, however NHS Norfolk and Waveney results told us a slightly different story. Our comparator group includes 41 organisations.

On the whole the organisation fared above our comparator average in every domain of the People Promise, and in some areas, we improved on our 2021 results. We will be focusing on improving learning and development opportunities for our staff and given the workload pressures and challenges we face; we will continue to prioritise health and wellbeing.

Our staff engagement score was 6.61 which is the same as our comparator average. The motivation factors include questions on involvement in decision-making, motivation and advocacy i.e. would they recommend this organisation as a place to work. Our staff morale score was 5.83 which was higher than the comparator average of 5.74. The moral element includes questions relating to thinking of leaving, work pressure and stressors. All results are summarised against the NHS People Promise, which we as an ICB are committed to delivering for our staff. The seven elements are;

People Promise Domain	Norfolk and Waveney ICB Score	Comparator Average Score
We are compassionate and inclusive	7.40	7.38
We are recognised and rewarded	6.68	6.51
We each have a voice that counts	6.82	6.71
We are safe and healthy	6.26	6.34
We are always learning	5.17	5.10
We work flexibly	7.26	7.26
We are a team	7.15	7.03
Staff Engagement	6.61	6.61
Staff Morale	5.83	5.74

Our 2023 ICB results include:

- above our comparator average for all 7 People Promise themes.
- above our comparator average for staff engagement and morale.
- areas showing most improvement include flexible working opportunities and bullying/harassment at work by patients/service users.
- a significant improvement in managers encouraging staff, involving them in decisions, supporting with wellbeing, and valuing work.
- areas showing a decline since our 2022 survey (in line with a national deterioration in these areas) include teams not working together to achieve objectives, feeling unwell because of work-related stress and staff reporting feeling worn out.

Our full results can be found here [National results across the NHS in England.](#)

Feedback into Action

NHS Norfolk and Waveney will continue to seek feedback from our staff through participation in quarterly 'People Pulse' surveys and participation in the annual national survey. NHS Norfolk and Waveney works positively with our Staff Involvement Group to continually look for ways to improve staff experience and to respond to their feedback.

The survey's strength is in providing a national picture alongside local detail. It captures how people experience their working lives and is aligned to the NHS People Promise. The National Staff Survey is a snapshot in time with the information gathered at the same time each year. It helps us to understand how staff are feeling and to help us to learn from their experience. The results are used to improve local working conditions and ultimately to improve patient care.

Staff experience is incredibly important to us at the ICB and across Norfolk and Waveney as a system, and we are committed to continue to listen to what our staff are saying and feeling so that we can make improvements where necessary. We are focused on being a great place to work as we want to recruit and retain the best people in our bid to continually provide outstanding care for our communities.

Following our organisational restructure, we have a plan to shape a culture that actively seeks the collaboration, inclusion, and voice of all our people, aligned to our Forward Plan to meet existing and future opportunities and challenges.

Our aim as an ICB is to co-create solutions with our staff to improve on the issues raised in the feedback from the survey and to move the organisation forwards.

Our Approach to Working with People and Communities in Norfolk and Waveney

Listening to the lived experience of the people and communities in Norfolk and Waveney is vital in helping people live longer, healthier and happier lives. It also helps us make sure that the care and support offered in Norfolk and Waveney is designed around our population.

All the partners in our ICS are talking and listening to people and communities every day. Our vision is that people would tell their story of lived experience once and it's heard by everyone in the ICS. We want to develop on-going relationships with communities to learn what matters to them, and work together to address waiting times, improve access to services and support people to live the healthiest life possible.

We want to build on the existing engagement and insight that happens across all our system partners and find ways of working together to share and learn from this insight. Working together will also mean we can pool our resources and work more efficiently across the ICS.

We have developed a [Working with People and Communities Strategy](#) which is currently being refreshed following engagement feedback.

People and Communities Hub

The ICS website hosts a dedicated [people and communities hub for Norfolk and Waveney](#), which aims to develop and maintain a shared vision in listening to and working with local people across the ICS.

The hub also gives a measurable focal point to engagement activity undertaken by the ICB as part of its legal duties. Specific projects and opportunities for working with people and communities are being advertised, and ['You said, We did/We can't'](#) reports detailing the results of the feedback and any improvements that resulted are being uploaded.

Patient Engagement Around Primary Care

General Practice

There are 105 GP practices in Norfolk and Waveney. Most of them have patient groups, often referred to as Patient Participation Groups (PPGs). They offer members of the public the opportunity to become more involved in how the practice runs. This could be about the physical building, waiting times, services offered or wider healthcare issues.

We have 17 PCNs – this is where GP practices work together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices known as PCNs.

We are working with patient representatives, practices and our local Healthwatch's to develop a programme of strategic support to local PPGs and practices so that the voice of people and communities can be reflected more locally. The ICB commissioned Healthwatch Norfolk to engage with local practices and PPGs to find out what support would be most useful.

The ICB is now working to deliver the key recommendations from [the report](#). A [webpage](#) is now in place which features case studies including examples that promote different models of patient engagement. There is also other information and links to resources including a [toolkit](#) produced by Healthwatch Norfolk following the period of engagement which aims to give practices and PPGs a step by step guide

Consultation on the Norwich Walk-in Centre

The ICB ran a consultation from 24 January – 26 March 2023 on plans for general practice services in the Norwich area when the contract for the Norwich Walk-in Centre (WiC), Vulnerable Adults Service – Inclusion Health Hub (VAS) and GP Practice at Rouen Road expired in March 2024.

A range of methods and formats were employed to seek feedback during the consultation, using a mix of face-to-face, digital, and postal engagement opportunities, as well as qualitative interviews with organisations supporting vulnerable adults, at-risk adults, adults with additional needs, and children and young people.

The consultation closed with over 3,000 responses which were received through an online survey and in writing.

[The ICB recommended to the Primary Care Commissioning Committee in May 2023 that the WiC remain open.](#) In addition, and further to feedback received, the ICB recommended that wider general practice capacity could be increased by reviewing a release of resources from the Norwich Practice Health Centre which could be channelled into increasing Enhanced Access appointment activity in early mornings, evenings and weekends in the Norwich area.

Targeted Patient Engagement – Norwich Practices Health Centre

Following the Norwich Walk-in Centre (WiC) consultation, a period of targeted patient engagement with patients registered at Norwich Practices Health Centre (NPHC) ran from 31 May – 28 June 2023.

Through this engagement, NHS Norfolk and Waveney investigated what capacity could potentially be released by reducing the opening hours of NPHC that fell outside of core opening hours (8am – 6.30pm, Monday – Friday), to create additional patient capacity at the WiC. NHS Norfolk and Waveney proposed changing the hours of NPHC to 8am – 6.30pm, Monday – Friday. This would free up 31.5 hours of funding per week that could be used to pay for additional medical services at the nearby WiC.

A total of 210 responses were received. Following a review of the feedback received by patients and staff, the ICB recommended taking a middle ground in reducing the opening hours outside of core hours. The ICB recommended for NPHC to be contracted to remain open for a minimum of 8am - 7pm on two nights during the week, and for a minimum of a 3-hour session on Saturdays. This released 27.5 hours of capacity for reinvestment into the WiC.

Engagement on priorities for NHS dental service commissioning

From 24 January – 21 February 2024, the ICB asked public, patients and healthcare stakeholders to [share their feedback on our planned priorities for commissioning NHS dental services](#) for the next two years. People were able to share their views through an online survey and paper copies of the survey returned to the ICB.

The dental engagement survey included a summary of our priorities for oral health and dental care services for the next two years. These include urgent care; developing capacity in our dental teams; improving access for children and young people and with a focus on reducing health inequalities; and promoting good oral health.

We asked for people's views on what priorities for dental services they want us to consider in our five-year long-term plans. Additionally, we also asked for feedback from those who've used the Urgent Treatment Service to inform future development of that service.

Over 2,000 people responded to the online survey and in writing. The feedback received will help develop the ICB's longer-term plans for dental services commissioning and to support development of the Urgent Treatment Service.

Norfolk and Waveney Community Voices (NWCV) Programme

Norfolk and Waveney has many different communities of interest often living alongside and merging with each other. This can make talking and listening to the different people very challenging. We are aware that although they still provide useful insight, the more traditional methods of engaging tend to have a 'response bias' where it is more likely you will hear from people if they are better educated, older, wealthier and white British.

During the COVID-19 pandemic we learnt that to reach people who are less likely to engage with us we had to use trusted communicators at very local levels, often street by street or village by village. We must focus on the hardest to hear, underserved and more vulnerable groups and actively go to them to find out what their priorities are.

The ICB is working with District Councils and the local VCSE sector to develop and deliver a new engagement programme to help us listen to our communities and better understand experiences and opinions of accessing healthcare. It started during the COVID-19 pandemic to help us understand vaccine uptake but has since looked at a range of services such as bowel cancer screening and stop smoking.

Community Voices, works with trusted communicators to speak with communities who may not already engage with the NHS and other statutory bodies to hear what is important to them. We have learned that when talking to people about health services they also talk about a range of other issues that affect their health and wellbeing, such as housing and employment. We are designing ways to capture all this insight and make sure it is shared with people who design and deliver a range of services across Norfolk and Waveney. We expect to hear about the challenges faced by local people in accessing services, and about the issues that prevent wellbeing across a range of factors, including those outside the direct health sphere such as housing, employment and finances.

Norfolk and Waveney Insight Bank

All the qualitative data we collect as part of the NWCV programme is being stored in an 'insight bank'. This is currently a survey collection tool but the vision is that it will be developed into a much wider

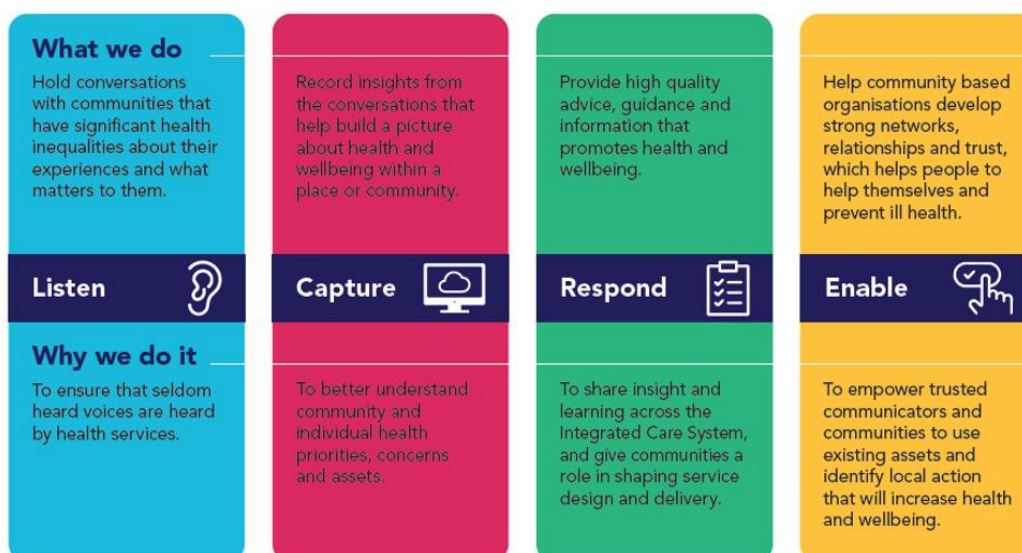
bank of insight for use across the ICS housed within a robust data platform. The qualitative data is already being shared with ICB staff through a Power BI platform, however it is envisaged that it will eventually provide anonymised information useful for all ICS partners giving insight on a street, neighbourhood, place and system level which will be useful for health and care planning and other services too.

Our vision

Norfolk and Waveney Community Voices aims to ensure that people who experience disadvantage because of where they live or who they are can be empowered to understand and act on their health, have a place to share their views, and can help shape how health services are designed and delivered.

How we do it

- By facilitating the right training and providing an infrastructure which works well – with networks, access to good quality resources and time to reflect on good practice.
- By building good quality insight data that can be shared appropriately across partner agencies
- By evaluating the effectiveness of what we do, why we do it and how we do it.
- In partnership with good governance and support from all the sectors involved.
- By recognising that good health is influenced by a range of factors.



Case Study – Norfolk and Waveney Community Voices

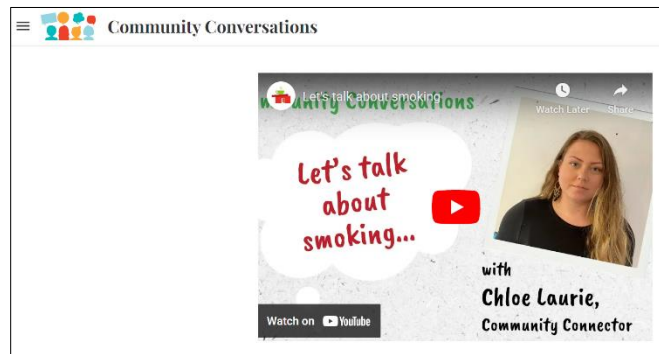
Discovering People's Experiences of Smoking and Quitting Smoking in Areas of Deprivation

From August to the end of September 2023, Community Connectors ventured out into local 'bumping spaces', pubs and community spaces in some of Norwich's most deprived communities to have conversations with residents about their experiences of smoking and quitting smoking. They were recruited and supported to do this by [The Shoebox Enterprises CIC](#).

The Connectors had received Community Voices training and smoking cessation training to help equip them with the knowledge needed to hold community conversations with residents on this topic. Their flexible approach means they can reach people where they are instead of expecting people to come to them.

The Connectors had over 100 conversations in their neighbourhoods with a wide range of people aged 18 and over who considered themselves occasional or regular smokers as well as those who had quit smoking. The conversations undertaken by Connectors through the Community Voices programme demonstrates how they can reach people who are often overlooked in communities and who typically may not engage with traditional surveys or focus groups. By operating in a non-judgemental way and just listening and being curious about people's experiences the Connectors have been able to obtain rich insights into people's realities and their complex relationships with smoking and experiences of attempting to quit.

To find out what they learned and hear from the connectors about what its like to reach out to people in this way, read the full case study on the Community Connectors website:



<https://www.communityconversations.info/project-information/stories-of-impact/exploring-experiences-of-smoking>

Working with people and communities at 'place'- level - how all the different voices of our people and communities can be part of local decision-making

The vision is to create a thriving environment for conversations with our people and communities using a spectrum of opportunities. Conversations about 'the place where I live' are often much richer.

By joining up and sharing insight gathered across the system we can hear the voice of people from all over the ICS alongside data on Place Boards, and to support the work of the [Health and Wellbeing Partnerships](#). We have the opportunity to use new sources of insight from different ICS partners, with the ambition to develop a platform(s) to enable the insight to be searchable by themes, postcode etc.

The pandemic helped all partners across Norfolk and Waveney better reach out to and hear from our more vulnerable, marginalised, underserved communities, who are better reached at place and neighbourhood level. This is especially the case if the conversations are facilitated by trusted intermediaries as referenced in the NWCV project above.

Communications and engagement resources from across the ICS are being brought together at place level to ensure the right people and communities are working in partnership to improve local health and wellbeing.

Protect NoW

The [Protect NoW programme of work](#) uses data-led, [population health management](#) approaches and comprises a growing number of distinct projects, each focused on a common cause of mental and/or physical ill health. It uses behavioural and Public Health insight to establish specific population needs and develop effective interventions through co-production with clinicians, system partners, wider stakeholders, patients and service-users.

Norfolk and Waveney Health Inclusion Group

The Norfolk and Waveney Health Inclusion Group is a multi-agency group that builds on partnership working during the COVID-19 pandemic and includes many ICS partners outside the NHS. Professionals from statutory and VCSE organisations come together to hear the voice of and understand the needs of vulnerable and health inclusion groups and align services accordingly. This group offers grassroots support to work with health inclusion groups to understand what matters to them as part of the people and communities work in Norfolk and Waveney.

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Equality Impact Assessments (EIAs)

We will continue to support the production of EIAs for projects and transformation within the engagement function of NHS Norfolk and Waveney Integrated Care Board (ICB). These have been recognised as key to reference that due thought has been given to protected characteristics and communities of interest, and also to highlight areas where the voice of people and communities is missing. They will be a key part of the Health Inequalities Strategic Framework, and are reviewed and monitored by the Health Inequalities Oversight Group (HIOG).

Listening to the voice of people in or leaving prison

It's important we recognise that the population of Norfolk and Waveney includes a significant number of prisoners. These are vulnerable people who have very little control over how their health appointments are managed outside of the prison. They experience inequality related to prison transfers which can disrupt planned care, they cannot control when or where their appointments take place, their appointment always depends on the prison being able to provide escort staff and so are regularly cancelled causing delays, and appointments are often not confidential due to escort staff having to be present.

Accessing care and support outside the prison is a really different and difficult experience for them, so it is important that we find a way for their voice to be heard in a meaningful way. Patient engagement and experience leads are working with healthcare provider representatives from the prisons in Norfolk and Waveney to improve communications channels between local health services and the prison population.

The Patients and Communities Committee

The [Patients and Communities Committee](#) provides NHS Norfolk and Waveney with assurance that it is delivering its functions in a way that meets the needs of our patients and communities across Norfolk and Waveney. That is based on engagement and feedback from local people and groups.

The Committee also specifically focusses on how NHS Norfolk and Waveney and the wider Integrated Care System is actively addressing and reducing health inequalities experienced by individuals and communities. Key to the Patients and Communities Committee will be two Committee members with lived experience, providing vital input, feedback and challenge to support our work as an organisation and the wider ICS. Recruitment for these members is due to start in 2024.

The Committee will also receive insight, make sure it is gathered appropriately, and monitor progress to ensure that change is happening. It will also constantly refer back to the 'so what' question – what this means for our people and communities.

Equality Diversity Inclusion (EDI)

We're continuously work to enhance resources for our staff and communities across Norfolk and Waveney to support EDI. Some of this work includes:

- The ongoing development of the [EDI Resource Hub](#), promoting best practices and fostering an inclusive workplace culture.
- Implementing local portals for anonymous reporting of micro-aggressions.
- Continuing to develop and promote [de-biasing recruitment and retention tools](#).
- Supporting the ['Stop the Abuse' anti-bullying and harassment campaign](#).
- Establishing Freedom to Speak Up Guardians to encourage a culture of open communication.

Our continued focus for 2023/24 was on the EDI Improvement Plan, prioritising actions to address discrimination and bias. We've been aligning with NHS values and the People Promise, implementing measurable objectives for leaders and Board members.

Leadership support programmes and mentoring/coaching opportunities are in place, alongside efforts for consistency across all provider organisations within the ICS. This includes:

- Just and Restorative Culture training
- Schwartz Rounds for empathy and compassionate care
- Support for staff network groups and psychological safety spaces.

As an organisation, we are committed to supporting initiatives like 'Let's Talk Menopause' and the Antiracism Strategy. Our aim continues to be to create environments where our workforce feels valued, respected, and motivated.

The ICB's EDI group continues to meet every two months to support and empower all staff to achieve their potential through creating positive change. The overall goal is to increase the level of knowledge, skills and understanding of issues surrounding equality, diversity and inclusion within the ICB.

We promote EDI awareness through various channels and provide Employee Assistance Programmes. Our focus areas include de-biasing policies, empowering staff voices, and enhancing education on EDI.

All of this work takes place to foster a culture of inclusion where everyone can thrive, leading to improved wellbeing and improved services for our staff, people and communities in Norfolk and Waveney.

Joint Health and Wellbeing Strategies

NHS Norfolk and Waveney ICB is an active member of both the Norfolk and Suffolk Health and Wellbeing Boards. The ICB has worked to support the four priorities in Norfolk's Joint Health and Wellbeing Strategy, as well as the cross-cutting themes in Suffolk's strategy. This section of our Annual Report summarises how the ICB has contributed to the priorities of our two local health and wellbeing strategies. Drafts of this section were shared with both Norfolk and Suffolk Health and Wellbeing Boards for their comments. In addition, the Norfolk board discussed the draft text at their meeting on 6 March 2024.

Norfolk priority: Driving integration

Suffolk cross-cutting theme: Greater collaboration and system working

The ICB has continued to work with partners to develop and strengthen our Integrated Care System over the past year. Notably, we agreed our first Joint Forward Plan in June 2023, which sets out how the local NHS and care services will implement our Integrated Care Strategy / the Norfolk Joint Health and Wellbeing Strategy. The plan has subsequently been refreshed for 2024/25, taking account of what had been delivered and to incorporate new projects.

As a system, we have delivered and made progress with a wide range of projects and changes that have and will improve the health, wellbeing and care of local people. The ICB has played an important role as a convenor, bringing together partners from across the system and providing skills and expertise, data and insight to enable us transform how we care for local people.

Examples include:

- **Working as a system to improve ambulance handovers and response times:** As a result of changes introduced at our hospitals, patients are now spending less time waiting in ambulances when they arrive at one of our hospitals. This in turn is enabling our ambulances to quickly get back on the road and to the next person who needs help.
- **Making changes to help ensure people are getting the right care, at the right time and by the right person:** RightCareNoW is a programme of work that has helped improve the way people are discharged from hospital back into the community, and reduced the number of people in our hospitals that have no medical reason to be there and who could be better cared for in their own home or another setting.

- **Sharing data better to make it easier for frontline health and care professionals to understand people's conditions and to treat them:** For example, the Norfolk and Waveney Shared Care Record can now be accessed by appropriate staff from general practice, our acute hospital trusts, the mental health trust, community services, Norfolk's Adult Social Services and Children's Services and Integrated Care 24. We have also developed and approved the Full Business Case for the Electronic Patient Record, which will see our three acute hospital trusts move from paper-based records to electronic ones. The plan is for the system to go live in March 2026.

While our Integrated Care System is not fundamentally about structures and governance, to achieve our mission and to deliver more projects and changes like these, it is vital that we have the right foundations and ways of working in place. A significant amount of work was done in 2023/24 on the ICB's organisational review. The ICB's new structure and operating model will enable greater collaboration and support system working, as well as deliver a reduction in the organisation's running costs. The structure takes account of the organisation's new functions and its role as a convener of the system. While this change has been challenging for the organisation and hard for staff this year, the benefits to the system will be felt in 2024/25.

As a system, we are strengthening integration at all levels. The ICB has:

- continued to support the development of our 17 PCNs and integrating our workforce.
- worked with partners to develop our five Place Boards, which bring together colleagues from across health and care to integrate services at a more local level.
- been an active partner in the eight local health and wellbeing partnerships, working with district councils, VCSE organisations and others to address the wider determinants of health.
- continued to contribute to the development of our Integrated Care Partnership and both Norfolk and Suffolk's Health and Wellbeing Boards.
- supported greater collaboration between providers, including through the Norfolk and Waveney Acute Hospital Collaborative and the development of two mental health collaboratives (one for adults and one for children and young people).

Norfolk priority: Prioritising prevention

Suffolk cross-cutting theme: Prevention: stabilising need and demand

The ICB has worked with a wide range of partners to make real progress with the prevention agenda, both through the use of population health management techniques and by commissioning services. Examples include:

- **Building on the success of Protect Norfolk and Waveney:** Protect NoW has continued to make strong progress and delivered a range of population health management projects over the past year. This is helping our system to provide more anticipatory and preventative care.
- **Joining-up primary care services:** On 1 April 2023, the ICB became responsible for pharmaceutical services, primary care optometry services and dental services, in addition to general practice, which we were already responsible for. This provides us with a real opportunity to commission services differently now that we are responsible for the whole of primary care. We want to use this opportunity to join-up services and to improve preventative care and the health of the population.

Norfolk priority: Addressing inequalities

Suffolk cross-cutting theme: Reducing inequalities

As a system, we are committed to working together to tackle unfair and avoidable differences in health outcomes between residents. We do this by listening to communities, prioritising prevention, and taking action together, making health inequalities everybody's business.

The ICB works with partners to reduce health inequalities by:

- using population health management techniques.
- improving access to services.
- collaborating through our place boards and local health and wellbeing partnerships
- having a Patients and Communities Committee, whose remit includes examining how the ICB is reducing health inequalities.

A key step we have taken this year is to develop our Norfolk and Waveney Health Inequalities Strategic Framework for Action, which sets out the actions we want to take as a system to tackle health inequalities.

Norfolk priority: Enabling resilient communities

Suffolk cross-cutting theme: Connected, resilient and thriving communities

The ICB is committed to supporting people to live independent healthy lives in their community for as long as possible, through promotion of self-care, early intervention and digital technology where appropriate. As set out above, we are using population health management techniques to provide more anticipatory care and early intervention. We are also using technology to empower people to manage their health and wellbeing better, for example by giving people greater visibility and control over their treatment and care journeys.

Vital to creating more resilient communities is building capacity in the voluntary, community, faith and social enterprise sector. The ICB values the work of the sector and wants to work with the sector as a trusted partner. The ICB has worked with both the sector and other partners to establish the VCSE Assembly, as well as to involve colleagues from the sector in the governance of the ICB, including by having a VCSE member on the ICB Board.

Financial review

The introduction of NHS Norfolk and Waveney on 1 July 2022 brought about the cessation of Clinical Commissioning Groups (CCGs) and inception of Integrated Care Boards (ICBs). Therefore, the financial year 2023/24 represents the first full 12-month reporting period for ICBs.

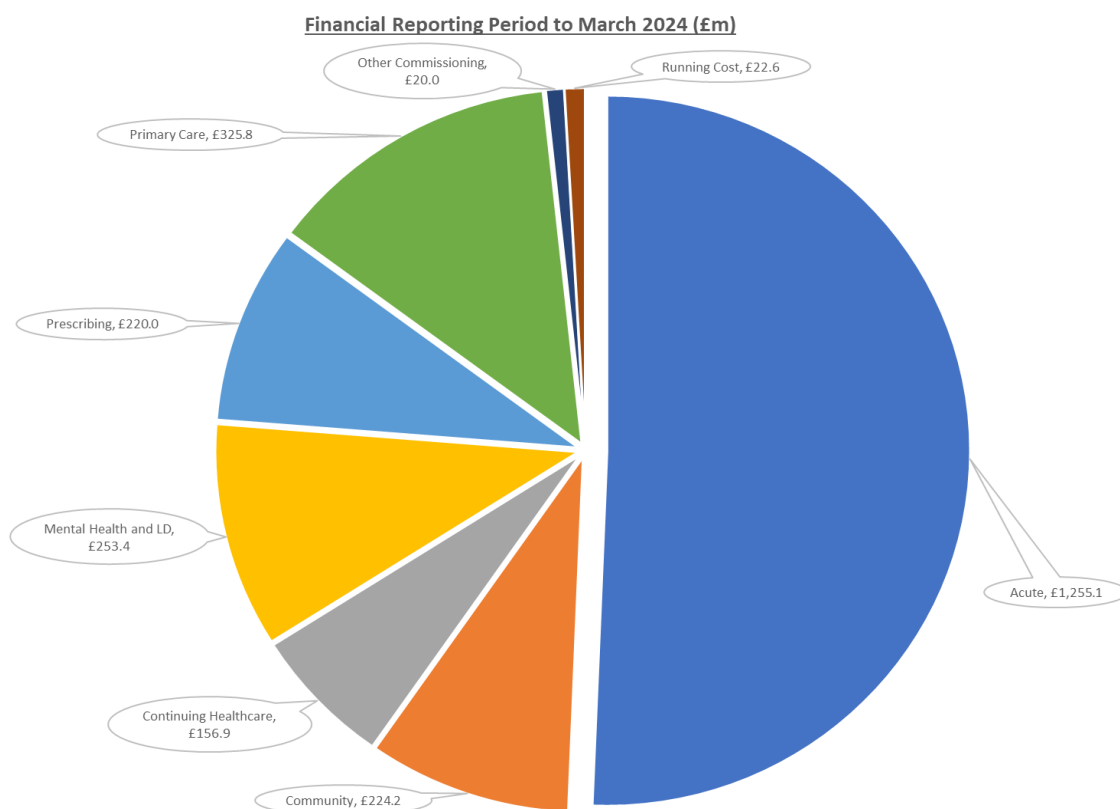
The following information reflects to the twelve-month accounting period for the ICB to 31 March 2024.

- The total allocation for the accounting period was £2,477m.
- This was split between Commissioning Health Services (£2,455m) and Running Costs (£22.6m).

The following table and chart provide a further breakdown by category of how the allocation was spent:

Area of spend	Total spend (£m)
Acute	£1,255.1
Community	£224.2
Continuing Healthcare	£156.9
Mental Health and LD	£253.4
Prescribing	£220.0
Primary Care	£325.8
Other Commissioning	£20.0
Running Cost	£22.6

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For 2023/24 Financial year, NHS Norfolk and Waveney delivered its statutory duty to breakeven, with the final reported position being a £57,000 underspend.

Within this underspend, NHS Norfolk and Waveney also remained within the allocated running cost budget and therefore delivered on all financial duties as reported in note 19 'Financial Performance Targets' of the Annual Accounts.

A key contributor to the achievement of the overall financial position was successful delivery of £39.4m of efficiencies. The main areas of delivery were:

- Prescribing (£9.7m)
- Continuing Health Care (£6.5m)
- Corporate (£8.6m) – this included the in-housing of the support services, rationalisation of corporate estate, non-recurrent benefits of phased recruitment and resolution of a long-standing dispute over invoices with NCC.
- Non-recurrent savings (£14.6m) – these included slippage on investments, contractual management and spend reviews.

The above efficiency delivery has enabled NHS Norfolk and Waveney to deliver its statutory financial duty, whilst simultaneously providing additional resources to support the ICS during a period of sustained operational pressure.

Further financial information is included in the Annual Accounts section.

SIGNED

Tracey Bleakley
Chief Executive Officer
26 June 2024

ACCOUNTABILITY REPORT

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 April 2023 to 31 March 2024, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

The **Remuneration and Staff Report** describes our remuneration policies for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Corporate Governance Report

NHS Norfolk and Waveney became a statutory body on 1 July 2022 in accordance with the Health and Care Act 2022 and following the dissolution of the NHS Norfolk and Waveney Clinical Commissioning Group on 30 June 2022.

Members' report

NHS Norfolk and Waveney's Constitution came into effect on 1 July 2022. The Chair of NHS Norfolk and Waveney is the Right Honourable Patricia Hewitt and the Chief Executive Officer is Tracey Bleakley.

Member profiles and practice

NHS Norfolk and Waveney has 105 member GP practices in Norfolk and Waveney grouped into 17 Primary Care Networks (PCNs). More information on PCNs can be found in the Performance Report.

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Composition of Board – the members of the Board are:

			
Rt Hon Patricia Hewitt Chair	Tracey Bleakley Accountable Officer	Steven Course Executive Director of Finance	Dr Frankie Swords Executive Medical Director
			
Patricia D'Orsi Executive Director of Nursing	Hein van den Wildenberg Non-executive Member	Cathy Armor Non-executive Member	David Holt Non-executive Member
			
Aliona Derrett Non-executive Member	Bill Borrett Member - Integrated Care Partnership	Debbie Bartlett Partner Member Local Authority	Stuart Keeble Partner Member Local Authority
			
Emma Ratzer Member from VCSE Assembly Board	Jon Barber Partner Member NHS Foundation Trust	Dr Hilary Byrne Partner Member	Caroline Donovan Partner Member NHS Trust

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Committees, including Audit and Risk Committee

Please see the Annual Governance Statement page 79 for details of the Audit and Risk Committee and all other Board Committees.

Register of Interests

The Register of Board Interests can be found here: <https://improvinglivesnw.org.uk/about-us/our-nhs-integrated-care-board-icb/conflicts-of-interest/>. More information on how NHS Norfolk and Waveney manages interests can be found in the Annual Audit of Conflicts of Interest Management section on page 97.

Personal data related incidents

During the period 1 April 2023 to 31 March 2024 and up to the submission of the Annual Report and Accounts there was one data security breach reported to the Information Commissioner's Office (ICO). The ICO confirmed they would not be taking any action, provided general feedback to the ICB and confirmed the case was closed.

Modern Slavery Act

NHS Norfolk and Waveney ICB fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

SIGNED

Tracey Bleakley
Accountable Officer
26 June 2024

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Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the NHS Norfolk and Waveney ICB and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that Officer shall be appointed by NHS England.

NHS England has appointed the Chief Executive Officer to be the Accountable Officer of NHS Norfolk and Waveney Integrated Care Board (the ICB). The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the ICB and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding the NHS Norfolk and Waveney ICB's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS Norfolk and Waveney ICB's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

SIGNED

Tracey Bleakley
Accountable Officer
26 June 2024

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Governance Statement

Introduction and context

NHS Norfolk and Waveney Integrated Care Board (NHS Norfolk and Waveney) is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended).

NHS Norfolk and Waveney's statutory functions are set out under the National Health Service Act 2006 (as amended).

NHS Norfolk and Waveney's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

Between 1 April 2023 and 31 March 2024, the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Norfolk and Waveney Integrated Care Board's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in the NHS Norfolk and Waveney Integrated Care Board's Accountable Officer Appointment Letter.

I am responsible for ensuring that NHS Norfolk and Waveney is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within NHS Norfolk and Waveney as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the Board is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

NHS Norfolk and Waveney Governance Framework

NHS Norfolk and Waveney's Constitution and Governance Handbook

NHS Norfolk and Waveney's Constitution is based on the Integrated Care Board Model Constitution produced by NHS England in May 2022

The Constitution sets out NHS Norfolk and Waveney Board membership, the appointment process for Board as well as the organisation's governance arrangements and includes the standing financial instructions. It also sets out how NHS Norfolk and Waveney discharges its statutory functions via its governing structure.

This is supported by NHS Norfolk and Waveney's Governance Handbook which includes the terms of reference for each of NHS Norfolk and Waveney's committees as well as the scheme of reservation and delegation, conflicts of interest policy and standards of business conduct policy.

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Board

The Board is comprised of 16 members; the chair, chief executive officer, four non-executive members, five partner members from local NHS trusts, foundation trusts, primary medical services and Norfolk County Council and Suffolk County Council, an executive director of finance, an executive medical director and executive director of nursing, a member from the VCSE Assembly Board and a member from the Integrated Care Partnership Board.

The quorum for the Board is 10 members and needs to include either the chief executive officer or the executive director of finance and either the executive medical director or the executive nursing director and at least one independent member which can include the chair and at least one partner member.

There have been three changes to the membership of the Board during the reporting period as follows:

- Stephen Collman, Chief Executive of Norfolk Community Health and Care NHS Trust stood down in November 2023 and Caroline Donovan, Chief Executive of Norfolk and Suffolk NHS Foundation Trust was appointed to the role in November 2023.
- James Bullion, Executive Director of Adult Social Services of Norfolk County Council stood down as a Partner Member in June 2023 and Debbie Bartlett, Interim Executive Director Adult Social Services was appointed to the role in June 2023.
- Sue Cook stood down in July 2023 and Stuart Keeble, Director of Public Health at Suffolk County Council was appointed to the role in October 2023.

Meetings

NHS Norfolk and Waveney held six Board meetings in public between 1 April 2023 and 31 March 2024.

Details of how members of the public are able to attend public meetings in person or join virtually, access meeting papers and minutes from previous meetings can be found on NHS Norfolk and Waveney website: <https://improvinglivesnw.org.uk/about-us/our-nhs-integrated-care-board-icb/our-icb-meetings-and-events/>. Members of the public are also able to raise questions with the Board by submitting questions to: nwicb.contactus@nhs.net.

Each meeting had been well attended and quorate. Members of the Executive Management Team also routinely attended meetings.

Membership and 'voting' attendance is recorded in the table below:

Name	Member	Attendance
Patricia Hewitt	Chair	6 out of 6 meetings 100%
Tracey Bleakley	Chief Executive Officer	6 out of 6 meetings 100%
Steven Course	Executive Director of Finance	6 out of 6 meetings 100%
Dr Frankie Swords	Executive Medical Director	4 out of 6 meetings 67%

Patricia D'Orsi (deputy Karen Watts attended 1 meeting)	Executive Director of Nursing Nursing Director, nominated deputy for Executive Director of Nursing	6 out of 6 meetings 100%
Hein Van Den Wildenberg	Non-Executive Member	6 out of 6 meetings 100%
Cathy Armor	Non-Executive Member	6 out of 6 meetings 100%
David Holt	Non-Executive Member	4 out of 6 meetings 67%
Aliona Derrett	Non-Executive Member	6 out of 6 meetings 100%
Dr Hilary Byrne	Partner Member Primary Medical Services	6 out of 6 meetings 100%
Bill Borrett	Member from Integrated Care Partnership	6 out of 6 meetings 100%
James Bullion <i>Until 02/06/2023</i>	Partner Member Local Authorities, Norfolk County Council	1 out of 1 meeting 100%
Debbie Bartlett <i>From 15/06/2023</i>	Partner Member Local Authorities, Norfolk County Council	5 out of 5 meetings 100%
Sue Cook <i>Until 31 July 2023</i>	Partner Member Local Authorities, Suffolk County Council	1 out of 1 meeting 100%
Stuart Keeble <i>From 10 October 2023</i>	Partner Member Local Authorities, Suffolk County Council	3 out of 3 meetings 100%
Emma Ratzer	Member from the VCSE Assembly Board	3 out of 6 meetings 50%
Jonathan Barber	Partner Member NHS Trusts and Foundation Trusts	6 out of 6 meetings 100%
Stephen Collman <i>Until 5/11/2023</i>	Partner Member – NHS Trusts (Mental Health and Community Services)	2 out of 3 meetings 67%
Caroline Donovan <i>From 28/11/2023</i>	Partner Member – NHS Trusts (Mental Health and Community Services)	1 out of 3 meetings 33%

Additional private meetings were held throughout the year for Board development and to discuss matters where the wider public interest or commercial confidentiality clearly required it.

The Board approved the Constitution and Governance Handbook at its inaugural meeting on 1 July 2022. The Governance Handbook has been updated regularly since then with updates approved by the Board in May, November 2023 and January and March 2024.

The Board has a number of functions conferred on it by the Health and Social Care Act 2012 (the "Act"). The main function is to ensure that NHS Norfolk and Waveney has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with good governance. The Board also leads on setting the vision and strategy of the organisation. The Board has established a Remuneration, People, Culture Committee to determine the remuneration, fees and

other allowances payable to employees or other persons providing services to NHS Norfolk and Waveney.

NHS Norfolk and Waveney's Constitution sets out the responsibilities delegated to the Board. These include providing assurance of strategic risks, ensuring registers of interest are reviewed regularly, and that financial reports including details about allocation and financial variances against plan are reviewed. These matters are standing agenda items at each Board meeting.

The following topics are frequently discussed by the Board at its meetings:

- System pressures
- Elective recovery
- Clinical threshold policy recommendations
- Financial reporting
- Risk reporting
- Reports from Committees

The Board completed a self-evaluation of its own performance and effectiveness in May 2024. This was discussed at a Board meeting on 22 May 2024 and the findings from the self-evaluation were that the Board was effective. However, areas were identified where actions could be taken to support the continued improvement and development of the Board. In addition, the Board continues to undertake a programme of development and regularly meets to focus on this work.

Board Joint Committee – Integrated Care Partnership

The Integrated Care Partnership (ICP) Committee is a joint statutory committee of NHS Norfolk and Waveney ICB, Norfolk County Council and Suffolk County Council. Councillor Bill Borrett is the Chair of this joint committee, and the ICB's chair, Rt Hon. Patricia Hewitt, is one of the Vice-Chairs.

The role of the Committee is to promote the close collaboration of the health and care system. It builds on the existing Norfolk Health and Wellbeing Board, with the expanded geography to include Waveney, to ensure better health and care outcomes for all our residents.

The Committee provides a forum for stakeholders to come together as equal partners to discuss and resolve crosscutting issues. The Committee has a central role in the planning and improvement of health and care in Norfolk and Waveney. Details of the ICP and its meetings can be found here: <https://improvinglivesnw.org.uk/about-us/our-integrated-care-partnership/>.

Since 1 April 2023 and up to 31 March 2024 the Committee met four times. Meeting attendance was good and all meetings were quorate.

The work of the committee during the reporting period 1 April 2023 to 31 March 2024 included:

- Pharmacy, ophthalmology and dental services
- Mental Health System Collaboratives
- Childrens Social Care reforms, SEND and Alternative Provision Improvement Plan
- Public Health Prevention: Cardiovascular Disease, Respiratory Disease, Cancer and Mental Health
- CQC Local Authority and Integrated Care System Assessments
- Ageing Well Priorities
- Right Care, Right Person – Norfolk and Waveney Implementation
- Integrated Winter Plan for 2023/24
- Driving Integration Through Digital, Data and Technology

- Norfolk and Waveney Health Inequalities Strategic Framework for Action
- LeDeR Annual Report and Learning Disabilities Plan
- Public Health Strategic Plan
- Department for Education Families First for Children Pathfinder Update
- Driving Integration through system wide training opportunities
- Norfolk and Waveney NHS System Capital Distribution for 2024/25
- Norfolk and Waveney Integrated Care System Suicide Prevention Strategy 2023-28

Board Committees

The Board appointed eight committees, and these are detailed below.

Primary Care Commissioning Committee

The role of this Committee is to carry out the functions relating to the commissioning of primary care matters under the terms of Delegation Agreements with NHS England. This includes the functions relating to the commissioning of primary medical services (except those that relate to individual GP performer list concerns which have been reserved to NHS England) and also from 1 April 2023 responsibility for pharmaceutical, general ophthalmic and dental (primary, community and secondary care) services.

The Committee reviewed its terms of reference during the reporting period in line with its terms of reference and these were approved by the Board.

Membership of the Committee comprises:

- A local authority partner member from NHS Norfolk and Waveney Board (Chair)
- Non-Executive Member (Vice Chair)
- Executive Director of Nursing or their nominated deputy
- Executive Director of Finance or their nominated deputy

Since 1 April 2023 and up to 31 March 2024 the Committee met 12 times.

Membership of the Primary Care Commissioning Committee together with the attendance record is provided in the table below

Name	Member	Attendance
Debbie Bartlett From July 2023	Chair, Local Authority (Norfolk) Partner Member from the Board	8 out of 9 meetings 89%
James Bullion Until April 2023	Chair, Local Authority (Norfolk) Partner Member from the Board	1 out of 1 meetings 100%
Hein Van Den Wildenberg	Deputy Chair, Non-Executive Member	11 out of 12 meetings
Steven Course (or nominated deputy)	Executive Director of Finance	12 out of 12 meetings 100%
Patricia D'Orsi (or nominated deputy)	Executive Director of Nursing	12 out of 12 meetings 100%

Highlights of the work of the committee during April 2023 to March 2024 include:

- Understanding of responsibilities for contractual, commissioning and quality matters for all primary care services: medical including PCN contracting matters, dental, optometry and community pharmacy.
- Strategic leadership, challenge and support to the primary care system drive improvement in primary care
- Performance review and monitoring of activity and finance across all primary care including transformation, workforce, digital and estates budgets to manage risk and provide assurance
- Oversight and development of new governance structures for managing responsibilities for all four primary care contractor groups through the establishment of two new delivery groups for dental and general practice, to ensure robust decision making, assurance and escalation processes are in place
- Review, monitoring and assurance of Primary Care Risk including work to improve the interface between primary and secondary care, and measures taken to improve resilience of all primary care services and establishment of practice visit programmes
Overseeing achievement against national primary care priorities such as the uptake and quality of learning disability health checks and severe mental illness health checks
- Considered individual general practice resilience issues and approving action plans, including the approval of section 96 funding support in exceptional circumstances
- Made decisions in relation to complex or reputational contractual and resilience matters thereby ensuring continuity of patient care for the local population
- Approval of programmes and strategic plans, such as primary care workforce development and transformation, access and improvement and primary care ambitions in the Joint Forward Plan including the ICB's Short Term Dental Plan and Primary Care Access and Recovery Plan
- Drive improvement in quality of primary care services including the oversight of CQC inspections, understanding the challenges emerging and the actions being taken by practices and ICB support needed
- Receiving regular reports on GP practice prescribing especially in relation to opiates and dependence forming drugs, monitoring progress to meet national benchmarks
- Receive regular reports on primary care estates plans and progress in digital developments to support general practice and PCN plans
- Approve plans for the commissioning of Locally Commissioned Services
- Receive reports from the Pharmaceutical Services Regulations Committee to provide assurance and oversight of decision making
- Receive reports on optometry contractual and commissioning matters and make decisions as required
- Represent primary care matters in the wider system and at Board level

Audit and Risk Committee

The Audit and Risk Committee provides the Board with an independent and objective view of NHS Norfolk and Waveney's assurance processes. This is achieved by reviewing financial systems, the risk management structure and ensuring compliance with the laws, regulations and directions that govern NHS Norfolk and Waveney.

The Audit and Risk Committee is comprised of:

- Non-Executive member with a lead for Audit and Risk, who is also the Chair;

- A minimum of one further ICB Board Non-Executive member in addition to the Chair
- Any further members of the Committee need not be ICB Board members

The Chair of the Audit and Risk Committee is David Holt who is the Non-Executive member with a lead for Audit and Risk and also NHS Norfolk and Waveney's Conflicts of Interest Guardian.

The Committee reviewed its terms of reference and membership during the reporting period. The Committee proposed changing the membership beyond Non Executive members and the Board approved this amendment at its meeting in November 2023.

During the reporting period the Audit and Risk Committee met 5 times. Each meeting was well attended and quorate.

Membership of the Audit and Risk Committee together with the attendance record is provided in the table below:

Member	Name	Attendance
David Holt	Chair, Non-Executive Member	5 out of 5 meetings 100%
Cathy Amor	Non-Executive Member	3 out of 5 meetings 60%
Hein Van Den Wildenberg (stepped down October 2023)	Non-Executive Member	3 out of 3 meetings 100%
Emma Ratzer (From November 2023)	Partner Member	2 out of 2 meetings 100%

The Committee was supported by regular attendance of NHS Norfolk and Waveney's Executive Director of Finance, Executive Director of Corporate Affairs and ICS Development, Director of Financial Management and Director of Commissioning Finance.

The primary role of the Audit and Risk Committee is to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across NHS Norfolk and Waveney's activities supporting the achievement of NHS Norfolk and Waveney's objectives.

The Audit and Risk Committee reviewed the adequacy and effectiveness of:

- Internal control systems;
- Risk and control related disclosure statements prior to endorsement by NHS Norfolk and Waveney;
- Principal risks and policies for ensuring compliance with regard to regulatory, legal, code of conduct requirements and self-certification;
- Policies and procedures for work related to fraud and corruption and information governance.

The Committee primarily utilises the work of Internal Audit and External Audit but is not limited to these sources. It also seeks reports and assurances from directors and managers as appropriate. The Committee concentrates on the overarching systems of integrated governance, risk management and internal control.

The Audit and Risk Committee is also responsible for ensuring that arrangements are in place for countering fraud and reviews the work of the counter-fraud specialist.

The Committee has undertaken a series of deep dives that have focused on key strategic risks that could potentially impact the organisation. These deep dives have included a review into the transition of specialist commissioning services from NHS England, risk management, the staff reorganisation and an update on the impact of the ending of the Control of Patient Information regulations by the Executive Director of Digital and Data. Each of these deep dives has stimulated discussion and review of key areas of strategic risk for NHS Norfolk and Waveney and have helped inform the work of the Committee as well as provide assurance on work being undertaken to address and mitigate risks.

Other key areas of work of the Audit and Risk Committee during the reporting period includes:

- Reviewing the Risk Management Framework and Board Assurance Framework providing assurance to the Board
- Reviewing the Annual Report and Accounts
- Reviewing reports on internal controls and counter fraud
- Discussion on delegation of responsibility for specialised commissioning from NHS England to NHS Norfolk and Waveney

The Audit and Risk Committee Chair has also met with system audit Chairs to review system effectiveness. Meetings have discussed the Joint Forward Plan and financial environment as well as system risk registers and risk appetite. Risk registers are shared between partners to ensure a system wide understanding of key issues.

Conflicts of Interest Committee Sub Committee

This committee is a sub-committee of the Audit and Risk Committee. It contributes to the overall delivery of NHS Norfolk and Waveney objectives by providing oversight and assurance to the Audit and Risk Committee on the adequacy and effectiveness of conflict of interest processes within NHS Norfolk and Waveney. The committee is authorised to make decisions on behalf of the Board about issues which could not be decided by the Board due to conflicts of interest and thus acts independently and provides a space to deliberate matters of interest.

Membership of the committee consisted of the following:

- Non-Executive Member (Chair)
- At least one further Non-Executive Member from the Board
- Executive Director of Finance (Deputy Chair)
- Executive Medical Director

The committee reviewed its terms of reference to ensure that it has the appropriate level of responsibility to discuss and decide upon possible breaches of NHS Norfolk and Waveney's Conflicts of interest Policy. The committee also reviewed the refreshed the Conflicts of Interest Policy.

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The Committee met three times during the reporting period of 1 April 2023 to 31 March 2024. The membership of the Conflicts of Interest Committee together with the attendance record is provided in the table below:

Name	Member	Attendance
David Holt	Chair, Non-Executive Member	3 out of 3 meetings 100%
Hein Van Den Wildenberg	Non-Executive Member	3 out of 3 meetings 100%
Dr Frankie Swords	Executive Medical Director	2 out of 3 meetings 67%
Steven Course	Executive Finance Director	3 out of 3 meetings 100%

Key areas of the work for the committee include:

- Committee's terms of reference
- Review of refreshed Conflicts of Interest Policy
- Review of process

Remuneration, People and Culture Committee

The Remuneration, People and Culture Committee is accountable to the Board. This Committee contributes to the overall delivery of NHS Norfolk and Waveney objectives by providing oversight and assurance to the Board on the strategic people and culture agenda as well as determining pay arrangements.

The members of the Part 1 and Part 2 Remuneration, People and Culture Committee are:

- Three non-executive members of NHS Norfolk and Waveney who are not the Chair of the Audit and Risk Committee.

In addition, the following are members of the Part 1 section of the meeting only:

- One other member appointed from the wider Norfolk and Waveney System with the relevant experience as to people and culture.
- Executive Nursing Director or nominated deputy.

The Committee's terms of reference were reviewed during the reporting period, but no changes were made.

From 1 April 2023 to 31 March 2024 the Part 1 section of the Remuneration, People and Culture Committee met 3 times. Part 1 meetings were supported by the Executive Director of People or nominated deputy. This section of the meeting contributes to the overall delivery of NHS Norfolk and Waveney objectives by providing oversight and assurance to the Board on the strategy people and culture agenda for NHS Norfolk and Waveney and its partner constituents. It scrutinises the delivery of the strategic people priorities in order to provide assurance to the Board that risks to the delivery of the people agenda are being managed appropriately. The Executive Nursing Director became a member of the Committee during the year, but an internal error did not enable attendance. This has been corrected for forthcoming meetings. The member for the wider Norfolk and Waveney System was invited to attend meetings and appointed from February 2024.

Membership of the Part 1 section of the Committee together with the attendance record is provided in the table below:

Name	Member	Attendance
Cathy Armor (Chair)	Non-Executive member	3 out of 3 meetings 100%
Hein van den Wildenberg	Non-Executive member	3 out of 3 meetings 100%
Aliona Derrett	Non-Executive member	3 out of 3 meetings 100%
Tricia D'Orsi (or nominated deputy)	Executive Director of Nursing	0 out of 3 meetings 0%
Njoki Yaxley (From 19 February 2024)	NCHC Non-Executive Member	1 out of 1 meetings 100%

The Part 1 Remuneration, People and Culture Committee's work during the reporting period included:

- Review and oversight of the strategic People agenda across the Integrated Care System including system workforce transformation programmes to scale people services, work force planning and system performance against core metrics.

From 1 April 2023 to 31 March 2024 the Part 2 section of the Committee met 9 times. Part 2 meetings were supported by the Executive Director of Corporate Affairs and ICS Development or nominated deputy and the Executive Director of People or nominated deputy.

The Part 2 meeting determines the pay and remuneration for the Chief Executive, Members of the Board and other Very Senior Managers as well as termination of employment and other contractual terms and non-contractual terms. In addition, it determines NHS Norfolk and Waveney pay policy for staff including contractual arrangements and termination arrangements taking into account national guidance as appropriate. NHS Norfolk and Waveney is supported in its work by specialty advisors and the Committee is responsible for determining their pay and overseeing contractual arrangements. This section of the meeting also reviews HR policies and is responsible for providing assurance in relation to ICB statutory duties including the Fit and Proper Person Regulations.

Membership of the Part 2 section of the Committee together with the attendance record is provided in the table below:

Name	Member	Attendance
Cathy Armor (Chair)	Non-Executive member	9 out of 9 meetings 100%
Hein van den Wildenberg	Non-Executive member	8 out of 9 meetings 89%
Aliona Derrett	Non-Executive member	9 out of 9 meetings 100%

The Part 2 Remuneration, People and Culture Committee's work during the reporting period included:

- Reviewing and determining executive and Board level pay
- Reviewing and approval of HR policies for the Integrated Care Board
- Oversight of the ICB's organisational change programme including voluntary redundancy scheme
- Review and approval of Fit and Proper Persons Test Policy

- Review and approval of national pay increase for Very Senior Managers

Patients and Communities Committee

This Committee provides NHS Norfolk and Waveney with assurance that it is delivering its functions in a way that meets the needs of patients and communities. This is based on engagement and feedback from local people and groups and takes account of and reduces the health inequalities experienced by individuals and communities. The committee exists to scrutinise the robustness of, and gain, and provide assurance to NHS Norfolk and Waveney that there is an effective system of internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care.

The Committee reviewed its terms of reference and membership during the reporting period and amendments were reviewed and approved by the Board at its meeting on 30 May 2023.

Since 1 April 2023 and up to 31 March 2024 the Committee met 6 times. Membership of the Committee together with the attendance record is provided in the table below:

Name	Member	Attendance
Aliona Derrett	Non-Executive Member of NHS Norfolk and Waveney Board (Chair)	6 out of 6 meetings 100%
Cathy Amor	Non- Executive Member of NHS Norfolk and Waveney Board	5 out of 6 meetings 83%
Emma Ratzer	VCSE Board Member on NHS Norfolk and Waveney Board	2 out of 6 meetings 33%
Mark Burgis	Executive Director Patients and Communities, ICB	5 out of 6 meetings 83%
Dr Frankie Swords	Executive Medical Director	4 out of 6 meetings 67%
Karin Bryant (from September 2023)	A representative from Commissioning, ICB	3 out of 4 meetings 75%
Suzanne Meredith	Senior Public Health Officer Norfolk County Council	6 out of 6 meetings 100%
Tracy Williams	A representative from the Place Boards and Health Inequalities advisor	6 out of 6 meetings 100%
Paula Boyce	A representative from the Health and Wellbeing Partnerships	5 out of 6 meetings 83%
Alex Stewart or deputy	A representative from Healthwatch Norfolk	4 out of 6 meetings 67%
Andy Yacoub	A representative from Healthwatch Suffolk	3 out of 6 meetings 50%

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Quality and Safety Committee

The Quality and Safety Committee is accountable to the Board. The Committee provides the Board with assurance in relation to the quality and safety of its commissioned services and NHS Norfolk and Waveney's internal processes to support safe, effective, and continuous improvement in services.

A key role of the Committee is to monitor the quality and safety of care. The Committee identifies risks and issues and provides assurance to NHS Norfolk and Waveney ICB Board. The Committee receives, and reviews quality and safety focussed reports and agrees any recommended actions to fully understand and work towards mitigation of potential and known clinical risks. It ensures all such risks are documented within the directorate or risk register for the Committee and where relevant, escalated to the Board Assurance Framework. The Committee identifies learning and improvement opportunities and communicates and shares them appropriately. Where appropriate it provides reports to external bodies.

The Non-Executive Member Deputy Chair remained a member of the Committee during the year but an internal error did not enable attendance. This has been corrected for forthcoming meetings. The Committee reviewed its terms of reference during the year to ensure they were fit for purpose.

From 1 April 2023 to 31 March 2024 the Quality and Safety Committee met eleven times.

The membership of the Committee together with the attendance record is provided in the table below:

Name	Member	Attendance
Aliona Derrett (Chair)	Non-Executive Member	11 out of 11 Meetings, 100%
Cathy Armor (deputy Chair)	Non-Executive Member	0 out of 11 Meetings, 0%
Patricia D'Orsi	Executive Director of Nursing	10 out of 11 Meetings 91%
Dr Frankie Swords	Executive Medical Director	8 out of 11 Meetings 73%
Dr Hilary Byrne	Partner Member Primary Medical Services	6 out of 11 Meetings 55%
Sue Cook until July 2023/ Stuart Keeble From October 2023	Partner Member, Local Authorities Suffolk County Council	2 out of 11 Meetings 18%
Nancy Fontaine / Rachael Cocker from March 2024	Acute provider representation, Director of Nursing - NNUH	8 out of 11 Meetings 73%
Diane Hull / Tumi Banda from September 2023	Mental health lead, Chief Nurse – NSFT	5 out of 11 Meetings 45%
Carolyn Fowler	Community provider representation, Director of Nursing - NCHC	8 out of 11 Meetings 73%

The Quality and Safety Committee provides constructive feedback on ICB policies and reports that impact on clinical quality and patient safety. Documents that have been reviewed and ratified by the Committee during the reporting period include:

- New ICB Patient Safety Incident Response Framework Policy
- New ICB Patient Choice Policy
- New ICB Safeguarding Supervision Policy
- New ICB Quality Visit Protocol
- New ICB Fabricated or Induced Illness Policy
- Annual Update to ICB Adult Safeguarding Policy
- Annual Update to ICB Safeguarding Children Policy
- Child Death Overview Panel Annual Report
- Learning from Lives and Deaths (LeDeR) Annual Report
- ICS Research & Innovation Strategy (prior to Board Approval)
- ICS Infection Prevention & Control Strategy (prior to Board Approval)
- ICS Quality Strategy (prior to Board Approval)
- ICS Learning Disabilities and Autism Plan (prior to Board Approval)

Finance Committee

The Finance Committee supports the Board in scrutinising and tracking delivery of key financial priorities, plans and targets from both a system perspective, as well as NHS Norfolk and Waveney as a stand-alone entity, as specified in NHS Norfolk and Waveney's Strategic and Operational Plans. The Committee submits information as appropriate to the Audit and Risk Committee and makes recommendations to the Board on strategic financial matters.

The membership of the Finance Committee comprises of:

- Non-Executive Member with the lead for Finance (Chair)
- Non-Executive Member (vice-Chair)
- Executive Director of Finance
- Executive Director of Performance, Transformation and Strategy
- Acute Chief Finance Officer (a serving Norfolk & Waveney Chief Finance Officer with current experience in an acute NHS provider setting)
- Non-acute Chief Finance Officer (a serving Norfolk & Waveney Chief Finance Officer with current experience in a non-acute NHS provider setting)
- Non-Executive Director (from NHS provider organisation)
- A clinical person with primary care experience.
- A finance lead from Local Authority
- A person with financial expertise from the VCSE or wider community.

The Finance Committee met 11 times from 1 April 2023 to 31 March 2024 including an extraordinary meeting in November 2023. Each meeting was well attended and quorate. Membership of the Finance Committee together with the attendance record is provided in the table below:

Name	Member	Attendance
Hein van den Wildenberg	Chair, Non-Executive Member	11 out of 11 meetings 100%
Cathy Amor	Non-Executive Member	8 out of 11 meetings 73%
Steven Course	Executive Director of Finance	11 out of 11 meetings 100%

Andrew Palmer	Executive Director of Performance, Transformation and Strategy – Deputy Chief Executive	7 out of 11 meetings 64%
Roy Clarke (or nominated deputy)	Acute Chief Finance Officer	9 out of 9 meetings 100%
Andrew Hopkins	Non acute Chief Finance Officer	8 out of 11 meetings 73%
Dr Imran Ahmed (from July 2023)	Person with primary care experience	8 out of 9 meetings 89%
Graham Ward	Non-executive director from NHS provider organisation	10 out of 11 meetings 91%
Andrew Jamieson	Finance lead from local authority	6 out of 11 meetings 55%
Lucy De Las Casas	Person with financial expertise from the VCSE or wider community	7 out of 11 meetings 64%

Key pieces of work undertaken to secure assurance include:

- Review of the membership, terms of reference, and remit of the Committee;
- Review annual budgets, medium term financial plans and detailed plans for approval by the Board;
- Monitor NHS Norfolk and Waveney's financial standing in-year and recommend corrective action to the Board should year-end forecasts suggest that the financial plan will not be achieved. For much of the financial year, the system was in a so-called 'double lock', placing additional controls on expenditures above a certain threshold
- Monitor the financial standing and financial risk profile in-year of NHS organisations in the N&W system and keep Board and other stakeholder apprised in case of financial plan not being achieved.
- Receive detailed reports at each meeting concerning the financial performance of all 6 NHS organisations in the N&W system, to incorporate narrative relating to key variances from plan;
- Receive in-depth insights into area requiring specific attention of the committee.
 - During this financial year, the committee received updates from the CFOs of NHS Norfolk and Waveney, Queen Elizabeth Hospital King's Lynn, Norfolk and Norwich University Hospital, James Paget University Hospital, Norfolk Community Health and Care Trust, East of England Ambulance Trust, respectively, as part of a rolling financial update to the committee from NHS providers and NHS Norfolk and Waveney. A similar session for Norfolk and Suffolk Foundation Trust will be held in April 2024.
 - The committee received deeper insight through briefings about and by VCSE and Norfolk County Council.
 - The committee also received updates, including financial implications, on the following topics: Mental Health Investment Standard, Discharge to Assess, Continuing Health Care, Elective Recovery Fund, Better Care Fund, Primary Care and Medicines Prescribing, ICB efficiency schemes.
- Scrutinise NHS Norfolk and Waveney's Strategic Financial Risk Register;
- Monitor implementation of any recommendations arising from the internal audit of finance functions;

The committee's work dovetailed with that of the Audit and Risk Committee in order to provide assurance to the Board that robust management of finance was in place.

Performance Committee

The Performance Committee has been established to provide NHS Norfolk and Waveney with assurance that it is delivering its functions in a way that ensures a high performing system. The Committee exists to scrutinise the robustness of and gain and provide assurance to NHS Norfolk and Waveney regarding the delivery of key performance standards by commissioned providers, performance of the system against the NHS Outcomes Framework and progress with improving wider population health outcome measures.

The membership of the Performance Committee comprises of:

- ICB Board Partner Member, Primary Medical Services (Chair)
- Executive Director of Performance, Transformation and Strategy (Deputy Chair)
- Non- Executive Member
- Executive Director of Nursing or nominated deputy
- Executive Director Patient and Communities or nominated deputy
- NHSEI Director or nominated deputy (to discharge NHSEI's statutory responsibilities in relation to provider undertakings or other SOF requirements, from time to time the NHSEI Director may need to chair an extraordinary part 2 of the committee)

Other attendees include provider Chief Executives, County Council representatives and ICB functional leads. The Committee reviewed its terms of reference during the reporting period.

The Performance committee met 6 times from 1 April 2023 to 31 March 2024. Each meeting was well attended and quorate. Membership of the Performance Committee together with the attendance record is provided in the table below:

Member	Name	Attendance
Dr Hilary Byrne	Chair, ICB Board Member, Primary Medical Services	5 out of 6 meetings 83%
Andrew Palmer	Deputy Chair, Executive Director of Performance, Transformation and Strategy	6 out of 6 meetings 100%
Hein Van Den Wildenberg	Non-Executive Member	6 out of 6 meetings 100%
Patricia D'Orsi (or nominated deputy)	Executive Director of Nursing	4 out of 6 meetings 67%
Mark Burgis	Executive Director Patient and Communities or nominated deputy	4 out of 6 meetings 67%
Adam Cayley, Helen Geall	NHSE Director and/or NHSE Director nominated deputy	6 out of 6 meetings 100%

Key pieces of work undertake to secure assurance include:

- Regular review of activity, performance, issues and risks from key areas of:
 - Urgent and Emergency Care
 - Elective Recovery

- Cancer services
- Diagnostic services
- Mental Health services
- Children, Young People and Maternity services
- Learning Disability and Autism programme
- Oversee the performance and improvement against the NHS Oversight Framework.
- Oversee the development of the Integrated Performance Reporting system, which will be used by system partners review progress against activity and performance measures and highlight where further action may be needed.
- Consider areas for an in-depth review, to seek greater assurance of service delivery, access and transformations being undertaken to improve performance.

The Committee held its last meeting in March 2024 as the meeting is being refocused to become the Commissioning and Performance Committee. Refreshed terms of reference have been approved by the Board and its first meeting has taken place in May 2024.

Freedom to Speak Up (Whistleblowing)

NHS Norfolk and Waveney is keen to ensure that staff can speak up about any concerns that relate to within the workplace or externally, in relation to danger, risk, malpractice or wrong doing which affects others. Speaking up plays a vital role in protecting patients and ensuring their safety and also improves the lives of workers.

NHS Norfolk and Waveney has adopted the 'standard integrated policy' as recommended by Sir Robert Francis following his review into whistleblowing in the NHS aimed at improving the experience of whistleblowing in the NHS; this policy has been further updated with the strengthened arrangements set out by NHS England in 2022. We have adopted this policy which is produced by NHS England as a minimum standard to help to normalise the raising of concerns for the benefit of NHS staff and patients so that staff can speak up about anything that affects patient safety or affects their working life. This can be something that doesn't feel right such as not following a process, feeling discriminated or where the behaviour of others is affecting the wellbeing of patients or colleagues.

NHS Norfolk and Waveney has a Non-Executive Board Member as sponsor for Freedom to Speak Up and has an interim guardian in place while actively recruiting to substantively cover the vacant Freedom to Speak Up Guardian role. In addition, NHS Norfolk and Waveney has Freedom to Speak Up Champions who raise awareness and promote speaking up. NHS Norfolk and Waveney also includes as mandatory training for all staff 'Speak Up' and 'Listen Up'. 'Follow Up' training for senior managers is being rolled out in 2024. The three modules are cumulative and managers and senior staff were required to complete the requisite number of modules.

Executive Management Team Meeting

The Executive Management Team (EMT) is an ICB meeting comprising the Accountable Officer, Executive Director of Finance and the Executive Directors of NHS Norfolk and Waveney (as set out in the Remuneration report) as well as other senior representation. It is the operational forum for exercising the Accountable Officer and Executive Director of Finance's authority under NHS Norfolk and Waveney's Scheme of Reservation and Delegation. It is not, however, a formal committee of the Board.

The EMT meets weekly and monitors the operational discharge of statutory duties, approves corporate contracts and oversees HR and organisational development and establishment control and monitors budgets. The EMT also regularly reviews the Board Assurance Framework. The EMT report relevant items to the Board via the Accountable Officer's report.

In addition, an ICS EMT meets fortnightly. This meeting is attended by all the system Chief Executives and ICB Executive Directors. The aim of this meeting is to provide a forum to discuss system issues including system pressures, and financial matters.

Joint Senior Leaders Meeting (JSL)

The Joint Senior Leaders (JSL) meeting is a forum for the ICB's senior managers, including EMT members, to meet and discuss a range of ICB issues. The meeting facilitates the sharing and communication of key matters. The JSL meets monthly and has no formal decision-making authority. It is chaired by the Chief Executive and topics discussed during the year include general updates from members, the staff reorganisation, the ICB's budget and financial updates, and commissioning intentions.

NHS Arden & Greater East Midlands Commissioning Support Unit (AGEM CSU)

NHS Norfolk and Waveney is supported in its work by a range of outsourced support services by AGEM CSU. These services are transactional HR support, GPIT, DSCRO and Data Services, Procurement and Freedom of Information Request services from AGEM CSU.

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance.

Discharge of Statutory Functions

NHS Norfolk and Waveney Integrated Care Board (NHS Norfolk and Waveney) has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that NHS Norfolk and Waveney is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of NHS Norfolk and Waveney's statutory duties.

Risk management arrangements and effectiveness

NHS Norfolk and Waveney's integrated risk management strategy and framework sets out NHS Norfolk and Waveney's approach to risk management.

In accordance with the framework, risks are evaluated in terms of the likelihood and consequence using an organisational risk matrix. Scores for likelihood and consequence are given out of 5 and multiplied together. The results give one of four categories of risk grading as follows:

Serious risk - immediate action required by a director

High risk – urgent senior management attention needed with action plan

Moderate risk - responsibility for assessment and action planning allocated to a named individual

Low risk – normal risks which can be managed by routine procedures

NHS Norfolk and Waveney developed a Risk Management process to ensure that risks were identified throughout the organisation. This is supported by a staff handbook to ensure that the process is clearly understood.

The Audit and Risk Committee reviews the risk management framework. Risk is reviewed regularly by the Executive Management Team with risks assessed, rated and agreed for either escalation or removal from the Board Assurance Framework (BAF). The Audit and Risk Committee reviews the risk register to ensure that matters are appropriately reported and that action plans are robust and progress is being made. Through these mechanisms NHS Norfolk and Waveney's risk appetite is assessed and regulated.

The Board meets in public every other month. Members of the public are able to see Board papers including the BAF ahead of the meetings and they are able to ask questions at the meeting or raise queries via the website in advance.

NHS Norfolk and Waveney has various controls to address its risks and identifies both internal and external assurances on these controls. These are set out clearly for each risk in the assurance framework. In addition, consideration is given to any gaps in controls or assurances so that they are considered and factored into decision making.

NHS Norfolk and Waveney's control mechanisms are used to protect financial assets, operational systems and ensure that important laws and regulations are complied with. The table below sets out some of the internal controls used and the benefits they provide:

Management of current risks	ICB Board Assurance Framework; Regular assurance and finance reports to the Board. This year a key aspect of assurance reporting focussed on the vaccination programme. Identification of risks associated with the provision of services to patients. These are mitigated through the work of the quality team and contract management of provider contracts via the contract with the CSU and in house commissioning staff; A robust programme of counter fraud and anti-bribery activity supported by the Counter Fraud Specialist whose annual plan is scrutinised by the Audit and Risk Committee.
Prevention of Risk	Through the processes mentioned above NHS Norfolk and Waveney regularly horizon scans to identify potential areas of risk. In addition, NHS Norfolk and Waveney uses its experience of and learning from adverse events to ensure that lessons are learnt. Preventative measures include: • Policy development; • Identifying and ensuring that staff comply with mandatory training requirements; • Establishing risk-sharing agreements; • Root cause analysis of incidents; • Mandating limits to decision making authority; and • Ensuring secure access to IT systems.
Deterrent to risks arising	Developing risks are managed through a number of systems and include: • Risk review by Committee and Board meetings as well as executive management team meetings; • Finance reports to the Board; • Robust programme of counter fraud and anti-bribery supported by the Counter Fraud Specialist.

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Capacity to Handle Risk

NHS Norfolk and Waveney's Integrated Risk Management Strategy and Framework supports a positive staff attitude to risk management, encouraging staff to identify, assess, manage and report risks. Staff are clear about their personal accountability and responsibilities through the Risk Management Staff Handbook, appraisal, induction and on-going training. Support is given to risk owners by the Corporate Affairs Team.

As set out above Board Assurance Framework risks are reviewed monthly by the senior management including the Executive Management Team (EMT). At these meetings risks are further discussed and escalated as appropriate on to the Board Assurance Framework. This ensures that changes to risk registers are debated and agreed at the EMT before being put on to the BAF.

To provide further assurance the Audit and Risk Committee reviews the overarching Risk Management Framework which incorporates the Integrated Risk Management Strategy and Framework and the Staff Handbook, this having been approved by the Board.

In addition, work is underway to look at risks across the system as a whole to better inform and direct the work of NHS Norfolk and Waveney. This work is reviewed by a meeting of system audit committee chairs.

NHS Norfolk and Waveney continues to develop its approach to risk management, drawing on best practice and recommendations from the internal auditors. The internal audit assurance rating for risk management in May 2024 is a split opinion with reasonable assurance for the design of controls and supporting documentation and limited assurance for the level that risk is embedded across the organisations. More detail on the limited assurance findings is set out in the Control Issues section on page 102.

Risk Assessment

Risk is assessed using a standardised organisational risk matrix, looking at risk based on likelihood and consequence. Guidance in the form of a staff handbook has been produced setting out a formal process for risk identification and evaluation.

The key risks identified as part of this process with an average risk rating of 16 or above include:

System Urgent & Emergency Care (UEC) Pressures

There is a risk that the Norfolk and Waveney health and social care system does not have sufficient resilience or capacity to meet the urgent and emergency care needs of the population whenever a need arises. This can result in longer than acceptable response times to receive treatment, delays in being discharged from hospital and as a result potentially poorer outcomes for our patients with associated clinical harms.

The above risk manifests itself as worsening ambulance response times for patients with a life threatening and / or life changing condition and an increasing number of patients remaining in hospital when they no longer meet the nationally prescribed 'criteria to reside'. The associated increase in longer lengths of stay and higher occupancy levels in all acute and community hospitals results in delays in admitting patients from our emergency departments (EDs) into a bed, this in turn congests the EDs slowing down ambulance handover leading to more crews outside hospital who are unable to be released to respond to 999 calls.

Mitigation to this risk is provided by strategic oversight by the Urgent and Emergency Care Programme Board. This meeting oversees non-elective flow and monitors a system wide transformation programme to improve the responsiveness of our urgent and emergency care pathways. In addition, there is a System Control Centre and East of England Ambulance Service

System Oversight Cell. These work alongside providers to coordinate operational responsiveness when individual or multiple providers are unable to meet patient demand in a timely and safe way.

Barriers to Full Delivery of Mental Health Transformation Programme (CYP)

There is a risk that during a period of unprecedented mental health demand and acuity of need current system capacity and models of care are not sufficient to meet demand. If this happens individual need will not be met at the earliest opportunity, by the right service or by the most appropriate person and need will escalate. This may lead to worsening inequality and health outcomes, increased demand on other services and reputational risk.

There is a system approach to increasing knowledge, skills and expertise across agencies and an effective system wide governance framework. As well as these mitigations there is a commitment from system partners to adopting Thrive approach which recognises that mental health needs to be considered and addressed in wider health and social care settings.

Providers in CQC Special Measures (NSFT)

There is a risk that services provided by Norfolk & Suffolk Foundation Trust (NSFT) do not meet the required standards in a timely and responsive way. If this happens, people who use our services will not receive access to services and care that meets the required quality standard. This may lead to clinical harm, poor patient experience and delays in treatment or services.

Mitigations in place for this risk include an Improvement Plan that is overseen by an Improvement Board, high level oversight of Grant Thornton actions, and the Trust continuing to receiving enhanced support from NHS England to sustain improvements. The Trust was reinspected and a report published in February 2023 that increased the overall rating from 'inadequate' to 'requires improvement'.

Underlying Deficit Position

If the ICB underpins its financial position via non-recurrent funding, then, this provides a risk to future years financial sustainability due to lower allocations based on historic expenditure.

This risk is being mitigated with the development of a detailed medium-term financial model that will highlight the key drivers of the deteriorating underlying deficit. In addition, key lines of enquiries have been reviewed and provide assurances as to strong financial governance and best practice adoption.

Continuing Health Care

There is a risk that NHS Continuing Healthcare (CHC) funded packages will not be filled by the provider either due to the complexity of the care required and/or their capacity or the proposed cost of care. If this happens significant pressures will be placed on the CHC nurses to source a package of care. Staff vacancies and absences may increase and the infrastructure to support provision of safe and effective care packages will be compromised. This may lead to increased financial cost to secure a care package, could impact on hospital discharges and admissions and poor outcomes for people requiring NHS funded care in the community.

There are a number of controls in place to mitigate this risk. These include but are not limited to recruiting to vacant posts within the CHC team, linking with local authority workforce teams to support care providers in additional training and support required, monitoring of time taken to secure complex care packages and escalation process for the CHC team if unable to source.

Elective recovery

The number of patients waiting for elective treatment in Norfolk and Waveney grew significantly during the pandemic. There is a risk that this cannot be reduced quickly enough to a level that meets NHS Constitutional commitments. This would also contribute to poor patient experience and may lead to an increased clinical harms for individual patients resulting from prolonged waits for treatment.

The controls and mitigations for this risk include a bi-weekly Elective Recovery Board that oversees all workstreams to improve performance and reduce harm, waiting list validation completed by each provider so that all patients are clinically prioritised, and workstreams in place to expand capacity, share learning, maximise efficiency and reduce variation in waiting times between different providers.

RAAC Planks

There is a risk of failure of the current roofing structures at two Norfolk and Waveney Acute Trusts due to their composition with RAAC Planks which are now significantly beyond their initial intended lifespan.

This could affect the safety of patients and staff. The rolling programme of inspections and remedial work to detect and mitigate this also presents a risk to the system through the requirement to close areas for remedial work, further impacting patient and staff experience as well as the ability to deliver timely urgent, emergency and elective care to our patients.

A regional RAAC response plan has been established and there is a region-wide scoping piece commissioned to look at ongoing service transition and recovery. Trusts have robust plans to manage a possible incident, however, these only cover immediate evacuation and not reprovision.

EEAST Response Time and Patient Harms

Clinical risks to patients awaiting ambulances in community. There are four categories of calls with category 1 being the most serious and category 4 the least serious. Category 1 and Category 2 response times including inability to undertake rapid release of ambulances. System-wide pressures continue affecting ambulance handover and inter-facility transfers resulting in patient harms.

This risk is managed with daily situation reports to ensure that NHS Norfolk and Waveney is sighted on real-time demand and resource. This includes pre-alert drop and go processes in place with safety netting for patients waiting to be seen. In addition, there are proactive public communications to promote the use of NHS service options reinforced by seasonal campaigns.

Right Care Now

There is an increased risk to patients no longer meeting the 'Criteria to Reside' in both acute and community hospitals, numbers of which continue to fluctuate. The cause is insufficient pathway 2 and 3 beds for people needing onward care, particularly for people with complex needs, as the local care market is not designed to meet current acuity and care requirements. This risk was previously name 'Discharge from inpatient settings' but has been renamed to align with the new programme.

Grant Thornton Mortality Review

Grant Thornton was commissioned by Norfolk and Waveney and Suffolk and North East Essex Integrated Care Boards to review the collection, processing and reporting of data. This found the processes to be unclear and rely on multiple systems to record and produce the data with inconsistencies in the categorising and grouping of expected and unexpected deaths and unclear and inconsistent decision making and reporting of community deaths. There is a risk that the Integrated Care System fails to learn from the tragic events reported in the review. This could potentially lead to

missed opportunities for prevention of future deaths which could lead to further distress of bereaved families, friends and carers who lose trust and confidence in the service. There is a significant risk of reputational damage and national media interest.

NHS Norfolk and Suffolk Foundation Trust have formulated an Action Plan to address recommendations with senior staff and responsible officers aligned to specific actions. The Trust has also developed a Standard Operating Procedure to manage data recording and validation with an auditable trail.

System Failure to meet access standards for cancer diagnosis and treatment

There is a risk that patients will come to harm due to the failure to meet access standards for cancer diagnosis and treatment.

The system Cancer Programme Board works in partnership with the regional cancer screening and immunisation team and North East of England Cancer alliance to optimise uptake and coverage of screening and support system transformation projects to expand diagnostic and treatment capacity to transform how care is delivered to improve timeliness and efficiency.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in NHS Norfolk and Waveney to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The Board assures itself that the organisation has effective control via regular reporting of the highest red rated risks to the Board and delegating to its Audit and Risk Committee the review of the assurance framework. In addition, the Audit and Risk Committee has the role of reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control across NHS Norfolk and Waveney's activities.

NHS Norfolk and Waveney established the Quality and Safety Committee to seek assurance that robust clinical quality is in place. This Committee regularly reports to the Board.

Internal Audit provides regular reports to the Audit and Risk Committee on key areas as set out in its audit plan. This plan was reviewed and agreed by the Audit and Risk Committee in March 2024 for 2024/25.

NHS Norfolk and Waveney's External Auditor is Ernst and Young who were appointed by NHS Norfolk and Waveney's predecessor organisation in January 2021. Other control mechanisms include:

- Financial Plan and Reporting;
- The Serious Incident (SI) process for reporting and investigating serious incidents
- Adoption and review of various policies
- The Quality and Safety Committee monitors provider serious incidents and risks
- The Finance Committee reviews finance performance and risk
- The Information Governance team including the Senior Information Risk Owner, Data Protection Officer and Caldicott Guardian, review data protection and confidentiality compliance, implementation of privacy by design and default, information and cyber security, management of

information risk, which is evidenced by NHS Norfolk and Waveney's annual Data Security Protection Toolkit submission.

- The work of the Counter Fraud Specialist

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest (published June 2016) requires commissioners to undertake an annual internal audit of conflicts of interest management. To support ICBs to undertake this task, NHS England has published a template audit framework.

NHS Norfolk and Waveney's Internal Auditors completed the conflicts of interest audit in March 2024. The audit reviewed business interests and secondary employment policy and compliance. It also assessed the adequacy of the process for declaration and approval of business interests', recording, monitoring, reporting and reviewing of business interests.

The finding from this audit was that reasonable assurance could be provided to NHS Norfolk and Waveney's management of conflicts of interest. The audit found three routine recommendations, one important recommendation, but no urgent recommendations. The important recommendation concerned the need for regular activity and sickness absence reviews are undertaken on staff with a business interest to ensure it is not impacting on performance.

As part of conflicts of interest management, NHS Norfolk and Waveney maintains Registers of Interests for Board and Committee members and all staff.

Declarations of interest are a standing item on all ICB Committee agendas. A Declaration of Interest form is also completed by all candidates as part of the recruitment process, and by all parties involved in any procurement evaluation process. Parties involved in procurement evaluation processes are those people (typically only ICB employees) that are part of the evaluation team. Evaluation team members will typically be requested to contribute to evaluating specific aspects of a proposal or tender based on their area of expertise such as finance, quality etc.

NHS Norfolk and Waveney also ensures that staff and Board members complete mandatory conflicts of interest training. The ICB uses a training module produced by NHS England for this purpose which is a mandatory requirement for all ICB staff and Board members to complete.

NHS Norfolk and Waveney's Conflicts of Interest Guardian is David Holt, the Non-Executive Member for governance and audit and who is also the Audit and Risk Committee Chair and the Conflicts of Interest Committee Chair.

Data Quality

NHS Norfolk and Waveney recognises the need to provide accurate, timely and clear information. Papers for the board are provided one week in advance of the meeting. This gives members time to read and adequately prepare in advance of the meeting so that they can fully contribute to it. Papers are also reviewed by senior management prior to distribution to ensure that they are clear and complete.

The Board also considered the following statement in relation to the quality of data as part of their annual self-evaluation in May 2024 as follows:

- Are agendas, minutes, actions and reports circulated in good time for Board Members to give them due consideration?

All Board Members responding to this question answered 'yes'. It is noted that some comments also included that papers were long and that whilst the software used to circulate Board papers was appreciated it would be helpful to have the ability to print directly from the system.

Information Governance

The Data Protection Act 2018 and UK General Data Protection Regulation (UK GDPR) sets the legal framework by which the organisation handles information about patients and employees, in particular personal identifiable information. This is supported by the Data Security & Protection Toolkit (DSPT). The annual submission process provides assurances to the ICB, other organisations and to individuals, that personal information is dealt with legally, securely, efficiently, and effectively.

NHS Norfolk and Waveney ICB places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. NHS Norfolk and Waveney ICB has established an information governance strategy and framework and has information governance policies, processes, and procedures in place, in line with the DSPT. The DSPT is an online self-assessment tool that enables organisations to measure their performance against the National Data Guardian's 10 data security standards.

The national submission deadline for the DSPT is 30 June 2024. An initial internal audit was completed in March 2024 with the second part of the audit completed in May 2024. An overall assessment will be provided in June 2024 and included as part of the ICB's DSPT submission.

NHS Norfolk and Waveney ICB ensures that staff undertake annual information governance training, which is enhanced by additional in-house IG awareness sessions and bespoke training for teams. NHS Norfolk and Waveney ICB has implemented a suite of information governance policies and guidance to ensure staff are aware of their roles and responsibilities in relation to information governance. IG awareness is also promoted through staff briefings as well as via a dedicated IG intranet site where all staff have access to a comprehensive package of resources and learning.

NHS Norfolk and Waveney ICB has processes in place for incident reporting and investigation of serious incidents. NHS Norfolk and Waveney ICB confirms that there was one data security breach reported to the Information Commissioner's Office (ICO) during the period 1 April 2023 to 30 June 2024. This was a breach of confidentiality relating to one staff member. The ICO confirmed they would not be taking any action, provided general feedback to the ICB and confirmed the case was closed.

To demonstrate best practice and ensure that staff learn from the management of incidents, NHS Norfolk and Waveney ICB records low level or near miss incidents within an IG Incident Log, which is reported regularly to NHS Norfolk and Waveney ICB's IG Working Group. The learning from incidents is used to inform staff awareness bulletins, policy revisions and training.

The IG Team continue to embed a culture of "privacy by design and default" across the organisation which helps the ICB to identify and document its information risk profile and manage its risk appetite. In addition, NHS Norfolk and Waveney ICB has an Information Risk Management Policy in place to ensure that its processing activities are closely monitored, and any information risks are captured within an Information Risk Register. The Risk Register is reviewed regularly by NHS Norfolk and Waveney ICB's IG Working Group which is chaired by NHS Norfolk and Waveney ICB's Senior Information Risk Owner.

The key risks identified are:

1. Ransomware
2. Lack of user awareness
3. Phishing/Social Engineering

These risks are controlled by the management of NHS Norfolk and Waveney ICB's IT Estate through consistent patching, deployment of anti-virus, encryption of all portable endpoint devices and removable media, and Multi-Factor Authentication for all ICB staff. Devices are also protected by Microsoft Defender Enterprise which is monitored both locally and nationally by the National Cyber Security Operations Centre. All inbound emails are scanned by centralised systems managed by the NHSmail team, which includes Microsoft Safe Links and Attachments as an additional control layer. Annual penetration tests of both NHS Norfolk and Waveney ICB's network infrastructure and internet facing systems are conducted. All staff complete Cyber Security training and are regularly reminded of

Cyber risks through a dedicated Cyber Awareness channel in NHS Norfolk and Waveney ICB's MS Teams system.

The security and integrity of corporate data held with the ICB's N365 environment has received assurance via an NHS Digital report detailing the controls that are in place in relation to data stored within the N365 environment, which confirms that it complies with the principles of the NCSC recommendations for data storage in the cloud.

The Information Risk Register and associated policy mirrors NHS Norfolk and Waveney's Risk Management Assurance Framework, which facilitates a process for escalation and de-escalation of risks where necessary.

A key focus for NHS Norfolk and Waveney ICB in 2024-25 is the continued management of its information assets to ensure that they are managed in accordance with the latest information security standards, best practice and Records Management Code of Practice for Health and Social Care 2023 and the use of digital solutions to support integration across the Integrated Care System.

Business Critical Models

In line with best practice recommendations of the 2013 MacPherson review into the quality assurance of analytical models, confirm that an appropriate framework and environment is in place to provide quality assurance of business-critical models.

Third party assurances

NHS Norfolk and Waveney relies on third party providers for a number of services. Assurances are provided in the form of Service Auditor Reports (SARs). The following SARS have been provided to NHS Norfolk and Waveney:

Provider and Services Delivered	Comment
NHS Business Services Authority Prescription Payments Process SAR for the period 1 April 2023 to 31 March 2024	<i>Reasonable Assurance</i>
NHS Shared Business Services: Finance and Accounting SAR for the period 1 April 2023 to 31 March 2024	<i>Reasonable Assurance</i>
Capita – Primary Care Support England Services to NHS England and delegated ICBs	<i>Qualified Opinion</i>
AGEM CSU Accounts Payable, Accounts Receivable, Financial Ledger, Financial Reporting Treasury & Cash Management, Payroll	<i>Reasonable Assurance</i>
NHS England: GP Payments to providers of General Practice services in England SAR	<i>Qualified Opinion</i>
National Calculating Quality Reporting Service is an approvals, reporting calculation system for GP practices and supports the CCG's delegated functions	<i>Reasonable Assurance</i>
NHS Electronic Staff Record Programme SAR provides NHS organisations with integrated payroll and HR service system	<i>Reasonable Assurance</i>
NHS Business Services Authority Dental Payments Process SAR for the period 1 April 2023 to 31 March 2024	<i>Reasonable Assurance</i>

The ICB receives payroll services from Whittington NHS Trust which received a reasonable assurance opinion on the internal audit of payroll in March 2024.

Control Issues

The control issues identified by NHS Norfolk and Waveney and the mitigating actions are:

Quality and Performance – Accident and Emergency

Pressures across the Norfolk and Waveney Urgent and Emergency care pathways continued during 2023. All acute hospitals oscillated between Operational Pressures Escalation Levels (OPEL) 3 and 4, regularly utilising Full Capacity Protocols. During this period there has been a commitment by system leaders, especially acute hospitals, on progressing with a zero tolerance to ambulance handover delays commencing with a reduction to 30mins. This commitment has resulted in a drastic reduction in handover times. The focus has shifted towards continuing with UEC improvements plans, both ICB and providers to deliver the nationally required 76% Emergency Department flow metric. All the work to support reduction in handover delays links directly to improving the 4hr ED performance standard.

Mitigations and actions in place include:

- Escalation approach in line with new OPEL framework including on site senior support to accelerate discharges to provide additional flow.
- Executive leadership to non-criteria to reside patient review meetings, including complex discharges and closer working with local authority.
- Development of a system wide unscheduled care coordination hub bringing together ambulance access to the stack, urgent community response and 111 in order to support to assist with signposting and flow alternatively to ED.
- Development of Same Day Emergency Care units as an alternative to Emergency Department with further specialities and pathways being developed.
- Support from ECIST through tier 1 to develop areas of improvement against identified areas of front door and flow.
- System Control Centre established and embedded 7 days per week 8am - 8pm to support system resilience
- Acute improvement plans focus on capacity, flow processes, ways of working and discharge focus before 12:00.

Quality and Performance – Ambulance Services

There has been a significant effort to improve ambulance handover times at our three acute hospitals. This has resulted in a knock on improvement to C1 and C2 response times as ambulances are available to respond. Overall ambulance conveyances have not experienced the same year on year activity increase as a result of development of urgent care hubs and admission avoidance pathways.

- IC24 validate low acuity ambulance dispositions to reduce referrals to EEAST
- Increased availability of community pathways to avoid need for ambulance despatch e.g. IC24 care home support and increased virtual ward step up capacity
- Implementation of 'call before convey' initiatives - frailty phone lines
- Establishment of Unscheduled Care Hub for improved access to alternative community pathways to decrease need for conveyance to hospital including direct review of C3 and C4 patients waiting on the ambulance stack by community provider. Further work ongoing to enable segmented C2s to be triaged as well.
- Local EEAST Norfolk and Waveney System Oversight Cell to support localised decision making on conveyances
- Hospital Ambulance Liaison Officers at all acutes

- Actions above for ED support front door flow and ambulance off loading.

These are discussed as a focused risk item at the ICB Quality and Safety Committee on a monthly basis, highlighting the number of system wide serious incident and harm categorisation, from moderate to catastrophic harm. The is captured on the system risk register and ICB Board Assurance Framework.

Quality and Performance – Mental Health and Dementia

The Norfolk and Suffolk Mental Health Trust (NSFT) is our main statutory mental health provider and is currently in special measures. There is a risk that services do not meet the required standards in a timely and responsive way. If this happens, people who use our services will not receive access to services and care that meets the required quality standard. This may lead to clinical harm, poor patient experience and delays in treatment or services. A number of areas requiring mitigation, to support NSFT alongside the wider programme of work in mental health are:

- Workforce pressures. Staff sickness and absence combined with unfilled vacancies and difficulties recruiting to key posts. Impact of CQC rating on staff recruitment, retention, wellbeing and morale. Mitigation: Workforce plan being developed to address staffing vacancies. Trust appointed Director of People to work on organisational development plan for the trust.
- 12hr 'decision to admit' breaches reported for patients presenting to hospital Emergency Departments, who require a Mental Health bed, which requires a systemwide health and social care solution. Current position is that we have significantly reduced 12 h DTA's and further work is ongoing to support further improvement. Introduction of a Mental Health Operational Performance and Escalation Level framework is helping to identify and monitor operational flow metrics for our Mental Health provider. Better oversight is possible because of automated digital reporting of near live operational data and establishment of dedicated operational flow teams to coordinate bed allocation and balancing of clinical risk across acute and community admission pathways.
- Dementia prevalence is forecast to increase with aging population, whilst mental health providers have limited financed capacity to meet demand due to restrictions placed on the use of MHIS . Mitigation: through the initial work of the adult mental health collaborative a plan to improve Dementia awareness and management has been developed. Acknowledging Dementia is not a mental health condition, the programme of work will now move to the wider Aging Well programme within the ICB for implementation and ongoing review.
- ADHD wait lists are high due to significant increase in referrals for assessments, this is not an isolated Norfolk and Waveney system issue but is also noted across most areas. To provide mitigation for this a provider framework is being developed and there is a wait list initiative in place and reducing waits.
- There are long waits to access mental health support for children and young people. Historically demand in Norfolk and Waveney has been higher than national average but there have been recent indications of a reduction in requests for support to NSFT. Mitigations in place are; a rapid improvement plan within the Trust and an increase in commissioned provision from wider system partners to further reduce referrals to NSFT, bespoke offers of support for cyp with additional complexity and need, transforming care navigators, mental health navigator pilot, NSFT is developing a recovery trajectory, the System Integrated Front

Door is further reducing demand, CYP System Collaboratives are in place in Norfolk and Waveney supporting an holistic approach to meeting need and Collaborative partners are exploring the potential use of single session intervention to make more effective use of capacity and resource

Quality and Performance – Referral to Treatment (RTT)/52 week wait

There has been a significant impact on RTT/52 week waits. To mitigate this Elective Recovery is overseen by the ICS's Elective Recovery Board (ERB) which is chaired by an acute hospital Chief Executive and meets fortnightly. Reporting into this are workstreams on clinical harm review and prioritisation, diagnostics, and models of care (each led by a Medical Director), performance, theatres and unified waiting list management (each led by Chief Operating Officer), workforce, inequalities and outpatient transformation (each led by a director). There is a workstream looking at the particular needs for children and young people with a system wide commitment to adopt the use of the CHART tool to understand priorities and potential harms. Additionally, we have commissioned a number of community-based schemes aimed at providing appropriate alternative pathways to hospital care, and optimising health for patients waiting for outpatient appointments or procedures.

The ICB has maintained performance against 104 week waits and is on track to eliminate 78 week waits by April 2023. However, this has been particularly challenged due to: additional unexpected theatre closures at one trust due to (reinforced autoclaved aerated concrete (RAAC) plank issues, impact of BMA rate card and NHS pension changes leading to a loss of staff willingness to undertake additional theatre and clinic lists, loss of elective capacity due to the impact of Urgent and Emergency Care (UEC) pressures leading to very high bed occupancy and the opening of escalation areas (requiring the diversion of physical and staff resources to UEC patients, which would otherwise have supported elective capacity).

In addition to ERB oversight and performance monitoring, the Nursing and Quality Team sit within both provider and system forums to gain further oversight into patient safety and quality concerns. This includes the clinical harm review process of patients on waiting lists, for which the team have recently undertaken a scoping exercise into each Trust's processes around the monitoring and review of patients, including their prioritisation and escalation procedures. A System Clinical Harms Group has recently been established to reduce variation of these processes and to ensure shared learning and risk monitoring is undertaken at a system level. This group will report into ERB and the System Quality Group. The Nursing and Quality Team continue to have oversight of patient safety incidents, associated with waiting times in alignment with the Patient Safety Incident Response Framework.

In addition, the ICB has identified capacity and long wait times for assessments of neurodevelopmental conditions in children and young people as a concern. There has been an increase in capacity to undertake assessments, but demand has increased three-fold over the past three years. In addition to the funded increase in capacity the following mitigations have been established

- Development of a provider framework to create additional trusted capacity for assessment and diagnosis. This can be utilized when additional funding is available.
- Established clear guidance around choice including an ICSB policy and guidance information for parents/carers and professionals.
- Established as priority area for partnership focus through Children and Young People System Collaborative and Joint Forward Plan – working group in place and developing proposals for pathway transformation.

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- Pre-diagnostic service in place to support families while awaiting assessment
- Successful bid for Partnership for Inclusion in education funding.

The ICB received a 'limited assurance' opinion for the Primary Care Delegated Commissioning internal audit. The areas of weakness are listed below:

- The ICB Integrated Performance Report nor the papers considered at the Performance Committee contain any metrics by which the Primary Care Performance and Activity is triangulated with other system metrics.
- Within monitoring of primary care performance there is work being undertaken that is not formally documented, work that is planned for which there isn't sufficient capacity and no overarching process by which the outputs from the monitoring are collaged and reported.
- The Primary Care Commissioning Committee does not provide measures of success or assurance over primary care performance to the Board.

The ICB received a split opinion of 'limited assurance' and 'reasonable assurance' for the Risk Management and Board Assurance Framework (BAF). Reasonable assurance was provided for design of controls whilst limited assurance was the finding for the level that risk management is embedded across the organisation. Areas of weakness included:

- The design of controls underpinning policies and procedures was found to be in place with some improvement matters identified, however, the operational effectiveness i.e. compliance with processes and controls highlighted that there are significant improvement matters and these were the key drivers for limited assurance opinion.
- The BAF has not been revised to reflect the ICB's current strategic goals. It is therefore not supporting decision-making, committees are not effective in review of assurances over those risks and executive management are not overseeing management of those risks.
- The Risk Management Framework does not distinguish between the operational role of executive directors and the assurance role of Non-Executive members.

Review of economy, efficiency & effectiveness of the use of resources

The financial year of 2023/24 has seen the continuation of a planned and controlled use of NHS Norfolk and Waveney's financial allocation in line with guidance from NHS England and aligned to its strategy and operational plans. Services have been procured through robust processes in line with relevant guidance and contract management has taken place in-year where appropriate. The Board received reports of financial position and forecasts each month. The Executive Director of Finance was responsible for ensuring that proper procedures were in place to enable regular checking of the adequacy and effectiveness of the control environment, in line with the fiscal responsibilities of NHS Norfolk and Waveney and national guidance. The Finance Committee scrutinised the financial reports and held the Executive Director of Finance to account for financial performance on a monthly basis. This committee conveyed to the Board it's assuredness on the accuracy and transparency of the reported financial position.

The NHS oversight framework encapsulated NHS England's method of oversight of ICBs and trusts. This framework outlines NHS England's approach to NHS oversight and is aligned with the ambitions set out in the NHS Long Term Plan and the NHS operational planning and contracting guidance. This framework assigns a system to one of four support segments (NOF 1 to 4). The segmentation decision

indicates the scale and general nature of support needs for the system as a whole. During the financial year 2023/24, NHS Norfolk and Waveney ICS exited NOF4 and progressed to NOF3, as a result of an improvement in the clinical, operational and financial performance. Further details and the segmentation assessment can be found here: [NHS England » NHS oversight framework 2022/23](#).

External Audit provides an independent opinion on the Annual Accounts, which incorporates the Value for Money opinion. Internal Audit conducts audits and provides opinions on various aspects of business as directed by the work plan, which is set by the Audit and Risk Committee as part of its delegated functions.

NHS Norfolk and Waveney ICB has delivered (a pre-audit) surplus of £57,000, against a breakeven target, for the financial year ending on 31 March 2024. Despite a well-documented challenging financial environment, NHS Norfolk and Waveney ICB continues to use the system wide transformation and efficiency processes to identify opportunities to achieve economy, efficiency and effectiveness via the NHS Norfolk and Waveney Programme Management Office (PMO). The PMO team are also embedded within the system planning and transformation team undertaking wider reviews and benchmarking for best practices.

The central management costs for NHS Norfolk and Waveney ICB were £22.6m, representing circa 0.9% of the total ICB expenditure, which is consistent to the share reported in last year's position. On 2 March 2023, NHS England published further mandated efficiency targets for these costs of 20% in 2024/25 and a further 10% in 2025/26. This direction and accompanied reduction in allocations led the ICB to undertake an Organisational Change Programme during 2023/24 in order that these financial targets are delivered recurrently in subsequential financial years.

The challenging financial environment continued to have a profound effect on the 2024/25 planning within NHS Norfolk and Waveney ICB and the wider ICS's plan containing inherent risks. These included significant risks such as not fully delivering the efficiency plan, our reliance on non-recurrent measures to address recurrent expenditure increases, the scale of the elective recovery programme, the high volumes of patients classified as No-Criteria-to Reside impacting on patient flow and requiring additional bed capacity, the requirement to deliver a 20% reduction in central management costs in-year and the significant and deteriorating underlying deficit as a result of non-recurrent mitigations.

All of these risks continue into the next financial year and are being addressed as an organisation and system priority through a Financial Recovery Board to ensure that we do not breach the statutory Break-Even duty nor the Financial Targets, or impact the Value for Money opinion in 2024/25, all whilst ensuring that patient care is not adversely impacted. This emphasises the need for the continuation of efficiency delivery at a system level with a recurrent nature, effective financial governance and reporting and scrutiny processes via NHS Norfolk and Waveney Finance Team and Finance Committee respectively.

Budgets were reviewed by the Finance Committee and recommendations made to the Board as to their approval. Day-to-day financial management and responsibility was delegated to appropriate levels on assigned strategic or operational delegated roles, in accordance with the Detailed Delegated Financial Limits policy. These reviews were in addition to monthly senior finance reviews of variances to maintain a firm grip on NHS Norfolk and Waveney's ICBs financial management, risks and mitigations.

Delegation of functions

NHS Norfolk and Waveney delegates functions internally. In particular:

The Board delegated to committees of the Board responsibility for ensuring NHS Norfolk and Waveney exercised its functions effectively, efficiently and economically and adhered to generally accepted principles of good governance:

- the **Audit and Risk Committee** assures the Board that effective systems of integrated governance, risk management and internal control were in place across the whole of NHS Norfolk and Waveney's activities; both internal and external auditors attended these meetings;
- the **Finance Committee** monitors delivery of the Financial Plan and provided assurance to the Board on NHS Norfolk and Waveney's financial performance as well as the system financial performance of ICS NHS parties;
- the **Quality and Safety Committee** assures the Board concerning the safety and quality of NHS Norfolk and Waveney's commissioned services;
- the **Remuneration, People and Culture Committee** scrutinises proposals for the remuneration of employees and other people who provided services to NHS Norfolk and Waveney and made determinations taking into account national and local guidance;
- the **Conflicts of Interest Sub Committee** was established to determine matters where the Board was conflicted in commissioning decisions and to ensure the issue would be dealt with in a consistent and transparent way, avoiding conflicts of interest; and
- the **Primary Care Commissioning Committee** was established to carry out the functions relating to the commissioning of primary medical services which included receiving regular reports on GP practice prescribing especially in relation to opiates and dependence forming drugs.
- the **Performance Committee** was established to provide NHS Norfolk and Waveney with assurance that it is delivering its functions in a way that ensures a high performing system.
- the **Patients and Communities Committee** scrutinises the robustness of and provides assurance to NHS Norfolk and Waveney that it is delivering its functions in a way that meets the needs of patients and communities that is based on engagement and feedback from local people and groups.

The Chair of each Committee reported to the Board on the work of their respective Committees, both generally as part of the meeting and as necessary to provide further detail on Committee work.

NHS Norfolk and Waveney contracted with Arden and Greater East Midlands Commissioning Support Unit (AGEM CSU) for the delivery of certain functions. These functions were subject to both service auditor reporting and internal audit review. NHS Norfolk and Waveney's internal owners of functions are held to account by the Audit and Risk Committee for the resolution of adverse findings.

The Executive Director of Finance was responsible for the overall contract and associated performance discussions with the AGEM CSU, including scrutiny of budgetary performance.

Counter fraud arrangements

NHS Norfolk and Waveney is required under the terms of the Standard NHS Contract and in accordance with the new Government Functional Standard GovS 013: Counter Fraud - to ensure that appropriate counter fraud measures are in place.

NHS Norfolk and Waveney has a robust programme of counter fraud and anti-bribery activity, supported by the appointment of an accredited Local Counter Fraud Specialist (LCFS) whose annual proportionate proactive work plan to address identified risks is monitored by the Executive Director of Finance and the Audit and Risk Committee. The member of the executive board who is responsible for tackling fraud, bribery and corruption is the Executive Director of Finance. The Executive Director

of Finance is the first point of contact for any issues to be raised by the Local Counter Fraud Specialist. Online Fraud, Corruption and Bribery Act awareness training is mandatory for all ICB staff.

Counter fraud material including NHSCFA Fraud Prevention Notices is disseminated to staff through the intranet and email. Details of all policies, procedures and key documents reviewed are reported to the Audit and Risk Committee.

The LCFS attends ICB Audit and Risk Committee meetings regularly to provide progress reports and updates, as well as providing an Annual Report of the Counter Fraud Work undertaken. The Counter Fraud Functional Standard Return (CFFSR) for 2023-24 was completed by the LCFS and reported to the Audit and Risk Committee in May 2024. It received an overall rating of 'Green' for its CFFSR submission.

The NHS Counter Fraud Authority (NHSCFA) is a health authority charged with identifying, investigating, and preventing fraud and other economic crime within the NHS and the wider health group. As a health authority focused entirely on counter fraud work, the NHSCFA is independent from other NHS bodies and directly accountable to the Department of Health and Social Care. Appropriate action is taken regarding any NHS Counter Fraud Authority (NHSCFA) quality assurance recommendations.

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 April 2023 to 31 March 2024 for NHS Norfolk and Waveney, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of NHS Norfolk and Waveney’s system of risk management, governance and internal control. The Head of Internal Audit concluded that:

- 1. **Reasonable** assurance can be given that there is a generally sound system of internal control, designed to meet the organisation’s objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.
- 2. The basis for forming my opinion is as follows:
 - i. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
 - ii. An assessment of the range of individual opinions arising from risk-based audit assignments, contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management’s progress in respect of addressing control weaknesses.

Additional areas of work that may support the opinion will be determined locally but are not required for NHS England and Improvement purposes e.g. any reliance that is being placed upon Third Party Assurances.

- 3. There are no matters to bring to your attention which have had an impact on the Head of Internal Audit Opinion.

During the period, Internal Audit issued the following audit reports:

Area of Audit	Level of Assurance Given
Core Financial Systems	Substantial

Financial Management	Substantial
Delivery of Strategies in relation to elective recovery	Reasonable
Contract Management and Performance	Reasonable
Clinical Quality and Patient Safety Reporting	Reasonable
Business Interests, Secondary Employment and Declaration of Interests	Reasonable
Health Inequalities	Reasonable
Efficiency Savings	Reasonable
Risk Management and Board Assurance Framework*	Split opinion – Reasonable Assurance and Limited Assurance
Primary Care Delegated Commissioning*	Limited Assurance

* Detail on these audits is provided in the Control Issues section above

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within NHS Norfolk and Waveney who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to NHS Norfolk and Waveney achieving its principles objectives have been reviewed. I have been advised on the implications of the result of this review by:

- The Board who reviewed the BAF regularly at meetings in public and sought assurances on the effectiveness of controls from senior managers. This was supplemented by regular review at the Executive Management Team meetings;
- The Audit and Risk Committee who scrutinised the underpinning processes behind the BAF and sought assurances on the effectiveness of controls from senior managers;
- Internal Audit as it provided an independent, objective opinion on systems of internal control as described above;
- The Finance Committee that scrutinised annual budgets and medium-term financial plans prior to agreement by the Board and monitored delivery of financial standing in-year, including delivery of the productivity plan, to ensure that NHS Norfolk and Waveney met its financial statutory duties;
- The Quality and Safety Committee that scrutinised processes for holding providers to account for the quality and safety of their contracted services and utilised reports from regulatory bodies as appropriate;
- Reliance where possible was placed on third party assurance (Service Auditor Reports) as described above;

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- The work of the Health Overview & Scrutiny Committee that provided an independent view of ICB performance; and
- Patient and public engagement events and feedback through a variety of mechanisms including complaints and compliments which provided insight into provider services.

Conclusion

With the exception of the internal control issues that I have outlined in the Annual Governance Statement, to which appropriate actions have been or are being taken, my review confirms that a sound system of internal control was in place in NHS Norfolk and Waveney ICB for the period ended 31 March 2024 and up to the date of approval of the Annual Report and Accounts.

SIGNED

Tracey Bleakley
Accountable Officer
26 June 2024

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Remuneration and Staff Report

Remuneration report

Introduction

This report gives details of NHS Norfolk and Waveney ICBs (NHS Norfolk and Waveney) Remuneration, People and Culture Committee and its policies in relation to the remuneration of its senior managers which the Board defined as Executive Directors and members of the Board.

Details of remuneration payable to the senior managers of NHS Norfolk and Waveney in respect of their services during the period 1 April 2023 to 31 March 2024 (the reporting period) are given in the tables within this report.

This Remuneration and Staff Report is not subject to audit with the exception of those sections specifically marked as such.

Remuneration, People and Culture Committee

The Remuneration, People and Culture Committee is a committee of the Board and has responsibility, under its Terms of Reference for making determinations for the remuneration, terms of service and benefit arrangements for all staff (including the Accountable Officer and Executive Directors). The Committee also has responsibility for agreeing remuneration payable to speciality advisors that support the work of NHS Norfolk and Waveney.

The Remuneration, People and Culture Committee is chaired by Cathy Armor, a Non-Executive Member of the Board. The Committee's other members are Hein van den Wildenberg, and Aliona Derrett who are both Non-Executive Members of the Board. In addition, Tricia D'Orsi or nominated deputy, Executive Director of Nursing and Njokey Yaxley, NCHC Non- Executive Member complete the membership of the Part 1 section of the meeting. Further details of the Committee are available in the Governance Statement on page 71.

Policy on the remuneration of Executive Directors

The salaries for the Chief Executive Officer (CEO) and the Executive Director of Finance (EDOF) of NHS Norfolk and Waveney are determined by the Remuneration, People and Culture Committee and covered by the guidance issued by the NHS England which are informed by and consistent with the principles set out in the Hutton Fair Pay Review. Further, additional consideration of the pay and employment conditions of other employees is taken into account when determining senior managers' remuneration. No bonus payments were made to any Executive Director during the reporting period.

Direction for determining notice periods for the Chief Executive Officer and the Executive Directors were laid out in the NHS Bodies Employment Contracts (Notice Periods) Directions 2008. The contractual notice period for the termination of the Chief Executive Officer and all other Executive Directors of NHS Norfolk and Waveney is six months on either side.

Executive Directors are, subject to eligibility, able to participate in the NHS Pension Scheme which provides salary-related pension benefits on a defined benefit basis.

NHS Norfolk and Waveney did not apply any performance conditions or assessment methods associated with senior staff/Board member reward.

All Executive Directors have rolling service contracts; the table below discloses contract start and end dates for NHS Norfolk and Waveney:

Executive Directors in post 2023-24	Role	Position start date	Position end date
Tracey Bleakley	Chief Executive Officer	01/07/2022	N/a
Steven Course	Executive Director of Finance	01/07/2022	N/a
Patricia D'Orsi	Executive Director of Nursing	01/07/2022	N/a
Dr Frankie Swords	Executive Medical Director	01/07/2022	N/a
Mark Burgis	Executive Director of Primary & Community Care	01/07/2022	N/a
Jocelyn Pike	Acting Executive Director of Mental Health Transformation	01/07/2022	N/a
Karen Barker	Executive Director of Corporate Affairs & ICS Development	01/07/2022	N/a
Andrew Palmer	Executive Director of Performance, Transformation and Strategy – Deputy Chief Executive	01/07/2022 & 16/01/2023	N/a
Ema Ojiako	Executive Director of People	07/11/2022	N/a
Ian Riley	Executive Director of Digital and Data	01/11/2022	N/a

Board Remuneration Policy (excluding executive and partner members remunerated by partner organisations)

Remuneration for the Non-Executive Members consists of a fee that reflects the commitment and time required to fulfil their obligations effectively. They are also eligible to be reimbursed for out-of-pocket expenses incurred on ICB business. Non-Executive Members are not eligible to participate in the NHS Pension Scheme.

The Partner Member for Primary Medical Services is eligible to participate in the GP Solo pension scheme.

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Board members (excluding executive members and those partner members remunerated by partner organisations) during the reporting period were as follows:

Board Members	Role	Start date	End date
Patricia Hewitt	Chair	01/07/2022	N/a
Hein van den Wildenberg	Non-Executive Member	01/07/2022	N/a
Aliona Derrett	Non-Executive Member	24/10/2022	N/a
David Holt	Non-Executive Member	01/07/2022	N/a
Catherine Amor	Non-Executive Member	01/07/2022	N/a
Dr Hilary Byrne	Partner Member - Primary Medical Services	01/07/2022	N/a

Percentage change in remuneration of highest paid director

	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	4%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	10%	0%

The average percentage change in respect of employees includes a non-consolidated payment for employees relating to 2022-23 paid in June 2023.

For 2023 to 2024, the government has given Agenda for Change staff a 5% consolidated increase in pay, worth at least £1,065.

Pay ratio information (subject to audit)

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director/member in Norfolk & Waveney ICB against the 25th percentile, median and 75th percentile of remuneration of the organisation’s workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director/Member in Norfolk and Waveney ICB in the reporting period 1 April 2023 and 31 March 2024 was £205,000 to £210,000. ICB prior year is for 9 months only (1 July 2022 to 31 March 2023).

The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

2023-24	25th percentile	Median	75th Percentile
Total remuneration (£)	34,581	45,996	58,972
Salary component of total remuneration (£)	34,581	45,996	58,972
Pay ratio information	6.0:1	4.5:1	3.5:1
2022-23 (for the period 1 July 2022 to 31 March 2023)			
Total remuneration (£)	32,934	41,659	56,164

Salary component of total remuneration (£)	32,934	41,659	56,164
Pay ratio information	6.0:1	4.7:1	3.5:1

During the reporting period 2023-24, no employees received remuneration in excess of the highest-paid director/member (2022-23: none previous year comparator for ICBs is 9 months). Remuneration ranged from £16,608 to £205,485 (2022-23 £16,000 to £195,700 previous year comparator for ICBs is 9 months).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

No performance pay or bonuses were paid during the reporting period.

Remuneration increased in line with the 2023-24 Agenda for Change pay award.

Remuneration of Very Senior Managers

Details of remuneration payable to the senior managers of NHS Norfolk and Waveney ICB in respect of their services during the reporting period are given in the table below. 3 Senior managers were paid more than £150,000 per annum.

The salaries for these posts are in accordance with NHS guidance issued in April 2023 and developed and agreed with the Department of Health and Social Care for ICBs with a population size of 1 – 1.5 million. The salaries for these posts have also been approved by NHS England (NHSE).

All very senior manager salaries for ICB roles have been agreed by NHS Norfolk and Waveney's Remuneration, People and Culture Committee having been considered appropriate in line with NHSE guidance.

Senior manager remuneration (including salary and pension entitlements) (subject to audit)

Name and Title	1 April 2023 to 31 March 2024					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension- related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Tracey Bleakley - Chief Executive Officer	205-210	0	0	0	47.5-50	255-260
Dr Frankie Swords - Executive Medical Director	195-200	0	0	0	0	180-185
Patricia D'Orsi - Executive Director of Nursing	140-145	0	0	0	0	55-60

Name and Title	1 April 2023 to 31 March 2024					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension- related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Mark Burgis - Executive Director of Patients and Communities	125-130	0	0	0	7.5-10	135-140
Steven Course - Executive Director of Finance	170-175	0	0	0	0	0
Jocelyn Pike – Acting Executive Director of Mental Health Transformation	120-125	0	0	0	0	20-25
Karen Barker - Executive Director of Corporate Affairs & ICS Development	120-125	0	0	0	25-27.5	145-150
Andrew Palmer – Executive Director of Performance, Transformation & Strategy and Deputy Chief Executive Officer	140-145	0	0	0	0	30-35
Ema Ojiako - Executive Director of People	125-130	0	0	0	32.5-35	155-160
Ian Riley - Executive Director of Digital and Data	135-140	0	0	0	0	35-40
Hein van den Wildenberg - Non Executive Member	15-20	0	0	0	0	15-20
Aliona Derrett - Non Executive Member	15-20	0	0	0	0	15-20
David Holt - Non Executive Member	15-20	0	0	0	0	15-20

Name and Title	1 April 2023 to 31 March 2024					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension- related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Catherine Armor - Non Executive Member	15-20	0	0	0	0	15-20
Patricia Hewitt - Non Executive ICS Chair	60-65	0	0	0	0	60-65
Dr Hilary Byrne - Partner Member - Primary Medical Services	25-30	0	0	0	0	25-30

The pension 2023-24 figures are affected by the Public Service Pensions Remedy, McCloud, with membership between 1 April 2015 and 31 March 2022 moved back into the 1995/2008 Scheme on 1 October 2023 which resulted in some pension values presenting as negative. Negative values are not disclosed in this table but are substituted with a zero. For more detail see Pension Table note.

****Note:** Taxable expenses and benefits in kind are expressed to the nearest £100.

Name and Title	1 July 2022 to 31 March 2023					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension- related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Tracey Bleakley - Chief Executive Officer	145-150	0	0	0	52.5-55	200-205
Dr Frankie Swords - Executive Medical Director	125-130	0	0	0	0	125-130
Patricia D'Orsi - Executive Director of Nursing	100-105	0	0	0	55-57.5	155-160

Name and Title	1 July 2022 to 31 March 2023					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension- related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Howard Martin – Executive Director for Population Health Management & Health Inequalities to 31 October 2022 *	35-40	0	0	0	20-22.5	60-65
Mark Burgis - Executive Director of Patients and Communities	90-95	0	0	0	50-52.5	145-150
Steven Course - Executive Director of Finance	125-130	0	0	0	105-107.5	230-235
Jocelyn Pike – Acting Executive Director of Mental Health Transformation	90-95	0	0	0	60-62.5	150-155
Karen Barker – Executive Director of Corporate Affairs & ICS Development	85-90	0	0	0	35-37.5	120-125
Andrew Palmer – Executive Director of Performance, Transformation & Strategy and Deputy Chief Executive Officer	95-100	0	0	0	55-57.5	150-155
Ema Ojiako - Executive Director of People from 07 November 2022	45-50	0	0	0	42.5-45	90-95
Ian Riley - Executive Director of Digital and Data from 01 November 2022	55-60	0	0	0	57.5-60	110-115

Name and Title	1 July 2022 to 31 March 2023					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension- related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Hein van den Wildenberg - Non Executive Member	10-15	0	0	0	0	10-15
Aliona Derrett - Non Executive Member from 24 October 2022	5-10	0	0	0	0	5-10
David Holt - Non Executive Member	10-15	0	0	0	0	10-15
Catherine Armor - Non Executive Member	10-15	0	0	0	0	10-15
Patricia Hewitt - Non Executive ICS Chair	45-50	0	0	0	0	45-50
Dr Hilary Byrne - Partner Member - Primary Medical Services	20-25	0	0	0	0	20-25

The figures in the table above represent the actual payments made in year rather than full year salaries. The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual.

The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

Pension benefits as at 31 March 2024 (subject to audit)

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Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2024 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2023	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2024	(h) Employers Contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Tracey Bleakley - Chief Executive Officer	2.5-5	0-2.5	5-10	0-5	54	38	125	0
Francesca Swords - Executive Medical Director	0	52.5-55	70-75	205-210	1244	296	1681	0
Patricia D'Orsi - Executive Director of Nursing	0	22.5-25	40-45	110-115	867	79	1053	0
Mark Burgis - Executive Director of Patients and Communities	0-2.5	0-2.5	30-35	0-5	341	100	493	0
Steven Course - Executive Director of Finance	0	32.5-35	55-60	145-150	906	122	1142	0
Jocelyn Pike – Acting Executive Director of Mental Health Transformation	0	27.5-30	30-35	80-85	527	82	679	0
Karen Barker – Executive Director of Corporate Affairs & ICS Development	0-2.5	0-2.5	25-30	0-5	224	94	357	0
Andrew Palmer – Executive Director of Performance, Transformation & Strategy	0	25-27.5	40-45	110-115	690	111	879	0

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Ema Ojjako - Executive Director of People	0-2.5	0-2.5	20-25	0-5	180	54	269	0
Ian Riley - Executive Director of Digital and Data	0	35-37.5	35-40	100-105	593	142	814	0

On 1 April 2015, the government made changes to public service pension schemes which treated members differently based on their age. The public service pensions remedy puts this right and removes the age discrimination for the remedy period, between 1 April 2015 and 31 March 2022. Part 1 of the remedy closed the 1995/2008 Scheme on 31 March 2022, with active members becoming members of the 2015 Scheme on 1 April 2022. For Part 2 of the remedy, eligible members had their membership during the remedy period in the 2015 Scheme moved back into the 1995/2008 Scheme on 1 October 2023. This is called 'rollback'.

Where a member who is a senior manager is affected by rollback the benefits in respect of their pensionable service during the remedy period are valued as being in the 1995/2008 Scheme. This means you may notice a difference between the benefits and Cash Equivalent Transfer Value (CETV) we quote for this year as compared to the benefits and CETV we quoted for year ending 2023.

Francesca Swords, Patricia D'Orsi, Mark Burgis, Steven Course, Jocelyn Pike, Karen Barker, Andrew Palmer and Ian Riley are affected by the public service pensions remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

In accordance with the Disclosure of Senior Managers' Remuneration (Greenbury) 2020 guidance, no CETV will be shown for pensioners and senior managers over normal pension age (NPA).

The declaration of pension contributions in this report is made in accordance with the guidelines issued under the Greenbury Report.

The details contained in the above tables relate to those members of the Board and Senior Management Team for whom pension details were available. Those not included where:

- Non-Executive Members whose remuneration is not pensionable.
- GPs on the Board who were not members of the normal NHS Pension Scheme but did contribute to the NHS GP Solo Pension Scheme. The GP Solo Pension Scheme benefits are not included in the above table as we are unable to identify which part of that scheme relates to their work as Board Members.

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional

years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement or for loss of office (subject to audit)

No compensation was paid on early retirement or for loss of office.

Payments to past directors (subject to audit)

There were no payments made by NHS Norfolk and Waveney to past senior managers for services rendered or compensation due either in this or the previous financial year.

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Staff Report

NHS Norfolk and Waveney has a highly skilled, motivated and experienced workforce of commissioning managers and support staff. During the reporting period the average workforce was 711.1 WTE (whole time equivalent). In addition to employed staff, NHS Norfolk and Waveney engaged with general practitioners and nurses from across the Norfolk and Waveney area to provide clinical expertise and input into its decision making and actively supporting the organisation in aspiring for better health, better care and better value for the population.

Staff numbers and composition (subject to audit)

As an employer we adopt the National Agenda for Change (AfC) pay framework and the following tables show the breakdown of functional categories and gender as at year end:

The staff headcount is of all staff employed by NHS Norfolk and Waveney as at 31 March 2024.

Staff Composition by Occupational Code (headcount)	Female	Male	Total
Chair & Non-Executive Board Members	5	2	7
Clerical and Administrative	278	67	345
Clinical Members	17	11	28
Managers	96	59	155
Nursing Professionals	96	9	105
Scientific, Therapeutic & Technical Professionals	33	3	36
Senior Managers	20	16	36
Other - Non AfC non-ICB shared posts	8	3	11
Other - Seconded/Agency staff	43	10	53
Total	596	180	776

NHS Occupational codes presented above reflect the nature of the role undertaken, this may show a difference to the roles in the table below. For example, Board Members where occupational codes consider these as Nursing or Clinical.

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Staff Composition by band (headcount)	Female	Male	Total
VSM	7	4	11
Chair & Non-Executive Board Members	5	2	7
Other - Non AfC ICB members	18	14	32
Band 9	6	3	9
Band 8d	12	9	21
Band 8c	38	12	50
Band 8b	44	24	68
Band 8a	77	32	109
Band 7	91	35	126
Band 6	105	19	124
Band 5	65	14	79
Band 4	66	6	72
Band 3	54	3	57
NCC Recharges	8	3	11
Total	596	180	776

Whilst these tables detail the breakdown of staffing by banding from a gender perspective, other metrics are monitored including the Workforce Race Equality Standard (WRES) which reflects career progression and personal perceptions of black and minority ethnic staff treatment by colleagues. The progress against workplans are reviewed by both the workforce team and the staff Equality, Diversity and Inclusion Group.

NHS Norfolk and Waveney also recognises that individuals may identify themselves outside of female or male categories however these tables capture NHS Norfolk and Waveney's workforce.

Employee benefits (subject to audit)

For reporting period 1 April 2022 to 31 March 2023	Permanent Employees	Other	2023-24 Total
Employee benefits	£000's	£000's	£000's
Salaries and wages	34,501	2,487	36,988
Social security costs	3,825	154	3,979
Employer Contributions to NHS Pension scheme	6,354	168	6,523
Other pension costs	5	0	5
Apprenticeship Levy	153	0	153
Termination benefits	1,369	0	1,369
Gross employee benefits expenditure	46,207	2,810	49,017

PY Comparison	Permanent Employees	Other	2022-23
Employee benefits	£000's	£000's	£000's
Salaries and wages	23,974	2,236	26,210
Social security costs	2,470	161	2,631
Employer Contributions to NHS Pension scheme	3,900	185	4,085
Other pension costs	10	0	10
Apprenticeship Levy	97	0	97
Termination benefits	211	0	211
Gross employee benefits expenditure	30,662	2,582	33,244

Note the previous year comparator for the ICB is 9 months.

Sickness absence data

Department of Health & Social Care (DHSC) has taken the decision to not commission the data production exercise for NHS bodies. The link to the latest NHS Digital publication series is as follows:

<https://www.gov.uk/government/statistics/nhs-sickness-absence-rates-january-2024>

Staff Turnover

For the reporting period to 31 March 2024 the staff turnover for NWICB stood at 17.94%

Staff engagement percentages

NHS Norfolk and Waveney is committed to improving staff experiences across the NHS and takes part in the National Staff Survey (NSS) annually.

The response rate for the ICB was 67% which was slightly lower than our comparator average of 68% (41 ICBs participated in the 2023 survey).

Our 2022 response was 68% so not statistically significantly different, however the comparator average deteriorated from 2022 when the response rate was 73%

Our staff engagement score was 6.61 which is higher than the comparator average of 6.49 (out of a maximum score of 10)

The motivation factors include questions on involvement in decision-making, motivation and advocacy i.e. would they recommend this organisation as a place to work..

Our staff morale score was 5.83 which was higher than the comparator average of 5.60 (out of a maximum score of 10)

The moral element includes questions relating to thinking of leaving, work pressure and stressors.

Nationally in 2023 the overall results for the NHS declined for a third year, however our ICB results are on average above our comparable group average across the seven People Promise themes. We are committed to listening to our staff and improving their experience of working in the ICB, our results highlight areas that we want to specifically concentrate on. In response to feedback, and working in collaboration with our staff we will be focusing on key actions including; appraisals linked to development needs to support new ways of working, leadership and management development and we will continue to prioritise health and wellbeing, in particular on factors highlighted in our results.

Feedback into Action

NHS Norfolk and Waveney will continue to seek feedback from our staff through participation in quarterly 'People Pulse' surveys and participation in the annual national survey.

NHS Norfolk and Waveney works positively with our Staff Involvement Group to continually look for ways to improve staff experience and to respond to their feedback.

The survey's strength is in providing a national picture alongside local detail. It captures how people experience their working lives and is aligned to the NHS People Promise. The National Staff Survey is a snapshot in time with the information gathered at the same time each year. It helps us to understand how staff are feeling and to help us to learn from their experience. The results are used to improve local working conditions and ultimately to improve patient care.

Staff policies

NHS ICB HR policies are based on NHS Business Services Authority policies and as such have been agreed by Trade Unions. HR policies are reviewed and agreed at our People, Culture and Remuneration committee and where relevant HR personnel engage with trade unions to support good working relationships.

HS Norfolk and Waveney follows an Equality, Diversity and Inclusion Policy and is committed to equality of opportunity for all employees. This is about giving fair consideration to applications for employment from groups of people with particular characteristics who may otherwise face discrimination. The nine protected characteristics are age, disability, ethnic origin and race, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

NHS Norfolk and Waveney is committed to improving equality of opportunity to disabled people and gives full and fair consideration to applications for employment made by disabled persons and promotes the provision of training and guidance and the impartial application of all employment policies and procedures. Occupational health advice and support is available to all staff and specialist advice sought for disabled employees.

More information on NHS Norfolk and Waveney's approach to equality and inclusion can be found under 'Other employee matters' below.

Trade Union Facility Time Reporting Requirements

The Trade Union (Facility Time Publication Requirements) regulations 2017, requires relevant public sector organisations to report on trade union facility time in their organisations. Facility time is paid time off for union representatives to carry out trade union activities.

Table 1 - Relevant union officials

Total number of employees who were relevant union officials during 2023-24:

Number of employees who were relevant union officials during 2023-24	Full-time equivalent employee number
1	1

Table 2 - Percentage of time spent on facility time

Percentage of working time spent on facility time by employees who were relevant union officials employed during 2023-24:

Percentage of time	Number of employees
0%	0
1-50%	1
51-99%	0
100%	0

Table 3 - Percentage of pay bill spent on facility time

Percentage of total pay bill spent on paying employees who were relevant union officials for facility time during 2023-24:

Total cost of facility time	£
Provide the total cost of facility time	5,932
Total pay bill	49,017,324
Percentage of the total pay bill spent on facility time	0.01%

Table 4 - Paid trade union activities

Percentage of total paid facility time hours spent by employees who were relevant union officials during 2023-24 on paid trade union activities:

Time spent on paid trade union activities as a percentage of total paid facility time hours	3%

Other employee matters

Equality, Diversity and Inclusion

NHS Norfolk and Waveney has due regard to the three aims of the public sector equality duty under the Equality Act 2010 to:

- Eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act
- Advance the equality of opportunity between people who share a protected characteristic and people who do not share it, and
- Foster good relations between people who share a protected characteristic and people who do not share it.

Diversity is viewed positively, we recognise that everyone is different and value the unique contribution that everyone's experience, knowledge and skills can make. Equality and inclusion are stated objectives.

The promotion of equality, diversity and inclusion is pursued through policies that ensure employees receive fair, equitable and consistent treatment and existing and potential employees are not subject to any form of discrimination. Enabling employees to work in an environment where they can give their best. NHS Norfolk and Waveney's Equality, Diversity and Inclusion Policy seeks to meet and exceed our responsibilities as a public-sector employer under the Equality Act 2010.

To support this work an Equality, Inclusion and Diversity Lead has been appointed by NHS Norfolk and Waveney and NHS Norfolk and Waveney has established an Equality, Inclusion and Diversity Group to ensure that NHS Norfolk and Waveney continues to develop opportunities for all employees. More information can be found on our website here : <https://improvinglivesnw.org.uk/about-us/our-nhs-integrated-care-board-icb/equality-and-inclusion/>

Health and Safety

NHS Norfolk and Waveney is committed to ensuring the health, safety and welfare of its employees and of course others who may be affected by ICB activities. NHS Norfolk and Waveney takes all reasonably practicable steps to achieve this commitment and to comply with statutory obligations and

to promote a positive health and safety culture throughout the organisation. Health and safety training is provided via e-learning for all staff. This mandatory training covers the core requirements for a low risk office environment and each module contains an assessment that must be passed by staff.

Pension

Employees of NHS Norfolk and Waveney are covered by the provisions of the NHS Pension Scheme. For information as to how pension liabilities were treated, please refer to accounting policy 3.4. In respect of senior managers in NHS Norfolk and Waveney, pension entitlements are disclosed within this Remuneration Report.

Expenditure on consultancy

Where NHS Norfolk and Waveney does not have the requisite skills or capacity within the organisation to deliver specific aspects of its obligations or to develop further the services that it would wish to provide it relies on external organisations and individuals to provide those skills or capacity.

During the reporting period NHS Norfolk and Waveney spent £683,436 on consultancy services as outlined below. (1 July 2022 to 31 March 2023, 9-month reporting period £1,647,474).

Consultancy service	Cost £'s
Human Resource, Training & Education Consultancy	103,203
Strategy Consultancy	164,870
IT/IS Consultancy	415,363
Total	683,436

Off-payroll engagements

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2024 for more than £245* per day

	Number
Number of existing engagements as of 31 March 2024	20
Of which, the number that have existed:	
for less than one year at the time of reporting	11
for between one and two years at the time of reporting	8
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

The ICB can provide assurance that all existing off-payroll engagements have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary.

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2023 and 31 March 2024, for more than £245⁽¹⁾ per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2023 and 31 March 2024	30
<i>Of which:</i>	
No. not subject to off-payroll legislation ⁽²⁾	23
No. subject to off-payroll legislation and determined as in-scope of IR35 ⁽²⁾	0
No. subject to off-payroll legislation and determined as out of scope of IR35 ⁽²⁾	7
the number of engagements reassessed for compliance or assurance purposes during the year	1
Of which: no. of engagements that saw a change to IR35 status following review	0

⁽¹⁾ The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

⁽²⁾ A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2023 and 31 March 2024

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements.	2

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Exit packages, including special (non-contractual) payments (subject to audit)

Table 1: Exit Packages

Exit package cost band (inc. any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000			1	8,112	1	8,112		
£10,001 - £25,000	2	32,443	5	95,568	7	128,011		
£25,001 - £50,000	1	25,516	6	205,470	7	230,986		
£50,001 - £100,000			7	537,862	7	537,862		
£100,001 - £150,000			2	215,544	2	215,544		
£150,001 - £200,000			1	160,000	1	160,000		
TOTALS	3	57,959	22	1,222,556	25	1,280,515		

Redundancy and other departure cost have been paid in accordance with the provisions of the NHS Pension Scheme. Exit costs in this note are the full costs of departures agreed in year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period. Where NHS Norfolk and Waveney has agreed early retirements, the additional costs are met by NHS Norfolk and Waveney and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table (£Nil).

Table 2: Analysis of Other Departures

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	22	1,188
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0

Contractual payments in lieu of notice*	9	35
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval**	0	0
TOTAL	31	1,223

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 3 which will be the number of individuals.

*any non-contractual payments in lieu of notice are disclosed under “non-contracted payments requiring HMT approval” below.

**includes any non-contractual severance payment made following judicial mediation, relating to non-contractual payments in lieu of notice. None paid in 2023-24.

No non-contractual payments were made to individuals where the payment value was more than 12 months’ of their annual salary. The Remuneration Report includes disclosure of exit packages payable to individuals named in that Report.

SIGNED

Tracey Bleakley
Accountable Officer
26 June 2024

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Parliamentary accountability and audit report

NHS Norfolk and Waveney Integrated Care Board is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report. An audit certificate and report is also included in this Annual Report at page 165.

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ANNUAL ACCOUNTS

Financial Statement and Notes

NHS Norfolk & Waveney ICB - Annual Accounts 31 March 2024

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Statement of Comprehensive Net Expenditure for the year ended 31 March 2024

		31 March 2024	9 Months to 31 March 2023
	Note	£'000	£'000
Income from sale of goods and services	2	(57,059)	(16,062)
Other operating income	2	-	(56)
Total operating income		(57,059)	(16,118)
Staff costs	3	49,017	33,244
Purchase of goods and services	4	2,474,850	1,690,063
Depreciation and impairment charges	4	192	134
Provision expense	4	8,054	(2,938)
Other operating expenditure	4	2,833	3,556
Total operating expenditure		2,534,946	1,724,059
Net operating expenditure		2,477,887	1,707,941
Finance expense	6	7	6
Net expenditure for the year		2,477,894	1,707,947
Comprehensive expenditure for the year		2,477,894	1,707,947

NHS Norfolk & Waveney ICB was formed on 1 July 2022 and as a result of this, all comparatives within these accounts relate to a 9 month period up to 31 March 2023.

Notes on pages 131 to 161 form part of this statement.

Davey Heidi
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Statement of Financial Position as at 31 March 2024

	Note	31 March 2024 £'000	31 March 2023 £'000
Non-current assets:			
Right-of-use assets	8	673	1,005
Total non-current assets		673	1,005
Current assets:			
Trade and other receivables	9	23,673	8,676
Cash and cash equivalents	10	376	1,649
Total current assets		24,049	10,325
Total assets		24,722	11,330
Current liabilities:			
Trade and other payables	11	(174,924)	(225,918)
Lease liabilities	8	(218)	(219)
Provisions	12	(12,413)	(4,408)
Total current liabilities		(187,555)	(230,545)
Total assets less current liabilities		(162,833)	(219,215)
Non-current liabilities:			
Trade and other payables	11	(820)	(686)
Lease liabilities	8	(472)	(775)
Provisions	12	(373)	(324)
Total non-current liabilities		(1,665)	(1,785)
Assets less liabilities		(164,498)	(221,000)
Financed by taxpayers' equity:			
General fund		(164,498)	(221,000)
Total taxpayers' equity		(164,498)	(221,000)

The notes on pages 131 to 161 form part of this statement.

The financial statements on pages 127 to 130 were approved by the Board on 26 June 2024 and signed on its behalf by:

SIGNED

Tracey Bleakley
Chief Executive Officer
26 June 2024

Davey Heidi
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**Statement of Changes In Taxpayers' Equity for the year ended
31 March 2024**

		31 March 2024	9 Months to
		General fund	31 March 2023
	Note	£'000	General fund
			£'000
Changes in taxpayers' equity for 31 March 2024			
Balance at 01 April 2023		(221,000)	-
Transfers by modified absorption to (from) other bodies	7	-	(166,402)
Changes in NHS ICB taxpayers' equity for 31 March 2024			
Net expenditure for the financial year	SoCNE	<u>(2,477,894)</u>	<u>(1,707,947)</u>
Net recognised NHS ICB expenditure for the financial year		(2,477,894)	(1,874,349)
Net funding	SoCF	<u>2,534,396</u>	<u>1,653,349</u>
Balance at 31 March 2024		<u>(164,498)</u>	<u>(221,000)</u>

The notes on pages 131 to 161 form part of this statement.

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**Statement of Cash Flows for the year ended
31 March 2024**

		31 March 2024	9 Months to
	Note	£'000	31 March 2023
			£'000
Cash flows from operating activities			
Net expenditure for the financial year		(2,477,894)	(1,707,947)
Depreciation and amortisation	4	192	134
Movement due to transfer by modified absorption		-	(158,732)
(Increase)/decrease in trade & other receivables	9	(14,997)	(8,676)
Increase/(decrease) in trade & other payables	11	(50,860)	226,604
Increase/(decrease) in provisions	12	8,054	(2,938)
Net cash inflow (outflow) from operating activities		(2,535,505)	(1,651,555)
Cash flows from investing activities			
Interest paid	6	7	6
Net cash inflow (outflow) from investing activities		7	6
Cash flows from financing activities			
Net funding received		2,534,396	1,653,349
Repayment of lease liabilities	8	(171)	(151)
Net cash inflow (outflow) from financing activities		2,534,225	1,653,198
Net increase (decrease) in cash & cash equivalents	10	(1,273)	1,649
Cash & cash equivalents at the beginning of the financial year	10	1,649	-
Cash & cash equivalents at the end of the financial year	10	376	1,649

The notes on pages 131 to 161 form part of this statement.

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Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards (ICB's) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2023-24 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to ICB's, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis.

Public sector bodies are assumed to be a going concern where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

The financial statements for ICB's are prepared on a Going Concern basis as they will continue to provide the services in the future.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention.

1.3 Movement of Assets within the Department of Health and Social Care Group

NHS Norfolk & Waveney ICB was approved by NHS England to operate from 1 July 2022 and was created from the transfer of NHS Norfolk & Waveney Clinical Commissioning Group (CCG). The transfer of balances is detailed in note 7 of these accounts.

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care Group Accounting Manual requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

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1.4 **Pooled Budgets**

The ICB has entered into separate pooled budget arrangements with both Norfolk County Council and Suffolk County Council in accordance with section 75 of the NHS Act 2006. Under these arrangements, funds are pooled to jointly commission or deliver health and social care, known as the Better Care Fund.

The pools are hosted by Norfolk County Council and Suffolk County Council respectively. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

The ICB has exercised judgement on the accounting for pooled budgets, further details are included in note 16.

1.5 **Revenue**

The main source of funding for the ICBs is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation. Payment terms are standard reflecting cross government principles.

1.6 **Employee Benefits**

1.6.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

1.6.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.7 **Grants Payable**

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the ICB recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.8 **Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.9 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management.

1.10 **Financial Assets**

Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

All financial assets are recorded at amortised cost.

1.10.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.11 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.12 **Critical Accounting Judgements and Key Sources of Estimation Uncertainty**

In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.12.1 **Critical accounting judgements in applying accounting policies**

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the ICB's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Better Care Fund

The ICB has entered into a partnership agreement and a pooled budget with both Norfolk County Council and Suffolk County Council in respect of the Better Care Fund (BCF). From 2022-23 this includes the addendum of the Adult Social Care Discharge Fund. The BCF is a national policy initiative and the funds involved are material in the ICB accounts. Having reviewed the terms of the partnership agreement the Department of Health and Social Care Group Accounting Manual (DHSC GAM) and the appropriate financial reporting standards the ICB has determined that there are three elements to the BCF and they are accounted for as follows:

- (1) The major part is controlled by both Norfolk County Council and Suffolk County Council

which commissions services from various non-NHS providers. Whilst the services are determined in partnership the risks and rewards of the contracts remain wholly with the council. The ICB accounts for this on a lead commissioner basis as healthcare expenditure with the local authority.

(2) The second part is controlled by the ICB which commissions various services from NHS and non-NHS providers. The risks and rewards of these contracts are the responsibility of the ICB which considers itself to be acting as a lead commissioner for those services on behalf of the partnership. The ICB accounts for these costs as healthcare purchased from NHS and non-NHS providers.

(3) The final part of the BCF is an integrated community equipment store. Norfolk County Council acts as the host body for this service which is provided by a third party. Each partner is however wholly responsible for their own share of the expenditure, and this is accounted for as a joint operation. Otherwise, there were no critical judgements apart from those involving estimations (see below) that management has made in the process of applying the ICB's accounting policies that have the most significant effect on the amounts recognised in the financial statements.

1.12.2 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Prescribing Liabilities

NHS England actions monthly cash charges to the ICB for prescribing contracts. These are issued approximately 6 weeks in arrears. The ICB uses information provided by the NHS Business Authority as part of the estimate for period expenditure. For the year ended 31 March 2024 an accrual of £35,163,570 (2022-23 £ 34,639,526) was included for February and March anticipated expenditure, this figure is not believed to represent a significant level of uncertainty.

Dental Clawback

NHS Business Services Authority process the monthly cash charges for the ICB's Dental Contracts. Contractual payments are made monthly, with an adjustment for under/over performance occurring 6 months after year end. The ICB uses information provided by the NHS Business Services Authority as part of the estimate for performance adjustments. For the year ended 31 March 2024 a claw back value of £16,658,047 (2022-23 £Nil - as ICB delegation commenced 1 April 2023) was included for the delivery adjustment, this figure is not believed to represent a significant level of uncertainty.

1.13 Provisions

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

In March 2023 NHS England wrote to all Integrated Care Boards in England directing them to make a real-term running cost reduction of 30% by 2025-26, with at least 20% to be delivered in 2024-25. This direction has precipitated a restructure process within the ICB, resulting in a redundancy provision.

1.14 Contingent Liabilities

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

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1.15 Leases

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.

The ICB assesses whether a contract is or contains a lease, at inception of the contract.

1.15.1 The ICB as Lessee

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The HM Treasury incremental borrowing rate of 3.51% is applied for leases commencing, transitioning or being remeasured in the 2023 calendar year; and 4.72% to new leases commencing in 2024 under IFRS 16.

Lease payments included in the measurement of the lease liability comprise

- Fixed payments;
- Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
- The amount expected to be payable under residual value guarantees;
- The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
- Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy. Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

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Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.16 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

The ICB has written off £615,426 in the year to 31 March 2024 (2022-23 £Nil) in relation to historic legacy debt that was brought forward into the organisation as part of the absorption transfer on incorporation on 1 July 2022. This write off was fully provided for under the ICB's Bad Debt policy terms.

There were no Special Payments in the year ended 2023-24.

For the period ended 31 March 2023 a value of £83,333 has been incurred as part of the ICB's share of a payment relating to the abandonment of an East of England hosted procurement process. This Special Payment followed the ICB financial governance process.

Losses and special payments are charged to the relevant functional headings in expenditure on an accrual's basis.

1.17 **New and revised IFRS Standards in issue but not yet effective**

The Department of Health and Social Care GAM does not require the following IFRS Standard and Interpretation to be applied for the year ended 31 March 2024. IFRS14 is not applicable to the ICB as it has not been endorsed in the UK. IFRS 17 is still subject to HM Treasury FReM adoption.

- IFRS 14 Regulatory Deferral Accounts – Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted.

The application of IFRS 14 and IFRS 17 is not anticipated to have a material impact on the accounts.

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2. Other operating revenue

	31 March 2024	9 Months to 31 March 2023
	Total	Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Education, training and research	2	1
Non-patient care services to other bodies	16,402	4,182
Prescription fees and charges *	12,124	-
Dental fees and charges *	12,982	-
Other contract income	15,549	11,879
Total income from sale of goods and services	57,059	16,062
Other operating income		
Charitable and other contributions to revenue		
expenditure: non-NHS	-	56
Total other operating income	-	56
Total operating income	57,059	16,118

* As part of the delegation on 1 April 2023 from NHS England to ICB's for the management of Pharmacy, Dentistry and Ophthalmology services, the ICB is reporting 2023-24 income associated with these services for the first time. The income is as follows:

- Income from the NHS prescription charges to eligible patients of £12,124,000
- Income from NHS charges for dentistry to eligible patients of £12,982,000

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2.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Education, training and research	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income
	£'000	£'000	£'000	£'000	£'000
Source of Revenue					
NHS	-	2,955	-	-	9,546
Non NHS	2	13,447	12,124	12,981	6,003
Total	2	16,402	12,124	12,981	15,549

	Education, training and research	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income
	£'000	£'000	£'000	£'000	£'000
Timing of Revenue					
Point in time	-	-	12,124	12,981	-
Over time	2	16,402	-	-	15,549
Total	2	16,402	12,124	12,981	15,549

In line with the 2023-24 GAM both the prescription and dental fees and corresponding charges have been classified as being at a point in time whereas the remainder of the income derived by the ICB is classified as over time.

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3. Employee benefits and staff numbers

3.1 Employee benefits

31 March 2024

	Permanent Employees £'000	Other £'000	Total £'000
Employee benefits			
Salaries and wages	34,501	2,487	36,988
Social security costs	3,825	154	3,979
Employer contributions to NHS Pension scheme	6,354	169	6,523
Other pension costs	5	-	5
Apprenticeship levy	153	-	153
Termination benefits	1,369	-	1,369
Net employee benefits excluding capitalised costs	46,207	2,810	49,017

Further analysis of employee benefits is shown in the remuneration and staff report on pages 105 to 124

9 Months to
31 March 2023

	Permanent Employees £'000	Other £'000	Total £'000
Employee benefits			
Salaries and wages	23,974	2,236	26,210
Social security costs	2,470	161	2,631
Employer contributions to NHS Pension scheme	3,900	185	4,085
Other pension costs	10	-	10
Apprenticeship levy	97	-	97
Termination benefits	211	-	211
Net employee benefits excluding capitalised costs	30,662	2,582	33,244

Further analysis of employee benefits is shown in the remuneration and staff report on pages 105 to 124.

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3.2 Average number of people employed

	31 March 2024			9 Months to 31 March 2023		
	Permanently Employed Number	Other Number	Total Number	Permanently Employed Number	Other Number	Total Number
Total	672	39	711	612	38	650

Further information in respect of staff numbers is included from page 119 to 120 of the annual report.

3.3 Exit packages agreed in the financial year

	31 March 2024 Compulsory redundancies		31 March 2024 Other agreed departures		31 March 2024 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	1	8,112	1	8,112
£10,001 to £25,000	2	32,443	5	95,568	7	128,011
£25,001 to £50,000	1	25,516	6	205,470	7	230,986
£50,001 to £100,000	-	-	7	537,862	7	537,862
£100,001 to £150,000	-	-	2	215,544	2	215,544
£150,001 to £200,000	-	-	1	160,000	1	160,000
Total	3	57,959	22	1,222,556	25	1,280,515

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	9 Months to 31 March 2023		9 Months to 31 March 2023		9 Months to 31 March 2023	
	Compulsory redundancies		Other agreed departures		Total	
	Number	£	Number	£	Number	£
Less than £10,000	2	9,271	-	-	2	9,271
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	1	30,000	-	-	1	30,000
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	1	153,334	-	-	1	153,334
Total	4	192,605	-	-	4	192,605

Analysis of other agreed departures

	31 March 2024		9 Months to 31 March 2023	
	Other agreed departures		Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement				
contractual costs	22	1,187,683	-	-
Contractual payments in lieu of notice	9	34,873	-	-
Total	31	1,222,556	-	-

This table reports the number and value of exit packages agreed in the year. The expense associated with this departure may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions and conditions of Agenda for Change.

Exit costs are accounted for in accordance with relevant accounting standards in full at the year of agreement.

In March 2023 NHS England wrote to all Integrated Care Boards in England directing them to make a real-term running cost reduction of 30% by 2025-26, with at least 20% to be delivered in 2024-25. This direction has precipitated a restructure process within the ICB, resulting in some of the exit packages noted above in 2023-24 contributing towards the overall running cost reduction.

3.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

The employer contribution rate was 20.6% in 2023-24 and 2022-23.

3.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as at 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

3.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024. The Department of Health and Social Care has recently laid Scheme Regulations confirming the employer contribution rate will increase to 23.7% from 1 April 2024 (previously 20.6%).

For the year ended 31 March 2024 employers' contributions of £6,523,000 (2022-23 £4,085,000) were payable to the NHS Pensions Scheme at the rate of 20.6% of pensionable pay.

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4. Operating expenses

	31 March 2024	9 Months to 31 March 2023
	Total £'000	Total £'000
Purchase of goods and services		
Services from other ICB's and NHS England	4,098	5,644
Services from foundation trusts	1,339,116	927,462
Services from other NHS trusts	201,828	136,729
Services from other WGA bodies	103	80
Purchase of healthcare from non-NHS bodies	313,601	226,413
Purchase of social care	13,945	11,169
General dental services and personal dental services*	44,777	-
Prescribing costs	214,872	156,611
Pharmaceutical services *	34,494	-
General ophthalmic services *	10,935	-
GPMS/APMS and PCTMS	233,460	163,872
Supplies and services – clinical	2,386	1,201
Supplies and services – general	34,563	37,144
Consultancy services	674	1,638
Establishment	6,074	8,867
Transport	11,465	8,507
Premises	2,704	2,137
Audit fees	386	288
Other professional fees	1,004	743
Legal fees	600	251
Education, training and conferences	3,765	1,307
Total purchase of goods and services	2,474,850	1,690,063
Depreciation and impairment charges		
Depreciation	192	134
Total depreciation and impairment charges	192	134
Provision expense		
Provisions	8,054	(2,938)
Total provision expense	8,054	(2,938)
Other operating expenditure		
Chair and Non Executive Members	185	181
Grants to other bodies	730	1,283
Research and development (excluding staff costs)	2,866	1,999
Expected credit loss on receivables	(975)	-
Other expenditure	27	93
Total other operating expenditure	2,833	3,556
Total operating expenditure	2,485,929	1,690,815

* As part of the delegation on 1 April 2023 from NHS England to ICB's for the management of Pharmacy, Dentistry and Ophthalmology services, the ICB is reporting 2023-24 expenditure associated with these services for the first time. The expenditure is as follows:

- Delegated Pharmacy Services - £34,494,000
- Delegated Dental Services - £44,777,000
- Delegated Ophthalmology Services - £10,935,000

4.1 Limitation on Auditor's liability

The limitation on auditors' liability for external audit work is £2m.

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5. Better Payment Practice Code

Measure of compliance	31 March 2024 Number	31 March 2024 £'000	9 Months to 31 March 2023 Number	9 Months to 31 March 2023 £'000
Non-NHS Payables				
Total Non-NHS trade invoices paid in the year	84,878	724,775	55,951	455,692
Total Non-NHS trade Invoices paid within target	83,957	715,209	54,502	446,610
Percentage of Non-NHS trade invoices paid within target	98.91%	98.68%	97.41%	98.01%
NHS Payables				
Total NHS trade invoices paid in the year	1,968	1,578,090	1,074	1,068,580
Total NHS trade invoices paid within target	1,881	1,574,186	994	1,067,248
Percentage of NHS trade invoices paid within target	95.58%	99.75%	92.55%	99.88%
Total Payables				
Total trade invoices paid in the year	86,846	2,302,864	57,025	1,524,272
Total trade invoices paid within target	85,838	2,289,395	55,496	1,513,858
Percentage of all trade invoices paid within target	98.84%	99.42%	97.32%	99.32%

The Better Payment Practice Code requires the ICB to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice. Target performance against these categories is at 95%.

In the year ended 31 March 2024 this target delivery was achieved in all categories.

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6. Finance costs

	31 March 2024 £'000	9 Months to 31 March 2023 £'000
Interest		
Interest on lease liabilities	7	6
Total interest	7	6
Total finance costs	7	6

7. Net gain/(loss) on transfer by absorption

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

For transfers of assets and liabilities from those bodies that closed on 30 June 2022 a modified absorption approach was applied. For these transactions only gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure.

The ICB received balances on 1 July 2022 from NHS Norfolk & Waveney CCG.

	31 March 2024 NHS England Group Entities (non-parent) Total £'000	9 Months to 31 March 2023 NHS England Group Entities (non-parent) Total £'000
Transfer of Right of Use assets	-	53
Transfer of cash and cash equivalents	-	395
Transfer of receivables	-	5,236
Transfer of payables	-	(164,363)
Transfer of provisions	-	(7,670)
Transfer of Right of Use liabilities	-	(53)
Net loss on transfers by absorption	-	(166,402)

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8. Leases

8.1 Right-of-use assets

	31 March 2024	31 March 2023
	Buildings excluding dwellings £'000	Buildings excluding dwellings £'000
Cost or valuation at 01 April 2023	1,152	-
IFRS 16 Transition Adjustment	-	156
Additions	-	930
Disposals on expiry of lease term	(147)	-
Transfer (to) from other public sector body	-	66
Cost/Valuation at 31 March 2024	1,005	1,152
Depreciation 01 April 2023	147	-
Charged during the year	192	134
Disposals on expiry of lease term	(7)	-
Transfer (to) from other public sector body	-	13
Depreciation at 31 March 2024	332	147
Net Book Value at 31 March 2024	673	1,005

8.2 Lease liabilities

	31 March 2024	31 March 2023
	£'000	£'000
Lease liabilities at 01 April 2023	(994)	-
IFRS 16 Transition Adjustment	-	(53)
Additions purchased	-	(1,086)
Interest expense relating to lease liabilities	(7)	(6)
Repayment of lease liabilities (including interest)	171	151
Disposals on expiry of lease term	140	-
Lease liabilities at 31 March 2024	(690)	(994)

The accounts comparative show no opening balances as at 1 July 2022, as the opening assets and liabilities positions were transferred in via modified absorption accounting.

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8.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	31 March 2024 £'000	31 March 2023 £'000
Within one year	(218)	(219)
Between one and five years	(472)	(769)
After five years	-	(6)
Balance at 31 March 2024	(690)	(994)

8.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	31 March 2024 £'000	31 March 2023 £'000
Depreciation expense on right-of-use assets	192	134
Interest expense on lease liabilities	7	6
	199	140

8.5 Amounts recognised in Statement of Cash Flows

	31 March 2024 £'000	31 March 2023 £'000
Total cash outflow on leases under IFRS 16	171	151

8.6 Nature of lessee's leasing activities

The ICB has disclosed all lease liabilities under IFRS 16 in Note 8.2. This is for properties that the organisation occupies in order to carry out its provision of Healthcare Commissioning. The ICB has entered into no further leases which would have been capitalised under IFRS 16, however there were two properties which the ICB occupied in the year which have been treated as rental agreements. These are owned by NHS Property Services.

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9.1 Trade and other receivables

	31 March 2024 Current £'000	31 March 2023 Current £'000
NHS receivables: Revenue	2,857	4,857
NHS prepayments	26	4
NHS accrued income	816	258
Non-NHS and Other WGA receivables: Revenue	2,537	2,744
Non-NHS and Other WGA prepayments	395	1,031
Non-NHS and Other WGA accrued income	605	1,359
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice *	16,658	-
Expected credit loss allowance - receivables	(301)	(1,891)
VAT	80	306
Other receivables and accruals	-	8
Total trade & other receivables	23,673	8,676
	-	-
Total current and non current	23,673	8,676

* As part of the delegation on 1 April 2023 from NHS England to ICB's for the management of Pharmacy, Dentistry and Ophthalmology services, the ICB is reporting an adjustment for under delivery in dental of £16,658,047 this is included in the above Non-NHS receivable balance.

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9.2 Receivables past their due date but not impaired

	31 March 2024 DHSC Group Bodies £'000	31 March 2024 Non DHSC Group Bodies £'000	31 March 2023 DHSC Group Bodies £'000	31 March 2023 Non DHSC Group Bodies £'000
By up to three months	1,417	1,339	2,454	123
By three to six months	32	7	29	27
By more than six months	57	17	29	1,739
Total	1,506	1,363	2,512	1,889

9.3 Loss allowance on asset classes

	31 March 2024 Trade and other receivables - Non DHSC Group Bodies £'000	9 Months to 31 March 2023 Trade and other receivables - Non DHSC Group Bodies £'000
Balance at 01 April 2023	(1,891)	-
Lifetime expected credit losses on trade and other receivables-Stage 2	975	664
Amounts written off	615	-
Transfer by Absorption from other entity	-	(2,555)
Total	(301)	(1,891)

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10. Cash and cash equivalents

	31 March 2024 £'000	31 March 2023 £'000
Balance at 01 April 2023	1,649	-
Net change in year	(1,273)	1,649
Balance at 31 March 2024	376	1,649
Made up of:		
Cash with the Government Banking Service	376	1,649
Balance at 31 March 2024	376	1,649

The accounts comparative show no opening cash balance as at 1 July 2022, as the opening asset position was transferred in via modified absorption accounting.

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11. Trade and other payables

	31 March 2024 Current £'000	31 March 2024 Non-current £'000	31 March 2023 Current £'000	31 March 2023 Non-current £'000
NHS payables: Revenue	7,868	-	16,175	-
NHS accruals	4,057	-	14,038	-
NHS deferred income	492	331	1,039	-
Non-NHS and Other WGA payables: Revenue	21,086	-	41,812	-
Non-NHS and Other WGA accruals	122,682	-	124,834	-
Non-NHS and Other WGA deferred income	10,815	489	13,581	686
Social security costs	454	-	464	-
Tax	468	-	438	-
Other payables and accruals *	7,002	-	13,537	-
Total trade & other payables	174,924	820	225,918	686
Total current and non-current	175,744		226,604	

* Other payables include £1,886,000 (2022-23 £1,809,000) outstanding pension contributions at 31 March 2024.

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12. Provisions

	31 March 2024 Current £'000	31 March 2024 Non-current £'000	31 March 2023 Current £'000	31 March 2023 Non-current £'000
Redundancy	1,728	-	-	-
Legal claims	1,012	-	941	-
Other	9,673	373	3,467	324
Total	12,413	373	4,408	324
Total current and non-current	12,786		4,732	
	Redundancy £'000	Legal Claims £'000	Other* £'000	Total £'000
Balance at 01 April 2023	-	941	3,791	4,732
Arising during the year	1,728	850	9,046	11,624
Reversed unused	-	(779)	(2,791)	(3,570)
Balance at 31 March 2024	1,728	1,012	10,046	12,786
Expected timing of cash flows:				
Within one year	1,728	1,012	9,673	12,413
Between one and five years	-	-	373	373
Balance at 31 March 2024	1,728	1,012	10,046	12,786

* Other Provisions include estates, standard staffing costs and elective recovery funding conditions.

All provisions made satisfy the ICB's Accounting Policy in recognition of a present obligation from a past event with a reliable estimate for a probable expenditure.

13. Contingencies

	31 March 2024 £'000	31 March 2023 £'000
Contingent liabilities		
Legal Claim	200	200
Net value of contingent liabilities	200	200

The contingent liability relates to ongoing employment and other legal cases where financial risks remain, but the certainty of the value or the outcome is unknown.

14. Financial instruments

14.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the NHS ICB is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The ICB has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the ICB in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS ICB standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS ICB and internal auditors.

14.1.2 Credit risk

Because the majority of the ICB revenue comes parliamentary funding, NHS ICB has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

14.1.3 Liquidity risk

The ICB is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The ICB draws down cash to cover expenditure, as the need arises. The ICB is not, therefore, exposed to significant liquidity risks.

14.1.4 Financial Instruments

As the cash requirements of NHS England are met through the estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

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14.2 Financial assets

	Financial Assets measured at amortised cost 31 March 2024 £'000
Trade and other receivables with NHSE bodies	2,166
Trade and other receivables with other DHSC group bodies	2,246
Trade and other receivables with external bodies	19,061
Cash and cash equivalents	376
Total at 31 March 2024	23,849

14.3 Financial liabilities

	Financial Liabilities measured at amortised cost 31 March 2024 £'000
Trade and other payables with NHSE bodies	439
Trade and other payables with other DHSC group bodies	11,489
Trade and other payables with external bodies	151,458
Total at 31 March 2024	163,386

15. Operating segments

The ICB consider they only have one Operating Segment, being the provision of Commissioning of Healthcare Services.

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16. Joint arrangements - interests in joint operations

ICB's should disclose information in relation to joint arrangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

16.1 Interests in joint operations

Name of arrangement	Parties to the arrangement	Description of principal activities	Amounts recognised in Entities books ONLY				Amounts recognised in Entities books ONLY			
			As At		31 March 2024		As At		31 March 2023	
			31 March 2024		31 March 2024		31 March 2023		9 Months to 31 March 2023	
			Assets	Liabilities	Income	Expenditure	Assets	Liabilities	Income	Expenditure
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Norfolk County Council Better Care Fund	NHS Norfolk and Waveney ICB and Norfolk County Council	Joint Commissioning of Care services, hosted by Norfolk County Council, net accounting adopted	-	-	-	82,607	-	1,931	-	60,542
Suffolk County Council Better Care Fund	NHS Norfolk and Waveney ICB and Suffolk County Council	Joint Commissioning of Care services, hosted by Suffolk County Council, net accounting adopted	-	-	-	10,533	-	-	-	7,768
Suffolk County Council Mental Health Services	NHS Norfolk and Waveney ICB and Suffolk County Council	Joint provision of mental health services	-	-	-	224	-	9	-	158

Children and Young People's Alliance Agreement	NHS Norfolk and Waveney ICB, Norfolk County Council, Suffolk County Council, Norfolk and Suffolk NHS Foundation Trust, Ormiston Families, Mancroft Advice Project, Cambridgeshire Community Services NHS Trust, James Paget University Hospitals NHS Foundation Trust, East Coast Community Healthcare CIC and Norfolk Community Health and Care NHS Trust	Alliance agreement for Children and Young People	-	-	1,389	2,726	1,028	334	690	1,920

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17. Related party transactions

Details of related party transactions with individuals are as follows:

	31 March 2024		As at 31 March 2024		9 Months to 31 March 2023		As at 31 March 2023	
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr Hilary Byrne, South Norfolk Health Improvement Partnership (Clinical Director)	2,459	-	-	-	522	-	-	-
Dr Hilary Byrne, Attleborough Surgery (GP Partner at Attleborough Surgeries)	2,956	-	-	-	2,170	-	-	-
Aliona Derrett, Hear for Norfolk (Chief Executive)	801	-	-	-	397	-	-	-
David Holt, Tavistock and Portman NHS Foundation Trust (Senior Independent Director - Now ceased)	-	-	-	-	3	-	-	-
Bill Borrett, Broadland District Council (Elected Member of Broadland District Council, Upper Wensum Ward)	202	5	60	-	-	-	-	-
Emma Ratzer, Access Community Trust (Chief Executive Officer)	658	-	8	-	551	-	-	-

The payments to related parties for Dr Hilary Byrne for South Norfolk Health Improvement Partnership are significantly increased from 2022-23 to 2023-24. This is due primarily to Primary Care Network payments being made in 2022-23 to another lead practice. The payments in 2023-24 were paid directly to South Norfolk Health Improvement Partnership.

The Department of Health and Social Care is regarded as a related party. During the period the ICB has had a significant number of material transactions with entities for which the Department is regarded as the parent. The entities with whom the value of transactions exceed £500,000 are listed below:

- Bedfordshire Hospital NHS Foundation Trust
- Cambridge University Hospital NHS Foundation Trust
- Cambridge and Peterborough NHS Foundation Trust
- Cambridge Community Services NHS Trust
- Community Health Partnerships

- East of England Ambulance Service NHS Trust
- East Suffolk and North East Essex NHS Foundation Trust
- Essex Partnership University NHS Foundation Trust
- Guy's & St Thomas' NHS Foundation Trust
- Hertfordshire Partnership University NHS Foundation Trust
- James Paget University Hospital NHS Foundation Trust
- NHS Arden & Greater East Midlands Commissioning Support Unit
- NHS England
- NHS Property Services
- Norfolk Community Health and Care NHS Trust
- Norfolk & Norwich University Hospital NHS Foundation Trust
- Norfolk & Suffolk NHS Foundation Trust
- North West Anglia NHS Foundation Trust
- Royal Papworth Hospital NHS Foundation Trust
- The Queen Elizabeth Hospital NHS Foundation Trust
- University College London Hospital NHS Foundation Trust
- West Suffolk NHS Foundation Trust

In addition, there have been further material transactions in the ordinary course of the ICB's business with a number of other government departments, central and local government bodies as follows:

- Norfolk County Council
- Suffolk County Council

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18. Events after the end of the reporting period

There are no other events between the end of the reporting period and 26 June 2024 which will have a material effect on the financial statements of the ICB.

19. Financial performance targets

NHS Norfolk & Waveney ICB has a number of financial duties under the NHS Act 2006 (as amended). Performance against those duties was as follows:

	NHS Act Section	Duty Achieved?	31 March 2024 Target £'000	31 March 2024 Performance £'000	9 Months to 31 March 2023 Target £'000	9 Months to 31 March 2023 Performance £'000
Expenditure not to exceed income	223H(1)	Yes	2,535,010	2,534,953	1,724,273	1,724,065
Revenue resource use does not exceed the amount specified in Directions	223I(3)	Yes	2,477,951	2,477,894	1,708,155	1,707,947
Revenue administration resource use does not exceed the amount specified in Directions	223J(3)	Yes	22,619	22,618	17,652	17,496

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20. Losses and special payments

20.1 Losses

The total number of NHS ICB losses and special payments cases, and their total value, was as follows:

	31 March 2024	31 March 2024	9 Months to	9 Months to
	Total Number of	Total Value of	31 March 2023	31 March 2023
	Cases	Cases	Total Number of	Total Value of
	Number	£'000	Cases	Cases
			Number	£'000
Administrative write-offs	178	615	-	-
Total	178	615	-	-

The ICB has written off 178 transactions totalling £615,426 in the year to 31 March 2024 in relation to historic legacy debt transactions that were brought forward into the organisation as part of the absorption transfer on incorporation on 1 July 2022. This write off was fully provided for under the ICB's Bad Debt policy terms.

20.2 Special payments

	31 March 2024	31 March 2024	9 Months to	9 Months to
	Total Number of	Total Value of	31 March 2023	31 March 2023
	Cases	Cases	Total Number of	Total Value of
	Number	£'000	Cases	Cases
			Number	£'000
Ex Gratia Payments	-	-	1	83
Total	-	-	1	83

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INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS NORFOLK & WAVENEY INTEGRATED CARE BOARD

Opinion

We have audited the financial statements of NHS Norfolk & Waveney Integrated Care Board NHS Norfolk & Waveney Integrated Care Board ("the ICB") for the year ended 31 March 2024 which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 20, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by the HM Treasury's Financial Reporting Manual: 2023-24 as contained in the Department of Health and Social Care Group Accounting Manual 2023 to 2024, and the Accounts Direction issued by NHS England in accordance with the National Health Service Act 2006.

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Norfolk & Waveney Integrated Care Board as at 31 March 2024 and of its net expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2023 to 2024; and
- have been properly prepared in accordance with the National Health Service Act 2006, as amended by the Health and Social Care Act 2022.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's AGN01 and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for a period of 12 months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the ICB's ability to continue as a going concern.

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Other information

The other information comprises the information included in the Annual report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the Annual report.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements, or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- other information published together with the audited financial statements is consistent with the financial statements; and
- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2023 to 2024.

Matters on which we are required to report by exception

We are required to report to you if:

- we issue a report in the public interest under section 24 and schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or
- we make a written recommendation to the ICB under section 24 and schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 (as amended) because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we are not satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2024; or
- in our opinion the governance statement does not comply with the guidance issued in the Department of Health and Social Care Group Accounting Manual 2023 to 2024.

We have nothing to report in these respects.

Responsibilities of the Accountable Officer

As explained more fully in the '*Statement of Accountable Officer's Responsibilities*', set out on page 70, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is also responsible for ensuring the regularity of expenditure and income.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or has no realistic alternative but to do so.

As explained in the 'Governance Statement' on page 71, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the ICB's resources.

Auditor's responsibility for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant are the National Health Service Act 2006, Health and Social Care Act 2012 and Health and Care Act 2022, and other legislation governing NHS ICBs, as well as relevant employment laws of the United Kingdom. In addition, the ICB has to comply with laws and regulations in the areas of anti-bribery and corruption and data protection.

We understood how the ICB is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, the Head of Internal Audit, the Local Counter Fraud Specialist and those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance.

We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur by planning and executing a journal testing strategy and testing the appropriateness of relevant entries and adjustments. We have considered whether judgements made are indicative of potential bias and considered whether the ICB is engaging in any transactions outside the usual course of business. We identified two specific fraud risks, relating to the risk of fraud in expenditure recognition through key estimates/judgements and misstatements due to fraud or error in relation to the classification of Admin and Programme costs.

Based on this understanding we designed our audit procedures to identify noncompliance with such laws and regulations. Our procedures involved enquiry of management, the Head of Internal Audit, the Local Counter Fraud Specialist and those charged with governance, reading and reviewing relevant meeting minutes of those charged with governance and the Governing Body and understanding the internal controls in place to mitigate risks related to fraud and non-compliance with laws and regulations.

We addressed our fraud risks related to management override through implementation of a journal entry testing strategy, assessing accounting estimates for evidence of management bias and evaluating the business rationale for significant unusual transactions. This included testing the appropriateness of the each journal selected and that it was accounted for appropriately.

To address our fraud risk of fraud in expenditure recognition, we tested the appropriateness of expenditure recognition accounting policies and tested that they had been applied correctly during our detailed testing, tested the appropriateness of journal entries recorded in the general ledger and other adjustments made in the preparation of the financial statements, reviewed accounting for evidence of management bias, tested a sample of accruals based on our established testing threshold for reasonableness, performed cut-off testing of transactions both before and after year-end to ensure that they were accounted for in the correct year, reviewed the Department of Health (DoH) agreement of balances data and investigated significant differences (outside of DoH tolerances), considered the completeness of liabilities included in the financial statements by performing unrecorded liability testing.

To address our fraud risk in relation to the classification of Admin and Programme costs we reviewed accounting estimates for evidence of management bias, evaluated the business rationale for significant unusual transactions, considered the results of our work on revenue and expenditure recognition as set out above, specifically considering any instances of management bias and tested judgements made by management on the classification of programme and admin expenditure, ensuring the classification is compliant with relevant guidance.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at <https://www.frc.org.uk/auditorsresponsibilities>. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice 2020, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in May 2024 as to whether the ICB had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the ICB put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2024.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the ICB had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 (as amended) to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 (as amended) requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Report on Other Legal and Regulatory Requirements

Regularity opinion

We are responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Local Audit and Accountability Act 2014 (as amended) (the "Code of Audit Practice").

We are required to obtain evidence sufficient to give an opinion on whether in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

In our opinion, in all material respects the expenditure and income reflected in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Certificate

We certify that we have completed the audit of the accounts of NHS Norfolk & Waveney Integrated Care Board in accordance with the requirements of the Local Audit and Accountability Act 2014 (as amended) and the Code of Audit Practice.

Use of our report

This report is made solely to the members of the Governing Body of NHS Norfolk & Waveney Integrated Care Board in accordance with Part 5 of the Local Audit and Accountability Act 2014 (as amended) and for no other purpose. Our audit work has been undertaken so that we might state to the members of the Governing Body of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the members as a body, for our audit work, for this report, or for the opinions we have formed.

MARK HODGSON
ERNST & YOUNG LLP

Date: 27th June 2024.

Mark Hodgson (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Cambridge

Davey Heidi
19/09/2024 14:02:47

Subject:	Board Assurance Framework (BAF)
Presented by:	Karen Barker, Executive Director of Corporate Affairs and ICS Development
Prepared by:	Nikki Bartrum, Corporate Governance Senior Manager
Submitted to:	Integrated Care Board - Board Meeting – Part 1
Date:	25 September 2024

Purpose of paper:

For noting and approval

Executive Summary:

This paper provides an update on the revised Risk Management Framework and the Board Assurance Framework and Board Operational Risk Register.

RISK MANAGEMENT FRAMEWORK

Over the summer, the Executive Management Team have been reviewing the Risk Management Framework and the way that individual risks are managed, escalated/de-escalated.

The Audit and Risk Committee agreed to approve the revised Risk Management Framework document at their meeting on 18 September. This document sets out the new process around risk management which is being implemented by the teams within the ICB. There may still be further amendments required in the coming months as we test our processes in practice but to enable the ICB to begin working in this way the Audit and Risk Committee were asked to approve the Framework as it is very different the predecessor document which was in place.

RISK REGISTERS

The risk registers have also undergone significant review and realignment since the last Board meeting in July.

- **Board Assurance Framework (BAF)**
Risks have been aligned against the 8 ambitions as set out in the Norfolk and Waveney 5 year [Joint Forward Plan](#) (2024-29). The latest version of the BAF is attached as Appendix 1.
- **Board Operational Risk Register (BORR)**
In line with the revised Risk Management Framework, a new BORR has been created. Operational risks with a mitigated score of 15+ will be escalated to the BORR. The BORR is owned by the Executive Management Team. The latest version of the BORR is attached as Appendix 2.

The Board are asked to approve the following updates and proposed risk closures:

Board Assurance Framework

- **BAF02:** Primary Care Resilience and Transformation – this risk has been renamed and updated to incorporate both dentistry and primary care.

Board Operational Risk Register

- **BORR01:** Providers in CQC Special Measures (NSFT) and **BORR04:** Right Care NoW Programme – It is proposed that these risks are closed as the detail has been incorporated into the Urgent & Emergency Care risk (BAF06).

Recommendation to Board:

The Board are asked to note the contents of this paper and approve the following:

- Revision of risk BAF02 to include primary and dentistry.
- Closure of risks BORR01 and BORR4.

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

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NHS Norfolk and Waveney ICB – Board Assurance Framework

Version V4 Date last updated: 12 September 2024

Board Assurance Framework – Summary Page

Ref	Risk title	Executive lead	Committee	Date risk identified	Target delivery date	Risk appetite	Score at target delivery	2024/25 monthly risk rating											
								1	2	3	4	5	6	7	8	9	10	11	12
Ambition 1: Population Health Management, Reducing Inequalities and Supporting Prevention																			
BAF01 (was BAF06)	Health Inequalities and Population Management	Mark Burgis	Patients & Communities	01/07/22	31/03/25		4	12	12	12	12	12	12						
Ambition 2: Primary Care Resilience and Transformation																			
BAF02 (was BAF16)	Primary Care Resilience and Transformation	Mark Burgis	Primary Care Commissioning	31/08/24	31/3/27		12						20						
Ambition 3: Improving Services for Babies, Children and Young People and Developing Our Local Maternity and Neonatal System (LMNS)																			
BAF03 (was BAF05b)	Barriers to Full Delivery of the Mental Health Transformation Programme (CYP)	Tricia D'Orsi	Commissioning & Performance	01/07/22	30/11/24		8	16	16	16	16	16	16						
Ambition 4: Transforming Mental Health Services																			
BAF04 (was BAF05a)	Barriers to Full Delivery of the Mental Health Transformation Programme (Adult)	Jocelyn Pike	Commissioning & Performance	01/07/22	31/03/25		8	16	16	16	16	16							
Ambition 5: Transforming Care in Later Life																			
BAF05 (was BAF25)	Increasing number of ageing population with complex health conditions	Frankie Swords	People and Communities	20/06/204	31/03/28		12			New 15	15	15	15						

Ref	Risk title	Executive lead	Committee	Date risk identified	Target delivery date	Risk Appetite	Score at target delivery	2024/25 monthly risk rating											
								1	2	3	4	5	6	7	8	9	10	11	12
Ambition 6: Improving Urgent and Emergency Care																			
BAF06 (was BAF02)	System / Urgent & Emergency Care (UEC) Pressures	Mark Burgis	Commissioning & Performance	01/07/22	31/03/25		12	16	16	16	16	16	16						
Ambition 7: Elective Recovery and Improvement																			
BAF07	Elective Recovery	Andrew Palmer	Commissioning & Performance	01/12/22	31/03/25		12	12	12	12	12	12							
Ambition 8: Improving Productivity and Efficiency																			
BAF08 (was BAF11)	Achieve the 2024/25 Financial Plan	Steven Course	Finance	10/05/22	31/03/25		12	12	12	12	12								

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

BAF01 (Inphase ref 000000008)

Risk Title		Health inequalities and Population Health Management							
Risk Description		There is a risk that the ICB will not meet its statutory requirements to reduce HI or use PHM techniques to their full potential in line with the PHM strategy and HI strategic framework for action. If this happens, specific groups of people will experience poor outcomes which could have been prevented.							
Risk Owner		Responsible Committee		Operational Lead		Date Risk Identified		Target Delivery Date	
Mark Burgis / Dr Frankie Swords		Patients and Communities		Suzanne Meredith/ Tracy Williams/ Shelley Ames		01/07/2022		31/03/2025	
Risk Scores									
Unmitigated			Mitigated			Target			
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total	
4	4	16	3	4	12	1	4	4	
Risk appetite:					Risk tolerance:				
Controls					Assurances on controls				
- The HI Strategic Framework for action and the PHM strategy have been published. Implementation plans under development. - Specialty advisors are leading on HI, PHM.and the Core20Plus5 clinical areas. - ICP supported proposals for a strategic group and co-ordination group to formally overs delivery of the Health Inequalities Framework for action. Co-ordinating multi-partner health inequalities group now in place.SROs established for Lifestyle factors and Healthcare Inequalities - Health Inequalities & VCSE Partnering team appointed to lead health inequalities work programme development. - The Health Improvement Transformation Group (HITG) focusses on Primary Prevention: smoking, physical activity and Healthy weight, report to ICP. - Community Voices gathering insights into HI and connecting with local communities to help address. - ICS groups set up for Inclusion health groups, vaccines inequalities, Core20plus5 programme group, NHS Anchors group, access and support programme group, reporting to HIOG - Datahub Population Health dashboards in place to support reporting and health oversight. - Health and wellbeing partnerships and place boards overseeing local work programmes. - External factors that impact on “Plus groups” (such as the moving of hotels for asylum seekers which impacts on the services they receive) are raised by the HI team to be managed across the ICP.					Internal: PHM and addressing HI has been identified as a priority in our JFP. Progress against key national delivery timelines reported and led by appropriate governance structures: Health Inequalities Oversight Group (HIOG), PHM Oversight Group (PHMOG) and PH and Inequalities Board with assurance reporting to Patients and Communities Committee. NHSE reporting of NHS Inequalities Improvement Frameworks and annual reporting against NHS statement on Information for health Inequalities. Elective Recovery Board receive regular reporting on waiting lists per decile of deprivation index External: Integrated Care Partnership Board Health Inequalities governance structure including a strategic steering group and co-ordination group.				

Refresh of the VCSE Assembly and partnership working reporting into the PH&I Board	

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

Updates on actions and progress			
Date opened	Action / update	BRAG	Target completion
29/08/24	For Healthcare Inequalities, one of the priority areas of the framework, working groups established for NHS Anchors, Core20Plus5, and a refresh of the Inclusion Health network group. PH&I Board approved the refreshed terms of reference for the Board, HIOG and PHMOG, to reflect the implementation plans for the PHM Strategy and the HI Framework for action.	G	31/10/2024

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

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Ambition 2: Primary care resilience and transformation

BAF02 (Inphase ref 00000032)											
Risk Title		Primary Care Resilience and Transformation									
Risk Description		Under the Joint Forward Plan we have committed to integrating primary care services to deliver improved access (including digital tools and remote monitoring offers, etc.) to a wider range of services from multi-professional teams, focused on preventing illness and improving outcomes for our population within their communities. Our high-level outputs include: - Developing a vision for providing accessible enhanced primary care services - Improving patient outcomes and experience - Stabilise dental services and setting a strategic direction for the next five years Primary Care Services are the responsibility of the Integrated Care Board, including the recruitment and retention of healthcare professionals. There are particular risks to the resilience of general practice, access to NHS dentistry treatment and Level 2 dental services which are reflected in the risk scores. The community pharmacy and optometry landscape is less defined at the time of writing, but workforce and funding challenges are evident across community pharmacy which represent a risk, but could potentially be supported through greater integration and collaborative working with other primary care providers. Limitations of national contracts, collective action by General Practice, independent contractors ‘handing back’ NHS contracts, workload pressures, recruitment and retention and interface challenges are, together, impacting on access to high quality, sustainable primary medical, community pharmacy and dentistry services together with Level 2 dental services for our population. This may lead to delays in accessing care, unavailability of care (particularly dentistry), increased clinical harm because of delays in accessing services, failure to deliver the recovery of services adversely affected, and poor outcomes for patients due to pressured, and fragile services. - As the cornerstone of healthcare, primary care resilience risks system ability to deliver against key workstreams, including the overall aim of moving towards a more population-based proactive community model of care which addresses prevention, health inequalities and improves outcomes. Reduced access in primary care may also impact on the resilience of other system providers.									
		Risk Owner		Responsible Committee		Operational Lead	Date Risk Identified	Target Delivery Date			
		Mark Burgis		Primary Care		Sadie Parker	31/08/2024	31/03/2027			
		Risk Scores									
		Unmitigated			Mitigated			Target			
		Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total	
5	4	20	5	4	20	3	4	12			
Risk appetite:						Risk tolerance:					

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Controls	Assurances on controls
- ICB organisational change programme has seen a reduction in vacancies within the Primary Care Commissioning and Strategic teams. - Operational readiness work is seeking to align the Primary Care Team with colleagues from Workforce, Estates, Digital, Place, Quality, Planned Care and Finance, etc. to support joined up primary care; including access to sustainable dentistry and general practice services. - An overarching strategic vision and principles for primary care are being finalised to support the development long-term plans for general practice and community pharmacy during 2024/25, followed by optometry. - A long-term dental plan has been published, with delivery monitored through PCCC. - Performance/quality management and reporting in place. - Clinical expertise provided by Clinical and Care Professional and Clinical Fellow roles across primary care. - Ring-fenced budgets and commissioning targeted to simultaneously support population need and resilience. - Primary Care Access Recovery Plan delivery reported regularly to ICB Board and NHS assurance meetings. - System Interface Group and matrix working in place to support national requirements for self-assessment. - Local LMC General Practice Alert System established which informs improvement and support work monitored through the PCCC. - Strong relationships in place with local representative committees across all primary care services.	Internal: ICB Executive Management Team, Primary Care Commissioning Committee, Dental Services and General Practice & Community Pharmacy Delivery Groups, Workforce Steering Group, Primary Care Strategic Planning Meetings, Primary Care Team External: NHS England via delegation agreement and assurance framework, Health Education England, Norfolk and Waveney Local Dentistry and Medical Committees, Health Overview and Scrutiny Committee meetings, Regional and Local Professional Network and Managed Clinical Networks, Healthwatch Norfolk/Suffolk, NHS Business Services Authority. Primary Care Commissioning Committee meetings held in public.
Gaps in controls or assurances	
- Lack of in-depth knowledge about the resilience and stability of all primary care services across Norfolk and Waveney. - Lack of awareness and understanding across the system about the impact struggling primary care services will have in the longer term on other system partners and services. - Unknowns associated with the ongoing collective action associated with the BMA's 'Save General Practice' campaign in respect of pressure on primary medical care and other system partners and impact on access to healthcare for our population. - Significant gaps in ICB teams remain following restructure and reliance on wider teams (e.g. Quality and Workforce) to address the issues – there is a reduction in vacancies in the primary care team but building knowledge and relationships will take time, with operational readiness work in progress. - ICB's financial position is impacting on our ability to support resilience and transformation in primary care leading to temporary and more expensive solutions being put in place, particularly across dental and primary medical contractors. - Primary care dashboard/ delivery report remains in development, leading to a lack of integrated performance oversight. - Lack of access to NHS dentistry services is an area of quality and safeguarding concern - this impacts some of our most vulnerable patient groups. - Significant workforce shortfalls across general dental services, Level 2 services and secondary care dental services and a lack of comprehensive workforce data to support planning. - CQC activity is currently focused on private dental practice, rather than NHS practices. - General practice visit programme has been tested but not launched due to vacancies impacting capacity, CQC inspections focused on where there is a significant risk or concern. - Data to capture inappropriate transfers of workload and general practice pressures is incomplete - planning resources may be less effective if based on an incomplete picture. - Workforce and capacity shortages across general practice, community pharmacy and dental practices, together with the ongoing drug shortages, are having an impact on access to robust and effective primary care provision. - Resilience policy in development, which will link into any bids for section 96 support for general practice. - Five-year Primary Care Strategy has expired, new strategic framework/long term plans in development for integrated neighbourhood working, general practice and community pharmacy, however capacity and long term absence is affecting progress.	

Updates on actions and progress													
Date opened	Action / update										BRAG	Target completion	
28/08/24	Dental - ICB Clinical Advisor - Dental successful appointment made, going through recruitment checks. - Year-end reconciliation for 2023/2024 complete. - Review of urgent treatment pilot complete. - All Golden Hellos have been taken up for the year.										A	31/10/24	
28/08/24	Medical - New ICB interface manager post, successful appointment. Beginning to review the work programme and Terms of Reference for the System Group. - Close monitoring of BMA collective action ongoing. - Triple lock approval for funding of MGUS monitoring, now going through governance.										A	31/10/24	
28/08/24	Draft primary care vision and principles being presented to PCCC for discussion and approval.										A	31/10/24	
Visual Risk Score Tracker – 2024/25													
Month	1	2	3	4	5	6	7	8	9	10	11	12	
Score						20							
Change						New							

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

BAF03 (Inphase ref 00000007)								
Risk Title		Barriers to full delivery of the Mental health transformation programme (CYP)						
Risk Description		There is a risk that during a period of unprecedented mental health demand and acuity of need, current system capacity and models of care are not sufficient to meet demand. If this happens individual need will not be met at the earliest opportunity, by the right service or by the most appropriate person and need will escalate. This may lead to worsening inequality and health outcomes, increased demand on other services and reputational risk						
Risk Owner		Responsible Committee		Operational Lead		Date Risk Identified		Target Delivery Date
Tricia D'Orsi		Quality & Safety		Rebecca Hulme		01/07/2022		30/11/24
Risk Scores								
Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	4	4	16	2	4	8
Risk appetite:						Risk tolerance:		
Controls						Assurances on controls		
• Dedicated CYP strategic commissioning team now in place • Effective System wide governance framework • Collaboration with system partners to understand demand and capacity has begun and the shared resource is better understood. • Development of robust understanding of the financial envelope available to drive the transformation, and investment necessary, including appropriate measures to reconcile these is still in process. • System approach to increasing knowledge skills and expertise across agencies and developing additional capacity through use of digital. Greatly assisted by digital appointing a digital lead. Digital workstream initiated. • Financial slippage is being mitigated against protecting our ability to maintain MHIS investment. • Implementation of system wide transformation programme • Commitment from system partners to adopting Thrive approach – mental health needs being considered and addressed in wider health and social care settings. • Additional partnership working with VCSE. • All age Eating Disorder Strategy • Established Children and Young Peoples System Collaboratives in Norfolk and Suffolk • Working in partnership with Norfolk and Suffolk Constabularies to implement a system wide collaborative approach to Right Care Right Person • Intensive day support unit now open for eating disorders and parent support offer in place. • Professional Therapeutic Pathway in place • Integrated Front Door phase one in place. • Integrated Front Door phase two in place • Enhanced support offers for 18–25-year-olds in wellbeing hubs. • Gender Identity Service in place • Additional capacity within Professional Therapeutic Pathway in place						Internal: SMT, EMT, Integrated Care Board, Finance Committee, Quality Committee, Mental Health Oversight Board, Transformation Delivery Group		
						External: CYPMH Executive Management Group, CYP Strategic Alliance Board, HWBs Norfolk and Suffolk, NW Health and Care partnership MH Board, NHSE/I Regional MH Board and subgroups, HOSC Norfolk and Suffolk, System Improvement and Assurance Group, Children and Young People's System Collaborative		

Gaps in controls or assurances

- Capacity and commitment within providers to support transformation and collaboration impacted by increased demand and historical backlog.
- Capacity within the substantive CYP integrated commissioning team to deliver on the scale of transformation required.
- Conflicting priorities across complex system transformation agenda
Intra-system Electronic Patient Record connectivity, especially at the interface of primary/secondary/social care and third sector provision, remains a challenge and priority to address.
- Lack of clarity regarding workforce capacity to deliver support at required levels.
- Ability to recruit, retain and train a viable number of staff to enable service expansion and meet the MH and well-being needs of the N&W population.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
06/11/22	Recruitment remains challenging in core secondary care services. New staff in post but staff leavers nullifying effect. Requirement to address urgent presentations and increased community acuity reducing routine capacity to reduce waiting times. Update 02/01/2024. Recruitment remains problematic. Workforce information requested from NSFT through newly re-established SPQRG Update 28.08.24 Workforce information outstanding. Further discussion has taken place regarding information format.	R	30/11/24
25/08/23	Waiting list size within main provider continues to increase. Staff vacancies within central youth team critical. Proposal from provider to declare business continuity. Trust undergoing organisational restructure so delays to replacing key leadership roles. Plan to escalate to NSFT Executive. Update 19/06/24 referrals to NSFT reducing following introduction of Integrated Front Door. No corresponding reduction in waiting list to date. NSFT have developed a recovery plan for referral to assessment and are developing a similar plan for referral treatment. Exploring opportunities to utilise additional capacity. Update 28.08.24 significant work within main provider to reduce waits. All CYP waiting longer than 52 weeks for assessment have been addressed – plan now to look at those waiting >48 weeks. Corresponding work to reduce referral to treatment waits. Some concerns regarding sustainability raised at SPQRG	R	30/11/24
08/11/23	Castle Green Integrated Intensive Day Support/Short Breaks Unit paper presentation and prioritisation matrix complete. Risks identified regarding financial implications. Presented to deliberation panel – scoring ratified and funding identified. Awaiting next steps. Need to confirm with NHSE due to capital funding allocation. Update 19/06/24 funding approved, next steps meeting with NCC to mobilise plan. Update 28.08.24 meeting with NCC taken place. Refinement of model to further develop integrated model and to ensure best use of capacity	A	31/03/25
08/11/23	CYP Collaborative continues to develop. System workshop scheduled for 15/12/23 to progress system working and opportunities for stakeholders to align resource. Workshop completed 15/12/2023. Priorities for workstreams proposed and will be established within January 2024 Update 19/06/24 workstreams established and scoping vision for priority areas. Update 28.08.24 Case for change in development. For presentation to Executive team in October 2024	A	31/10/24
02/01/24	Integrated Front Door further role out to include NSFT direct referrals scheduled to commence April 2024	B	Complete
02/01/24	Recruitment to mental health care navigator team commenced. Some delays due to organisational restructure – Project Manager in post, recruiting to programme lead role.	B	Complete

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

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Ambition 4: Transforming Mental Health Services

BAF04 (Inphase ref 000000006)								
Risk Title		Barriers to full delivery of the Mental health transformation programme (Adults)						
Risk Description		There is a risk that during a period of unprecedented mental health demand and acuity of need current system capacity and models of care are not sufficient to meet the need. If this happens, individual need will not be met at the earliest opportunity, by the right service or by the most appropriate person and need will escalate. This may lead to worsening inequality and health outcomes, increased demand on other services and reputational risk						
Risk Owner		Responsible Committee		Operational Lead		Date Risk Identified	Target Delivery Date	
Jocelyn Pike		Commissioning & Performance		Emma Willey		01/07/2022	31/03/2025	
Risk Scores								
Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	4	4	16	2	4	8
Risk appetite:					Risk tolerance:			
Controls				Assurances on controls				
- System wide governance framework in situ - Finance & Planning working group meet monthly to drive robust financial arrangements and deliver planned MHIS investment. - Ongoing work with Population health management team to proactively contact and offer support/ physical health assessment and vaccination. - Working in partnership with Norfolk and Suffolk Constabularies to implement a system wide collaborative approach to Right Care Right Person				Internal: SPRG, SMT, EMT, Board External: N&W MH Strategic Oversight Board, HWBs Norfolk and Suffolk, NW Health and Care partnership MH Forum, HOSC, Norfolk and Suffolk NHSE/I Regional MH Board and subgroups, NHSEI System Improvement and Assurance Group,				
Gaps in controls or assurances								
- Impact of pandemic and cost of living crisis on mental health and well-being of population leading to increased need for support and adding to capacity pressures and resilience of providers - Organisational development required to drive forward internal cultural change. Cultural shift required as a system to enable successful transformation and ensure mental health is better understood and regarded as ‘everyone’s business.’ - Cultural, digital and operational collaboration to enable access and easily navigable mental health services, is at an early stage of development. - Conflicting priorities across complex system transformation agenda - Intra-system Electronic Patient Record connectivity, especially at the interface of primary/secondary/social care and third sector provision, remains a challenge and priority to address. - Ability to recruit, retain and train a viable number of staff to enable service expansion and meet the MH and well-being needs of the N&W population. - Limited influence on alternative provision within a tightly prescribed talking therapies model – National NHSEI and HEE guidance is restrictive and does not allow local flexibility. - The ICB restructure commenced July 2023 impacting on team capacity.								
Updates on actions and progress								
Date opened	Action / update					BRAG	Target completion	
29/04/22	Phase 1 of the N&W Long term Plan (LTP) funded MH Transformation Programme Plan completed 31/03/24. Phase 2 with focus on integration of new services and pathway development. Continued co-production with partners and Experts by Experience and Clinical Reference Group is central to sustaining and embedding positive change.					G	31/03/25	

29/04/22	Focus on MH Workforce and development of new roles central to success of LTP funded transformation funded programme. Several challenges to embedding localised integrated approach (as described in N&W MH workforce strategy published in 2021) including transition from Health Education England to Work, Training & Education at regional level, as well as local focus on ICB restructure. Paper presented to Strategic Oversight board and action agreed to review workforce oversight and set up a MH workforce group. Progress delayed due to restructure, date for completion extended. Met with Workforce Lead lack of organisational capacity and operational readiness currently to progress this action. Plan to review with MH SRO support.	A	31/10/24									
29/04/22	National MH KPI achievement; developed Oversight Plans with support from NHSEI to work towards recovery of trajectories for the following: Physical Health in Severe Mental Illness, improving Dementia Diagnosis and reducing Out of Area Placement OAP). Rated amber to reflect difficulties reducing use of OAP beds and eradicating 12-hour breaches during a time of extraordinary demand and pathway pressures. Work continues to increase Physical Health checks for people with severe mental illness and dementia diagnosis, trajectory submitted to achieve over a longer 2 year period in recognition of primary care capacity and QOF challenges.	A	31/03/25									
20/10/22	Community Transformation: Stocktake of Community Transformation (3-year LTP funded transformation programme) underway to understand current position regarding recruitment, activity and spend against original transformation ambition and plans. Working with NSFT to strengthen and embed the model going into 24/25. Timeline extended to accommodate totality of work. Effective primary care engagement and delayed CMHT diagnostic-is a risk to delivery.	A	31/03/25									
28/08/24	New update added to capture concerns raised by primary care concerning lack of clarity and responsiveness of NSFT crisis pathway; constructive meeting held 19 July (NSFT and ICB Exec Directors Medicine and Nursing) and clear communications to clarify crisis pathway shared by NSFT to primary care and LMC. Ongoing work to address wider challenges of referral management being supported by ICB mental health team. Concerns regarding timeline for CRHT and CMHT diagnostic being picked up through monthly NSFT SPRG (contractual) meeting. This and the action above regarding Community Transformation stocktake links with wider community pathway transformation work including national initiative 'Intensive & Assertive Outreach Review'.	A	31/03/25									
29/08/23	Right Care, Right Person (RCRP); ICB Leads working in partnership with Norfolk and Suffolk Constabularies. RCRP launched in Norfolk in early June. Suffolk Police went live October 2023. All workstreams have gone live with daily meetings to review any issues and learning. No significant issues reported to date.	G	31/03/25									
22/03/24	Worked through contractual changes, will continue to monitor any adverse impact with VCSE organisations affected by requirement to pay increased Living and Minimal Wage increases	B	31/07/24 Complete									
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16	16	16	16	16							
Change	➡	➡	➡	➡	➡							

*29/08/24: Please note, the risk was downgraded to a 12 (3x4) in Month 03 in error. This has now been corrected.

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Objective 5: Transforming care in later life

BAF05 (Inphase re 00000031)

Risk Title	Increasing numbers of older people with complex health needs in Norfolk and Waveney											
Risk Description	The period that older people spend in <i>ill</i> health in Norfolk is getting longer. Older people are already more likely to be living with multiple and complex health conditions. Common conditions that are more prevalent in older age include dementia, heart disease, hypertension (high blood pressure), respiratory disease, mental health conditions such as depression, cerebrovascular disease, joint problems, diabetes, and sensory impairment. The risks are that: a) services will be unable to continue to meet the increasing demand and needs of our ageing population with complex health needs. b) costs associated with care of this population will increase significantly adding to financial pressures. c) quality of care for older people may decline if a) and b) are not suitably mitigated.											
Risk Owner	Responsible Committee			Operational Lead		Date Risk Identified		Target Delivery Date				
Dr Frankie Swords	People & Communities Committee			Sheila Glenn		20/06/24		31/03/28				
Risk Scores												
Unmitigated			Mitigated			Target						
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total				
5	4	20	5	3	15	4	3	12				
Risk appetite:					Risk tolerance:							
Controls					Assurances on controls							
- Ageing Well Programme Board with substantive programme manager - Increased focus upon early intervention (identify and intervene) - Increased focus upon upstream prevention and remaining active					Internal: Transforming care in later life has been identified as a priority in our JFP. Progress against key national delivery timelines reported and led by appropriate governance structures: System Ageing well board reporting to Patients and Communities Committee. External: Integrated Care Partnership Board							
Gaps in controls or assurances												
- Embedding resources at Place level to co-ordinate the mechanisms needed to deliver Ageing Well Strategic Framework - Further work required to develop the data hub and dashboards to monitor medium / long term impacts. No specific budget allocated to the Ageing Well Programme to support emerging work and respond to system priorities.												
Updates on actions and progress												
Date opened	Action / update						BRAG	Target completion				
01/07/24	Dementia workstream now met, workforce education sessions delivered, work plan under development against 7 areas of need. Self assessment underway of available dementia services, Clinical ageing network has agreed unified frailty scoring for use across system. Population data analysis complete, social isolation and loneliness and falls prevention JSNAs groups established es						G	19/07/24				
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score			15	15	15	15						
Change			NEW	➔	➔	➔						

Objective 6: Improving urgent and emergency care

BAF06 (Inphase ref 00000003)

Risk Title	System / Urgent & Emergency Care (UEC) Pressures							
Risk Description	There is a risk that the Norfolk and Waveney health and social care system does not have sufficient resilience or capacity in the right care setting to meet the urgent and emergency care needs of the population whenever a need arises. This can result in longer than acceptable response times to receive treatment, delays in being discharged from hospital and as a result potentially poorer outcomes for our patients with associated clinical harms. This could lead to worsening ambulance response times for patients with a life threatening and / or life changing condition and an increasing number of patients remaining in hospital when they no longer meet the nationally prescribed ‘criteria to reside.’ The associated increase in longer lengths of stay and higher occupancy levels in all acute and community hospitals results in delays in admitting patients from our emergency departments (EDs) into a bed. In turn, this congests the EDs slowing down ambulance handover leading to more crews outside hospital who are unable to be released to respond to 999 calls.							
Risk Owner	Responsible Committee			Operational Lead	Date Risk Identified	Target Delivery Date		
Mark Burgis	Patients and Communities Quality and Safety			Ross Collett	01/07/2022	31/03/2025		
Risk Scores								
Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	5	20	4	4	16	3	4	12
Risk appetite:					Risk tolerance:			
Controls						Assurances on controls		
• Strategic Oversight: UEC Programme Board oversees non-elective flow and monitors a system wide transformation programme to improve the responsiveness of our Urgent and Emergency Care pathways to ensure patients receive the right treatment in the right place at the right time; that timely discharge for non-elective patients from inpatient hospital and community beds takes place and that appropriate discharge capacity is available to meet the discharge demand from health settings. • Business Continuity: ○ All Trusts, including community, 111 and primary care have business continuity plans in place to manage the operational response to in-year peaks in demand and periods where demand exceeds ‘business as usual’ levels. A seven-day System Control Centre (SCC) and East of England Ambulance Service (EEAST) System Oversight Cell (SOC) are in place. The SCC and SOC work alongside Providers to coordinate operational responsiveness when individual or multiple providers are unable to meet demand in a timely and safe way and to escalate to appropriate levels of management when decisions to mobilise additional resources are needed.						Internal: ICB Executive Management Team; Norfolk and Waveney UEC Programme Board; Three UEC Alliances aligned to each acute hospital system; System Control Centre (SCC) External: ICS Executive Management Team (CEOs Group); Trust Boards; NHSE Regional Strategic Oversight		

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Specific controls to appropriately manage urgent and emergency care demand ensuring patient's needs are met:

- **Hospital 'Admissions Avoidance':** A range of 'Admissions Avoidance' schemes are in place across N&W to ensure that patients who have an 'urgent' care need are seen in a timely way in the right care setting, the core services are:
 - **111 / GP led Clinical Advice Service (CAS):** This service provides advice to healthcare professionals and the public triaging and referring patients to the most appropriate service and setting that will best meet their needs.
 - **Unscheduled Care Coordination Hub (SPoA):** The UCCH has been established since October 2023 as a single point of access for urgent care. The UCCH reviews the 999 and 111 stack coordinating the most appropriate response based on the patients' needs. The UCCH focusses on some of our most vulnerable and frail elderly patients to ensure only those that need a hospital admission or the service provided by an ED are conveyed. The UCCH also supports ambulance crews en-route and on scene with additional clinical support via the MDT and will release crews from scene within 30 minutes taking responsibility for patients who require alternative urgent care services such as Virtual Ward and UCR.
 - **Urgent Community Response (UCR):** Patients that have been triaged can be referred to this service which provides a face-to-face response within 2 hours for those patients that need this 'urgent' intervention who would otherwise be at risk of admission to hospital. This community led service is underpinned by a plethora of discrete services across each 'place' that the UCR team can access to ensure the immediate need is met and that patients are referred onto appropriate health or social care services that can provide support to prevent or reduce the risk of further exacerbation.
 - **GP Streaming (ED Front Door):** is in place at all three acute hospitals to reduce the urgent care (minors) demand flowing through our EDs by providing a primary care led service to patients who walk-in to our EDs as well as redirecting them to other appropriate services in the community.
 - **Same Day Emergency Care (SDEC):** All three acute hospitals have SDECs in place. These are being further developed to include a wider range of symptom groups and referral routes to increase their effectiveness in avoiding 'avoidable' admissions to hospital.
 - **Virtual Ward:** Virtual Ward Project established in Q3 22/23. The project intends to increase the level of acuity of patients that can safely be managed in the community by increasing community capability in a "step up" model. See "discharge" for further information on VW project and "step down."
- **Creation of surge / escalation capacity:**
 - **Cohorting:** A range of cohorting measures are available at acutes to provide ED surge capacity and reduce waiting to handover at hospital.
 - **Rapid Ambulance Offload:** Arrangements in each ED enable a limited number of additional rapid ambulance handovers to release waiting ambulance crews to attend very urgent community calls where there is an extreme risk of adverse clinical outcome from delay.
 - **Escalation / Surge Beds:** Acute and community providers have created additional escalation / surge beds through internal operational changes and using some winter funding. This additional capacity has been maintained in to 24/25.
 - All acute hospitals have ambulance handover plans to improve handover performance and accommodate surges in demand.
- **Specific controls to improve discharge (cross-reference with BAF19):**
 - There is a tactical work programme led by the UEC Programme Board Chair to increase flow by increasing speed of discharge and reducing length of stay ahead of winter.
 - Each of the three UEC Alliances have a programme of work focussed on increasing flow and rate of discharge.
- Position continues to improve with a reduction in escalation beds at the Acute hospitals and improvement in C1 and C2 ambulance response times. Ambulance handover into ED is showing improvement, however this needs to embed and sustain before further risk reduction.

Gaps in controls or assurances

- Clearly defined cross-reference to PHM Strategy that will reduce latent demand for urgent and emergency care through better long-term conditions management reducing condition exacerbation.
- Limited alignment with Mental Health non-elective strategy and which in turn will reduce latent demand on acute hospital EDs.
- A number of UEC initiatives including uplifts in community bed stock are associated with short term funding. This could result in an increased risk of reduced bed stock from January 2025 and an associated increase in hospital bed pressures. Without a long term funding solution this risk will remain with continuous short term extensions providing mitigation which is not sustainable.
- The ICB currently has an interim Director of Resilience who is responsible for the SCC. As this post is interim and there is no substantive funding attached to this role there is a risk that the SCC does not meet the regional Minimum Viable Product
- Short term sustainability of SCC is a risk as all three operational leads have resigned from post. The triple lock process means the process of recruitment is delayed and there will be a gap in SCC service provision because of this.
- Assumptions made by our acute hospitals in the current round of operational planning highlights capacity in wider community (primary care, community, 111/CAS, 999) will be unable to meet the pre-hospital and discharge needs of our population accessing the non-elective pathways.
- Insufficient capacity in social care to meet the needs of our population who require timely discharge to complete their onward care journey

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
16/03/23	National UEC Recovery Strategy - Reduce LoS in inpatient settings. This is a core action in the Joint Forward Plan (JFP) to rebalance system flow and meet operational planning target of 78% A&E 4-hour performance. Baseline average LoS is currently 8.1days for non-elective pathway.	A	31/03/25
16/03/23	National UEC Recovery Strategy – Recover Ambulance category 2 response time to minimum 30mins. This is a core action in the Joint Forward Plan (JFP). Recovering to this performance will be underpinned by a range of Admissions Avoidance and Discharge initiatives to ensure we have the capacity to release ambulances to respond to category 2 calls.	A	31/03/25
16/03/23	National UEC Recovery Strategy – This is a core action in the Joint Forward Plan (JFP) Meet our Virtual ambition to achieve 40 beds per 100,000 population (368 beds). This initiative will support Admissions Avoidance and Early Supported Discharge to meet the 76% A&E 4-hour target.	A	31/03/25
29/8/24	The ICB has committed to recurrently supporting the Unscheduled Care Coordination Hun – this is a core deliverable in the Joint Forward Plan (JFP). The Unscheduled Care Coordination Hub will better coordinate admission avoidance activity and deliver right care, right place, first time which has demonstrated a reduction in in ambulance dispatch and unnecessary conveyance to hospital which in turn supports C2 improvements. As the UCCH becomes more established it will further improve hospital flow and outcomes for people with frailty.	A	31/3/26

Visual Risk Score Tracker – 2024/25

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

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Objective 7: Elective recovery and improvement

BAF07 (Inphase ref 00000010)								
Risk Title		Elective Recovery						
Risk Description		The number of patients waiting for elective treatment in Norfolk and Waveney grew significantly during the pandemic. There is a risk that this cannot be reduced quickly enough to a level that meets NHS Constitutional commitments. This would also contribute to poor patient experience and may lead to an increased clinical harm for individual patients resulting from prolonged waits for treatment, including waits for diagnostic tests and for cancer care.						
Risk Owner		Responsible Committee		Operational Lead		Date Risk Identified	Target Delivery Date	
Andrew Palmer		Commissioning & Performance				01/12/2022	31/03/2025	
Risk Scores								
Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	3	4	12	3	4	12
Risk appetite:					Risk tolerance:			
Controls						Assurances on controls		
• The Elective Recovery Board meets bi-weekly to oversee all workstreams to improve performance and reduce harm. • Each Provider has completed waiting list validation, all patients clinically prioritised. • Unified process of clinical harm review and prioritisation in line with national guidance. • Workstreams in place to expand capacity, share learning, maximise efficiency and reduce variation in waiting times, including through mutual aid, and to transform care pathways to accelerate elective recovery, each led by a chief operating officer or medical director. • EoE funding secured for mutual aid administrative support to contact long wait patients to confirm availability, signpost to While You Wait website and confirm if transfer to alternative provider via mutual aid. • EMT agreement to commission elective capacity through independent sector providers. • Introduction of national PIDMAS system to assist with offering alternative choice of provider to long wait patients with non-recurrent funding allocated to assist with travel costs. • Extending the use of insourcing and outsourcing opportunities to create capacity. • New theatre capacity opened at NNUH in December 23. Additional orthopaedic capacity at NNUH and JPUH due summer/autumn 2024						<u>Trusts are expected to ensure zero 52+ week waits by end of March 2025.</u>		
						QEH de-escalated from Tier 2 to non-tier in Feb 2023. JPUH escalated to Tier 2 in June. NNUH remains on Tier 1 Internal: Weekly and monthly performance metrics for each workstream scrutinised at biweekly elective recovery board.		
						External: Trust Board Governance processes and returns to NHSEI, National contract monitoring by NHSEI and Elective Recovery Board.		
						Weekly Tiering KLOE return from Trusts to system, region, and national teams, monitored through fortnightly Tiering meetings.		
Gaps in controls or assurances								
• Cessation/ reduction of elective activity due to RAAC plank works at JPUH and QEH. • Impact of industrial action in the acute and primary care sectors on elective recovery and administrative resources to support validation and booking processes. • Critical incidents declared at trusts due to intense pressure on emergency capacity. • Staffing challenges at the Trusts with consultant sickness and vacancies, particularly in oncology teams. • Limited Trust resource to undertake clinical and administrative validation of PIDMAS requests. • Limited capacity within the ICS and East of England to accommodate PIDMAS requests within timescales.								

Updates on actions and progress												
Date opened	Action / update										BRAG	Target completion
22/04/24	- All trusts submitted zero 104-week waits for end of March 2024 529 78-week breaches reported for end of March with x11 at the QEH, x242 at JPUH and x276 at NNUH. - NNUH is planning to clear 65 week waits by December 2024, with JPUH and QEH planning to clear by September 2025 (national target) - Trusts continuing to use ICB staff to contact patients and make arrangements to transfer patients to alternative providers including ISPs. - New elective orthopaedic theatre capacity will come onstream at the JPUH in October 2024. - The NNUH orthopaedic centre (NANOC) is due to open in summer 2024. - Recommend maintain risk rating due to steady decrease in number of 52-week breaches, clearance plans in place and opportunities for new capacity coming on stream over the summer.										A	31/03/25
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12	12	12	12	12							
Change	↓	→	→	→	→							

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Objective 8: Improving productivity and efficiency

BAF08 (Inphase ref 00000027)												
Risk Title		Achieve the 2024/25 financial plan										
Risk Description		IF the ICB does not deliver the 2024/25 Financial Plan of a break-even position, THEN the ICB may not be able to maintain spending on current levels of service, or to continue with plans for further investment. This may lead to a reduction in the levels of services available to patients.										
Risk Owner		Responsible Committee			Operational Lead		Date Risk Identified		Target Delivery Date			
Steven Course		Finance			Emma Kriehn Morris		10/05/2022		31/03/2025			
Risk Scores												
Unmitigated			Mitigated			Target						
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total				
5	4	20	3	4	12	3	4	12				
Risk appetite:					Risk tolerance:							
Controls					Assurances on controls							
- Monthly monitoring of risks and mitigations, reported to NHSE/I. - Detailed plan for 2024/25 approved by Board and submitted to NHSE/I as part of the wider ICS plan. - Monthly Finance Report presented to Finance Committee and Board.					Internal: Board Reports and Minutes, Audit Committee reports and Internal Audit work plan, Finance Committee reports, Executive Management Dashboards, Delegated Budget manager review, Internal monthly review of Risks & Mitigations. External: ICB assurance process, early flagging of risk with NHSE/I and Protocol conditions.							
Gaps in controls or assurances												
- No contingency reserve in plan; £51m of unmitigated risks against the plan at the point of final submission; As at M04 (July 2024) the £51m planning risks have been re-assessed to £34.8m (M03 £49.1m) on a probability basis. - In addition to the revised £34.8m Planning Assumption Risks, a further £1.5m (M03 £1.2m) of Net Risks have been noted resulting in a Total net risk of £36.3m (M03 £50.3m). - The financial position assumes full delivery of the unidentified Efficiencies equating to £15.7m. This is a significant risk to the delivery of the in-year financial plan.												
Updates on actions and progress												
Date opened	Action / update						BRAG	Target completion				
01/04/24	Review of monthly and year to date performance and assess forecast out-turn evaluated risks and mitigations.						G	Monthly to 31/03/25				
31/07/24	Review of all mitigations and recovery actions to support the financial delivery to plan.						A	Monthly to 31/03/25				
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	12	12	12	12								
Change	➔	➔	➔	➔								

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NHS Norfolk and Waveney ICB – Board Operational Risk Register (BORR)

Version: 2 **Date updated:** 12 September 2024

Summary Page

Ref.	Risk Title	Risk Owner	Date risk identified	Target delivery date	Score at target delivery	2024-2025 Monthly Risk Rating											
						1	2	3	4	5	6	7	8	9	10	11	12
BORR01	Providers in CQC Special Measures (NSFT)	Tricia D'Orsi	01/07/22	31/12/24	8	16	16	16	16	16							
BORR02	NHS Continuing Healthcare	Tricia D'Orsi	01/07/23	30/11/24	9	20	20	20	20	20							
BORR03	EEAST Response Time and Patient Harms	Tricia D'Orsi / Mark Burgis	01/07/22	30/11/24	9	16	16	16	12	12							
BORR04	Right Care Now	Tricia D'Orsi	25/10/22	30/09/24	6	16	16	16	16	16							
BORR05	Mortality Action Plan NSFT	Dr Frankie Swords	18/07/23	30/11/24	4	16	16	16	12	12							
BORR06	RAAC Planks	Steven Course	01/07/22	31/03/25	15	20	20	20	20	20							
BORR08	Underlying Deficit Position	Steven Course	01/07/22	31/03/24	12	20	20	20	20								
BORR09	Secondary care dental services (Oral Surgery and Maxillo Facial Services, Orthodontic Services)	Mark Burgis	01/02/24	31/03/26	12			16	16	16	16						
BORR10	Resilience of NHS General Dental Services in Norfolk and Waveney	Mark Burgis	01/04/23	31/03/26	12	20	20	20	20	20	20						
BORR11	Neuro-Developmental Service (NDS) Children and Young People	Tricia D'Orsi	01/07/24	30/09/24	12	20	20	20	20	20							
BORR12	The resilience of general practice	Mark Burgis	01/09/20	31/03/26	12	16	16	16	16	16	16						

BORR01 (Inphase ref 00000004)

Risk Title		Providers in CQC Special Measures (NSFT)							
Risk Description		There is a risk that services provided by Norfolk & Suffolk Foundation Trust (NSFT) do not meet the required standards in a timely and responsive way. If this happens, people who use our services will not receive access to services and care that meets the required quality standard. This may lead to clinical harm, poor patient experience and delays in treatment or services.							
Risk Owner		Responsible Committee		Operational Lead		Date Risk Identified		Target Delivery Date	
Tricia D’Orsi		Quality & Safety		Karen Watts		01/07/2022		31/12/2024	
Risk Scores									
Unmitigated			Mitigated			Tolerated (Target in 12 months)			
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total	
4	4	16	4	4	16	2	4	8	
Risk appetite						Risk tolerance			
Controls						Assurances on controls			
- The report published on 28/04/22 gave an overall reduced rating of inadequate. The Trust was able to provide adequate assurance to mitigate the need for a Section 31 enforcement notice during the inspection. - The Trust’s Improvement Plan is over seen by an Improvement Board with a focus on the areas set out in the section 29a letter and Must Do’s issued in April 2022. Stakeholder engagement has been strengthened. Evidence Assurance Panel established with attendance by ICB MD and DoN. - Transformation plans continue to progress alongside Quality Improvement. - ICB attending Trust Quality and Safety Reviews (QSR) with frontline teams and working closely with NHSE. - The Trust was reinspected, with its report published in February 2023. The overall rating increased from ‘inadequate’ to ‘requires improvement.’ - The Trust will continue to receive enhanced support from NHSE to sustain improvements and to support exit from NOF 4 criteria within the last quarter of 2024-25. Good progress is being made against RSP objectives. - A new model of care is currently being piloted in Suffolk. - High-level oversight of mortality review actions in place. Bereaved families, Healthwatch and ICBs included. - The Trust’s Evidence Assurance Group (EAG) continues to progress CQC actions. - The Trust has implemented four key priorities areas; Improving Health, Improving Care, Improving Culture, and Improving Value, under which sits several programmes of work.						Internal: Clinical Governance Meetings, Quality and Safety Committee, ICB Executive Management Team (EMT), System EMT, and ICB Board. Trust CQC Evidence Panel chaired by ICB. External: ICB attendance at Key Trust Meetings, Care Quality Commission, System Quality Group, Norfolk and Suffolk Healthwatch organisations, NHSE/I Oversight and Assurance Group, NSFT Quality Improvement Board, NSFT Quality Pillars and NSFT Quality Committee, Evidence Assurance Panel. Norfolk and Suffolk HOSCs.			
Gaps in controls or assurances									
- High levels of patient acuity are being reported. Capacity is not currently able to meet demand, particularly in the community. - Workforce pressures. Impact of ‘inadequate’ rating on staff wellbeing and morale. Significant change within top leadership level. - Long term sustainability of improvements, to BAU, is required to move out of NOF4 status. - Continued work to improve data validation across the Trust. - The Trust has commenced a restructure of Care Groups and has had significant changes in senior leadership. - Continued concerns and focus on the physical health monitoring of patients. The Trust has commenced an inpatient falls collaborative, involving their older people’s wards. - The key risk to delivery of NOF4 exit is around completion of staff training. The Trust remains in NOF4 with a recovery support programme in place with NHSE.									

Updates on actions and progress												
Date opened	Action / update								BRAG	Target completion		
24/06/23	New model of care is being piloted in Suffolk.								B	Complete		
19/02/24	RSP strategic framework is a priority focus to ensure the Trust does not re-enter RSP again. Key priorities; improving health, improving care, improving value, and improving culture with 11 large-scale change programmes.								G	31/03/25		
09/05/24	The Trust has recruited to several Executive posts; Chief Medical Officer, Chief Nursing Officer, and Chief Transformation Officer. Interim CEO is confirmed in post until Summer 2025. Chair has been accepted for a second term. Substantive CNO in post. Substantive CMO recruited and due to start 06/09/24.								G	30/09/24		
09/05/24	The Trust has completed 77% of the must and should do actions								G	30/11/24		
06/08/24	Recruitment of remaining 2x vacant non-executive member roles to Board. Trust reports good response to advert.								G	30/09/24		
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16	16	16	16	16							
Change	➔	➔	➔	➔	➔							

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Risk Title		NHS Continuing Healthcare							
Risk Description		There is a risk that not all NHS Continuing Healthcare (CHC) funded packages will be filled by the provider either due to the complexity of the care required and/or their capacity or the proposed cost of care.							
		If this happens significant pressures will be placed on the CHC nurses to source a package of care. Staff vacancies and absences may increase and the infrastructure to support provision of safe and effective care packages will be compromised.							
		This may lead to increased financial cost to secure a care package, could impact on hospital discharges and admissions and poor outcomes for people requiring NHS funded care in the community.							
Risk Owner		Responsible Committee		Operational Lead		Date Risk Identified		Target Delivery Date	
Tricia D'Orsi		Quality & Safety		Paul Benton		01/07/2022		30/11/2024	
Risk Scores									
Unmitigated			Mitigated			Tolerated (Target in 12 months)			
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total	
5	4	20	5	4	20	3	3	9	
Risk appetite						Risk tolerance			
Controls						Assurances on controls			
- Recruiting to vacant posts within the CHC team to support assessments and care sourcing. - Commence work with finance team and contract team in NWICB and Local Authorities (LAs) to work to stabilise the market. - Link with Local Authority (LA) workforce teams to support care providers in additional training and support required. - Regular financial updates to Finance Committee and Executive Management Team (EMT) to monitor impact of cost of care packages. - Monthly operational finance meetings for Quality in Care (QiC) team. - Monitoring of time taken to secure complex care packages and escalation process for CHC team if unable to source. - Attendance at regional meetings to support feedback and sharing of good practice and innovation. - Weekly meetings held with Norfolk and Suffolk NHS Foundation Trust (NSFT) and NCC to improve communication and partnership working around discharge planning. Complex discharges from acute mental health hospital beds are progressively delayed by lack of suitable complex care in the local provider market. - Contracting, Finance and CHC teams collaborating to share relevant information regarding uplifts. - Interim staff on secondment have been asked to extend the period of their secondment, with funding in place until end of September 2024. - Implementation of increased financial control. - Increased staff establishment. - Regular meetings in place with NCC to discuss financial and strategic risks to both commissioners.						Internal: Senior Management Team (SMT); EMT; Quality & Safety Committee; Finance Committee; Board External: NHS England/Improvement; Regional CHC Team, Joint Collaborative Forum (Norfolk County Council (NCC)), Care Market Cell (Suffolk County Council), System partners			
Gaps in controls or assurances									
- Ability to source and retain suitable workforce for either the NWICB CHC team or care provider market – ongoing. - Lack of a whole system Care Workforce Strategy. - Ability to stabilise the care market post Covid-19 and EU Exit. - Capacity of CHC team to source or revise care packages.									

Updates on actions and progress												
Date opened	Action / update									BRAG	Target completion	
21/06/23	The ICB is working very closely with NCC to establish models of joint commissioning and agreed funding streams to apply stability into the care market. We are currently working with a consultancy firm to identify the next steps for this process. ICB restructure consultation period extended so unable to recruit to posts.									G	31/09/24	
19/06/24	Recruitment to vacant posts commenced as part of the restructure of the organisation. The delay of the staff consultation has impacted our ability to influence the care market and control spend.									G	30/09/24	
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	20	20	20	20	20							
Change	➔	➔	➔	➔	➔							

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BORR03 (Inphase ref 00000012)

Risk Title	EEAST Response Time and Patient Harms			
Risk Description	Clinical risks to patients awaiting ambulances in community – C1 and C2 response times including inability to undertake rapid release of ambulances. handover and inter-facility transfers resulting in patient harms, occurring during periods of significant system pressure.			
Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Tricia D'Orsi / Mark Burgis	Quality & Safety	Karen Watts	01/07/2022	31/03/2025
Risk Scores				
Unmitigated			Mitigated	
Likelihood	Consequence	Total	Likelihood	Consequence
5	4	20	3	4
Tolerated (Target in 12 months)			Risk tolerance	
Likelihood	Consequence	Total	Likelihood	Consequence
3	3	9	3	3

Controls	Assurances on controls
- Daily sit-rep ensures ICB is sighted on real-time demand and resource. - HALO role across all Acute sites to support Emergency Departments (ED). 999 / 111 multi-disciplinary approach via CAS at IC24 to manage some ambulance calls and dispositions - Pre-alert and rapid release processes in place with safety netting for patients waiting to be seen. Ambulance and ED revalidations embedded. - Proactive public comms to promote appropriate use of NHS service options. This is reinforced across seasonal campaigns. - UEC Tactical Group continues to review system-wide SIs and identify trends / themes. - Interfacility transfers have improved with processes in place between organisations. - In August 2023, the ICB launched the Unscheduled Care Coordination Hub (UCCH) with the aim of reducing conveyances, this replaces and builds on the work of the previous 'Virtual Open Room' which triaged people waiting for an ambulance and re-routed appropriate calls directly into other community services. Funding agreed for the year ahead. - System has agreed to a zero-tolerance position for ambulance handovers >30min as of November-December 2023. This has resulted in a reduced number of adverse incidents and has supported improved ambulance response times in the community for C1 and C2. - Improved C1/C2 ambulance response time performance has continued, with some periods of escalation during times of increased pressure. The reduction in adverse incidents has sustained. - Hospital flow and 'corridor care' has been well managed and decompression continues. Optica implementation is improving system view; NNUH and QEHL online, JPUH planned over next quarter.	Internal: EMT, N&Q Senior Team, ICB Clinical Lead for UEC and UEC Commissioning Team, ICB Quality and Safety Committee, ICB Board, Provider Governance Forum. External: Regional Commissioning Consortium, NHSE Regional Team, OAG and CQC.

Gaps in controls or assurances
- System-wide pressures impact on the ability of ambulances to handover patients at Emergency Departments (ED) and release to respond to new calls in a timely way, during periods of increased pressure. - Discharge pressures, with high numbers of patients with no criteria to reside, are improving but still impacting on patient flow through the acute hospitals. The occupancy and utilisation of escalation areas, including 'corridor care, is an unintended consequence of 30min ambulance handover improvement, but has stabilised due to decompression actions. - Significant challenge remains in social care re: capacity and workforce required to support packages of care in the community. - Sustained periods of industrial action have an impact on flow, which also impacts ambulance handover times. This can be positive or negative depending on how the action effects the capacity of senior decision makers in ED, and the movement of patients through the wider hospital. - GP collective action creates a new risk which cannot be fully assessed until intelligence around potential impact (e.g. what elements of primary care will be affected) is collated.

Updates on actions and progress												
Date opened	Action / update									BRAG	Target completion	
10/01/23	Decompression measures continue to be utilised at each site (cross-reference BAF02). Escalation plan required to reduce use of escalation beds.									G	30/09/24	
29/08/23	System plans to mitigate industrial action are in place and working well. However, the resilience of staff and the pressure of prolonged action on interprofessional relationships is emerging as a risk. The system IA EPRR response continues to manage and mitigate risk. Potential impact of GP collective action is being monitored and assessed.									G	30/09/24	
01/11/23	Partners have been asked to ensure frontline staff are able to access support, including management oversight and access to wellbeing resources and interventions.									B	Complete	
03/01/24	All ambulance handovers equal or greater than 8hrs are to be reported to NHSE regional and national teams and the Department of Health. This is now BAU.									B	Complete	
19/06/24	OPTICA (optimised Patient Tracking & Intelligent Choices Application) implemented at NNUH and QEHL. The tool enables a clearer line of sight for discharges to prevent avoidable delayed discharges. JPUH waiting to onboard following resolution of interoperability issues before going live.									A	30/09/24	
19/06/24	Ambulance handover times have improved but there is still some variation in system pressures.									G	30/09/24	
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16	16	16	12	12							
Change	➔	➔	➔	⬇	➔							

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BORR04 (Inphase ref 00000013)

Risk Title			Right Care NoW Programme					
Risk Description			There is an increased risk to patients no longer meeting the 'Criteria to Reside' in both acute and community hospitals; numbers of which continue to fluctuate. The cause is insufficient pathway 2 & 3 beds for people needing onward care, particularly for people with complex needs, as the local care market is not designed to meet current acuity and care requirements. Risk previously named 'Discharge from inpatient settings. Renamed January 2024 to align with new programme title.					
Risk Owner			Responsible Committee		Operational Lead	Date Risk Identified	Target Delivery Date	
Tricia D'Orsi			Quality and Patient Safety Committee		Danny Edmonds	25/10/22	31/01/2025	
Risk Scores								
Unmitigated			Mitigated			Tolerated (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	4	4	16	2	3	6
Risk appetite					Risk tolerance			
Controls						Assurances on controls		
- Daily review of all system discharge delays. - Escalation process in place. - Supplementary P1 capacity/reablement commissioned long-term by NCC. - NCC trialling Social Work support to Community wards to reduce long length of stay (LLOS). - Seasonal funding has set up 10 additional beds coming online to support discharge. - Unmet care need list is being monitored through NCC. - Single agreed system dashboard established and continuously developing to strengthen oversight. - New Transfer of Care Form and processes approved for use across system. - The system has committed to commissioning of the Optica system, implementation has commenced at NNUH and QEHKL with JPUH planned across the next quarter. This has the potential to reduce length of inpatient stay and streamline system data. 7-day Discharge IDT is embedded in the Central and East localities. 7-day Discharge Hub has been set up across all localities. Hub Managers participate in LLOS meetings at Acute sites. - The system is engaged with the 2024 Deconditioning Games which are being launched by NHSE imminently. This will support staff to take forward interventions to improve patient mobility during their admission.						Internal: ICB Executive Management Team; UEC Board; Discharge Programme Board; ICB Quality and Safety Committee; Bi-weekly Discharge Touchpoint Meeting. Daily Integrated Discharge Team (IDT) Meetings; Strategic Operational Delivery Group; System Clinical Oversight Meeting. External: Trust Boards, Trust Discharge Programmes e.g. HomeFirst, 3 x Acute System Operations, Resilience and Transformation Boards; NHSE oversight. Local Authorities.		
Gaps in controls or assurances								
- Insufficient capacity within existing care market as local provision is not designed to meet current acuity and complex care requirements. - Workforce pressures. Staff sickness and absence continue to impact on performance. - Underutilisation of criteria led discharge. 7-day working needs to embed fully across the whole Norfolk and Waveney footprint. This is improving but is still a risk. - Breakdown and oversight of current ICB funding; what is recurrent and what is non-recurrent is unclear to Discharge Programme Board. - Willow Unit modular build continues to be delayed. Recruitment is in progress. This will provide an additional 48 beds from November 2024.								

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Updates on actions and progress			
Date opened	Action / update	BRAG	Target completion
09/11/22	Roll out of criteria lead discharge to all wards has commenced.	A	31/10/24
22/06/23	System awarded capital investment for Willow Ward modular build at NCH&C, with a potential of 48 beds. Planned to mobilise in June 2024. Update 19/06/24 The start date has been delayed with a plan to open in Autumn 2024. We are now looking at opening in November 2024. Additional beds remain open at Coleman site.	A	01/12/24
29/08/23	Roll-out of Optica system, this has the potential to reduce length of inpatient stay and streamline system data. Update 19/06/24 Implemented in NNUH and QEHL. JPUH resolving interoperability issues.	A	30/09/24
19/06/24	Alder Ward temporarily closed due to Fire Regulation issues. New fire doors ordered. Surge beds opened to support capacity with consideration for sourcing for additional capacity. Plan is for 12 beds to open on 02/09/24, with further phased in the following weeks.	G	31/09/24

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

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Risk Title		Mortality Action Plan NSFT						
Risk Description		Grant Thornton was commissioned by Norfolk and Waveney and Suffolk and North-East Essex Integrated Care Boards to review the collection, processing and reporting of data. This found the processes to be unclear and rely on multiple systems to record and produce the data, with inconsistencies in the categorising and grouping of expected and unexpected deaths and unclear and inconsistent decision making and reporting of community deaths. There is a risk that the ICS fails to learn from the tragic events reported in the review. This could potentially lead to missed opportunities for prevention of future deaths which could lead to further distress of bereaved families, friends and carers who lose trust and confidence in the service. There is a significant risk of reputational damage and national media interest.						
Risk Owner		Responsible Committee			Operational Lead	Date Risk Identified	Target Delivery Date	
Dr Frankie Swords		Quality and Safety Committee			Karen Watts	18/07/2023	30/11/24	
Risk Scores								
Unmitigated			Mitigated			Tolerated (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	3	4	12	1	4	4
Risk appetite						Risk tolerance		
Controls						Assurances on controls		
- NSFT have formulated an Action Plan and improvement programme focusing on learning from deaths, incorporating both Grant Thornton and Seagry recommendations, split in 3 areas: - Collecting, analysing and reporting on deaths; involving the creation of a new electronic system for mortality information collection, analysis and reporting. - Ensure learning through improvements to clinical practice; reviewing all Prevention of Future Deaths reports from 2013 to identify themes and ensure learning and improvement, including themes from the Forever Gone Report, Domestic Homicide Reviews and Serious Case Reviews. - Work with service users, carers and bereaved families; detailed work with service users, families, carers and bereaved relatives who sit on our Learning from Deaths Action Plan Management Group. - The Trust's Learning from Deaths quarterly Board report now includes thematic analysis of key metrics such as age, diagnosis, cause of death and deprivation indices. - The Trust has now adopted standardised classification of all deaths: natural and unnatural causes, expected and unexpected and has been using this reporting system for all deaths from 1.11.23. - The Trust is also systematically reviewing all historic deaths in the GT report to confidently categorise them in the same way and to ensure any learning is identified and acted on. - Medical examiner scrutiny of all NSFT and community deaths is also being introduced April 2024. - The Trust's new Mortality data report has been published and it has also been brought to ICB QSC for review and discussion by partners. This has provided additional assurance. - Mortality data is presented internally at Board level.						Internal: ICB EMT, Quality and Safety Committee, Board, System Quality Group, system Learning from Deaths Forum, ICB Serious Incident Oversight, LeDeR and Child Death Review. External: Regional Quality Group, NHS England Oversight and Assurance of NSFT, NSFT Board, NSFT Medical Examiners, NSFT Quality Committee, NSFT Mortality Improvement Board, NSFT Co-production Groups, Norfolk HOSC and CQC.		
Gaps in controls or assurances								
There is currently a lack of national guidance regarding recording of mental health mortality data with a gap concerning the oversight of deaths occurring in the community.								

Updates on actions and progress												
Date opened	Action / update									BRAG	Target completion	
11/01/24	Partnership Working Cause of death is now being achieved for approx. 84% as most GP practices and Acute hospitals are assisting with the information. Data sharing agreements in place with Acute Hospitals. In the process of exploring broader Information Sharing agreements for Mortality Reporting. Additional actions -Meeting has occurred with the Suffolk Registrar's Office following which a Data Sharing Application has been submitted. The Trust have been advised the process of approval could take 4-5 months. The same application will be made to Norfolk Registrar's Office. This will enable the Trust to directly gain the Cause of Death. Update 19/06/24 The ICB has supported with data collection of retrospective mortality review within Primary Care by setting up a process with agreed practices for named individuals from NSFT to access practice information. This process has ceased, and the Trust is looking for a solution with the local coroner' office.									B	Complete	
06/08/24	NSFT continue to lobby for national guidance regarding recording of mental health mortality data and categorisation. They are the first Mental Health Trust to progress with this work.									G	31/01/25	
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16	16	16	12	12							
Change	➔	➔	➔	⬇	➔							

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Risk Title			RAAC Planks					
Risk Description			There is a risk of failure of the current roofing structures at two Norfolk and Waveney Acute Trusts due to their composition with RAAC Planks which are now significantly beyond their initial intended lifespan. This could affect the safety of patients, visitors and staff. The rolling programme of inspections and remedial work to detect and mitigate this also presents a risk to the system through the requirement to close areas for remedial work, further impacting patient and staff experience as well as the ability to deliver timely urgent, emergency and elective care to our patients.					
Risk Owner			Responsible Committee		Operational Lead	Date Risk Identified	Target Delivery Date	
Steven Course			Board/Finance Committee		Steven Course	01/07/2022	31/03/2025	
Risk Scores								
Unmitigated			Mitigated			Tolerated (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	5	25	4	5	20	3	5	15
Risk appetite					Risk tolerance			
Controls					Assurances on controls			
- Trusts have robust plans in place to manage a possible incident; however, these only cover immediate evacuation and not reprovision. - Regional RAAC response plan is established. - Regular surveys and assessments are being conducted to determine the severity of the issue and to identify and address signs of deterioration. - Region-wide scoping piece commissioned to look at ongoing service transition and recovery. - Current work ongoing to address issues found on inspection as issues identified. Each issue is separately risk assessed using NHSE led guidelines for 'Best Buy' hospitals and a RAACter Scale used to assess level of issue. - Legal position and recommendations provided by Browne Jacobson on ICB responsibilities should there be a catastrophic failure at either acute. Regular meeting established with NCHC and regional RAAC team to track progress on the community storage site RAAC removal. These will now be concluded following the completion of demolition works					Internal: SMT, EMT, ICB Board External: ICS Boards, Estates, NHSE/I, Individual trust boards RAAC related exercises have been undertaken to provide assurance of plans and procedures in responding to an evacuation of a RAAC impacted trust. - Feb 22 - Exercise Farthing - Jun 22 – Exercise Walker - Nov 22 – Exercise Fox EPRR Core Standards incorporated a Deep Dive on health providers Evacuation and Shelter arrangements specifically due to the RAAC risk. Funding has been secured to support the mitigation of RAAC within the two acute hospitals by implementing programmes of interim works to mitigate risk, and planned replacement of each hospital under the NHS new hospitals programme. Funding has been secured to demolish the storage facility within the community site by the end of 23/24. Storage has been displaced to other sites. The demolition was completed by the end of March 2024			
Gaps in controls or assurances								
Lack of approval of region-wide scoping piece prevents full evaluation and plan of service transition and recovery								

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Updates on actions and progress			
Date opened	Action / update	BRAG	Target completion
16/02/22	Scoping piece to assess service transition and recovery post RAAC failure to concluded	G	ongoing
05/06/23	QEH approved for new hospital	G	ongoing
12/12/23	RAAC works at JPUH reduced to support ambulance handover capacity. works for the HSDU and kitchen will continue and will complete a significant area, so the overall programme is not significantly impacted	A	ongoing
12/03/24	Programme to eradicate RAAC at the community site is progressing well and is planned to be completed on budget within the financial year. Now Completed	G	Complete

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

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BORR07 (Inphase ref 00000002)

Risk Title	Underlying deficit position			
Risk Description	If the ICB underpins its financial position via non-recurrent funding, then, this provides a risk to future years financial sustainability due to lower allocations based on historic expenditure.			
Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Steven Course	Finance	Emma Kriehn Morris	01/07/2022	31/03/2025

Risk Scores

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

Risk appetite		Risk tolerance	

Controls	Assurances on controls
- Analysis and understanding of underlying recurrent position, including drivers of the deficit on a monthly basis. - ICS Medium Term Financial Model has been developed on consistent assumptions. - Key lines of Inquiries (KLOEs) have been reviewed and provide assurances as to strong financial governance and best practice adoption. The ICB is part of the Triple Lock process with self-imposed reduced limits of £25k.	Internal: Board Reports and Minutes, Audit Committee reports and Internal Audit work plan, Finance Committee reports. External: ICB assurance process, early flagging of risk with NHSEI. ICS CFOs.

Gaps in controls or assurances

- ICB has an underlying exit Planning deficit position of £(101.8)m at the end of March 2025 a much deteriorated position as compared to the exit plan for March 2024 at £(65.1)m. There are no plans at present to bring this to a break-even position in the short term. - The ICB are key members of the ICS Financial Recovery Board who are considering key system efficiencies of a recurrent nature. These may support the ICB in part in addressing its own underlying financial deficit. The ICB is exploring with other systems other approaches to address this financial risk. - The M04 assessment of the ICB's underlying deficit has deteriorated to £(119.3)m, the adverse movement of £(17.5)m against plan results from non-delivery of identified recurrent efficiencies and continued recurrent operational demands on CHC services and therefore costs.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
01/04/24	Refresh ICS and ICB medium term financial plan to determine likely future underlying position. Early review of 2025/26 planning.	G	31/08/2024
01/04/24	Identify mitigations to risk in plan to include unidentified efficiencies. Ensure new schemes deliver on a recurrent basis.	A	31/13/2025

Visual Risk Score Tracker – 2024/25

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

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Risk Title		Secondary care dental services (Oral Surgery and Maxillo Facial Services, Orthodontic Services)							
Risk Description		Primary Care Services, and secondary care dental services, became the responsibility of the Integrated Care Board from 1 st April 2023, the risk is the unknown resilience, stability and quality of secondary care dental services, and critical challenges relating to the recruitment and retention of professionals and waiting lists, and resources within the ICB Primary care team to implement the recommendations from the East of England NHSE report lack of resources to monitor and manage 3 secondary care contracts							
Risk Owner		Responsible Committee		Operational Lead		Date Risk Identified		Target Delivery Date	
Mark Burgis		Primary Care		Sadie Parker		01/02/2024		31/03/2026	
Risk Scores									
Unmitigated			Mitigated			Tolerated (Target in 36 months)			
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total	
5	4	20	4	4	16	4	3	12	
Risk appetite						Risk tolerance			
Controls					Assurances on controls				
- ICB primary care team recruited and in place working alongside newly recruited Quality Dental Nurse in Quality team and Finance colleagues to manage primary and community care contracts. - Ring fenced dental budget for investment. - Active engagement with dental contractors, secondary care, LDC and Local Professional Network (and Managed Clinical Networks), regular dental newsletter in place. - Dental Development Group established to engage with key stakeholders to input to commissioning plans. - Dental Services Delivery Group established reporting to PCCC. - Dental Long-Term Plan and local primary care Workforce Plan agreed 7 May 2024 sets out ambitions for primary care, Level 2 and secondary care service collaboration - NHS England Long Term Workforce plan published June 2023. - Clinical expertise provided by NHSE through the Regional Chief Dental Officers and Managed Clinical Networks extended for 2024/2025 for strategic development, transformation and commissioning purposes - NHSE Recommendations for secondary care services in East of England 2024 published. - Suffolk and North-East Essex ICB (SNEE) lead in region for secondary care work programme. - Monthly OMFS meetings in place all ICBs in region					Internal: EMT, Primary Care Commissioning Committee, Dental Services Delivery Group External: NHS England, Norfolk and Waveney LDC, regional Local Professional Network and Managed Clinical Networks, Healthwatch Norfolk/Suffolk, NHS Business Services Authority				
Gaps in controls or assurances									
- The level of the unmet need for general dental services and consequent impact on secondary care service referrals and waiting lists for oral surgery and orthodontic services is unknown. - The financial consequence given the transfer for funds was based on 2022-23 current expenditure which are below budget required to meet population need. - Lack of access to NHS dentistry services is an area of quality concern resulting in higher numbers of referrals into secondary dental care, urgent and emergency and planned care with waiting lists. - Significant workforce shortfalls across general dental services, Level 2 services and secondary care dental services and a lack of comprehensive workforce data to support planning, training and education of whole dental workforce.									

- Lack of knowledge about the resilience and stability of existing secondary care dental services
- Lack of ICB resources to manage and monitor secondary care contracts and the impact for primary and community care referral pathways.
- Lack of understanding and management of waiting lists in secondary care by commissioners
- Unable to implement the NHSE East of England recommendations for collaborative working between secondary care providers to support patient care and management of waiting lists across Trusts.
- Lack of support for workforce plans and succession planning, understanding of impact for primary and community dental services.
- Lack of ICB resources to implement the East of England recommendations for secondary care dental services.
- Lower priority in operating theatres for GA extractions led by Community Dental Services
- Inappropriate referrals for cancer treatment in secondary dental care.
- Primary care/secondary care interface could be improved.

Updates on actions and progress

Date opened	Action / Update	BRAG	Target completion
May 24	• Suffolk and North East Essex ICB (SNEE) lead for East of England (EoE) ICBs in relation to secondary care matters that rely on collaboration and wider impact across EoE and for escalation., MOU agreed by Primary Care Directors. • Proposals to prepare an ICB business case to establish a provider collaborative discussed but no resources to take forward in ICB. • To draw up an Equality Impact Assessment and Clinical Quality Risk Assessment with support from Quality team • Medical Needs pathway under development by ICB	A	30/9/2024
Jul 24	• MOU signed with SNEE ICB supported by programme management resources • Paper re Shared Care Pathway (previously known as Medical Needs Pathway) to Dental Services Delivery Group for approval July 2024. Mobilisation plan to be drawn up. • ICB resources to be identified to take forward discussions for JPUH notice to terminate orthodontic provision, currently provided by NNUH on behalf of JPUH	A	31/10/2024
Aug 24	• Paper presented to EMT relating to the emerging risk with NNUH as lead provider for both JPUH and NNUH patients for secondary care orthodontic services following JPUH notice to terminate. Paper to be presented to ICB Performance and Commissioning Committee in September. • Shared Care Pathway approved for mobilisation. • Trauma pilot in primary care ceases end September 2024. Discussions under review to consider if to extend pending review of pilot. If not extended, more patients will be seen in secondary care including Emergency Departments.	A	30/9/2024
Sep 24	• Regional ICB agreement to extend the Trauma pilot to end March 2025, subject to ICB governance arrangements, to enable evidence based informed discussion to take place re future of the service and links to urgent treatment pathway and OOH services	A	30/09/2024

Visual Risk Score Tracker – 2024/25

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

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BORR09 (Inphase 00000025)

Risk Title	Resilience of NHS General Dental Services in Norfolk and Waveney								
Risk Description	Primary Care Services became the responsibility of the Integrated Care Board from 1 st April 2023, the risk is the unknown resilience, stability and quality of dental services, and critical challenges relating to the recruitment and retention of dentists and dental care professionals and the limitations of the national dental contract, leading to a poor patient experience for our local population with a lack of access to NHS general dental services and Level 2 dental services.								
Risk Owner	Responsible Committee			Operational Lead	Date Risk Identified	Target Delivery Date			
Mark Burgis	Primary Care			Sadie Parker	01/04/2023	31/03/2026			
Risk Scores									
Unmitigated			Mitigated			Tolerated (Target in 12 months)			
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total	
5	4	20	5	4	20	4	3	12	
Risk appetite						Risk tolerance			

Controls	Assurances on controls
- ICB primary care team recruited and in place working alongside newly recruited Quality Dental Nurse in Quality team and Finance colleagues, and Planned Care Team (for secondary care dental services). - Ring fenced dental budget for investment. - Active engagement with dental contractors, LDC and Local Professional Network (and Managed Clinical Networks), regular dental newsletter in place. - Dental Development Group established to engage with key stakeholders toto commissioning plans, including the Long-Term Dental Plan. - Dental Services Delivery Group established reporting to PCCC. - Dental Long-Term Plan and local Primary Care Workforce Plan agreed 7 May 2024 sets out ambitions for primary care, Level 2 and secondary care service collaboration - NHS England Long Term Workforce plan published June 2023. - NHS Business Services Authority performance/quality management reporting and quality framework in place with regular meetings established with the ICB. Access to eDen dental data management reports and dashboard for ICB staff. - Clinical expertise provided by NHSE through the Regional Chief Dental Officers, MCN supported by ICB Senior Clinical Fellow roles during 2024/2025 for strategic development, transformation and commissioning purposes. - Dental Data Review being updated to inform commissioning plans. - Primary care workforce and training team working closely with primary care commissioning team to ensure workforce retention programmes and training support is linked to the Dental Delivery Plans. - Clinical Dental Advisor role to be recruited for ICB in 2024 to replace NHS England roles.	Internal: EMT, Primary Care Commissioning Committee, Dental Services Delivery Group External: NHS England, Norfolk and Waveney LDC, regional Local Professional Network and Managed Clinical Networks, Healthwatch Norfolk/Suffolk, NHS Business Services Authority
Gaps in controls or assurances	
- The level of the unmet need for general dental services and the associated financial consequence of this once addressed (if possible) given the transfer for funds was based on 2022-23 current expenditure which are below budget required to meet population need. - Concern around the financial consequences due to dental contracts currently being returned or removed from providers, resulting in temporary and more expensive contracts with reduced activity and higher UDA (Unit of Dental Activity). - Lack of access to NHS dentistry services is an area of quality concern. This impacts on some of our most vulnerable patient groups	

- Significant workforce shortfalls across general dental services, Level 2 services and secondary care dental services and a lack of comprehensive workforce data to support planning.
- Lack of in-depth knowledge about the resilience and stability of all dental services across Norfolk and Waveney: primary; community and secondary services.

Updates on actions and progress

Date opened	Action / Update	BRAG	Target completion
Mar 24	ICB Engagement survey closed 21 February 2024 with over 2000 responses to be analysed for the Long-Term Dental Plan to be finalised for approval. NHS England Dental Recovery Plan 2024/2025 published 7 February 2024 (Faster, simpler and fairer: our plan to recover and reform NHS dentistry - GOV.UK (www.gov.uk)) and the ICB is working to mobilise the individual elements of the Plan as details are released and adapt ICB plans accordingly: • New patient premium to encourage dentists to see individuals who've not seen a dentist for more than two years, effective from 1 March 2024 • UDA uplift to £28 minimum. This is superseded by the ICB's agreed plan to uplift to £30 minimum UDA rate from 1 April 2024 • Mobilisation of a mobile dental van to improve access and oral health prevention schemes. • Golden Hello to retain dentists working in NHS services for 3 years. This is addition to the ICB initiative. 14 dentists have benefited from the ICB's workforce schemes to date. An early review of the Urgent Treatment Services pilot is underway to see if any learning can be applied to improve services going forward. The total patient appointments offered since November 2023 is 5339, and only 8 Did Not Attend. The average number of appointments offered per month to date is 1779.	B	Complete
Apr 24	Actions to implement the Dental Recovery Plan, the UDA uplift and new patient premium, are complete. Discussions underway with NHS England region, Cambridgeshire & Peterborough and Suffolk & North- East Essex ICBs to mobilise a dental van across the 3 ICB areas.	B	Complete
May 24	Both the Long-Term Dental Plan and the Dental Workforce Plan approved by Committee 7 May 2024 to help improve resilience and stability of NHS dental services and improve access. Risk raised with Dental Services Delivery Group about the risks associated with managing secondary care dental services contracts and lack of resources to monitor and support. The risk has been escalated to Primary Care Commissioning Committee for review in June 2024. ICB Clinical Advisor recruitment underway to support ICB with clinical advice and to work with East of England Regional Chief Dental Officers, Managed Clinical Networks and Clinical Fellows. Review of the Urgent Treatment service pilot is still underway and will report back to Dental Services Delivery Group in July 2024. Feedback from patient survey, providers, UEC, NHS 111 and IC24 will all inform the evaluation. The review is receiving clinical input from the Managed Clinical Network Chairs (General Dental Practice/UEC) Level 2 endodontics and periodontics pilot in East of England ceased 31 March 2024 increasing possibility of secondary care referrals or lack of access to these services for patients. Options are being explored as an interim measure – development of plans is built into the Long Term Dental Plan for 2025/2026. Task and Finish Group to look at mobilising Child Focused Dental Practices established. Work has commenced on Year End reconciliation for 23/24.	B	30/06/2024 Complete

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Jul 24	Notice given by a dental practice to terminate their contract summer 2024 – to reinvest monies for access to NHS dental services in line with ICB priorities. Secondary Dental Care risk reviewed by Board and to be managed through Primary Care Commissioning Committee (DSDG). Task and Finish Group discussions underway to mobilise Child Focused Dental Practices framework based on toolkit and evidence from pilot autumn 2024 Pre-election Period has delayed rollout of some projects such as the Dental van project being led nationally and access investment plans. Application for Clinical Advisor role closes 3 July 2024	A	31/10/2024
Aug 24	ICB has been informed that an NHS dental provider is in administration in North Norfolk operating out of 2 sites providing both NHS and private dental care. Discussions are underway with the administrators to see if an alternative provider can secure patient care. ICB governance processes will need to be followed to award a new contract. There will be a debt owed to the ICB. UTS review paper to DSDG in August 2024 for consideration.	A	30/09/2024
Sep 24	Emergency contract agreed for 12 months, subject to all regulatory, CQC registration and quality controls being in place, to replace services offered by provider in administration. Two other providers have advised the ICB they intend to terminate their contracts March 2025 – primary care team is working with each provider to try and retain NHS services. Contract termination (highlighted above) effective end of August. Clinical Advisor – Dental appointed subject to recruitment checks. Year end process completed, clawback monies being recovered. Local providers invited to expand their capacity for new patients either through sessional payments or extension of UDA contract. Deadline for submissions is 30 August. Aim is to reduce health inequalities in line with Long Term Plan. All 23 Golden Hellos offered for 2024/2025 (national and local programmes)	A	30/9/2024

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

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BORR10 (Inphase ref 00000030)

Risk Title		Neuro-Developmental Service (NDS) Children and Young People (CYP)						
Risk Description		There is a risk that due to increasing requests for assessment, access to diagnostic pathways for NDS across Norfolk and Waveney is not timely or equitable with children and young people waiting up to seven years from receipt of request. If this happens there is the potential for long term health, education and care implications for CYP and their families due to lack of access to appropriate education, health, care and support. This may lead to worsening inequality and health outcomes, increased demand on other services, financial and reputational risk.						
Risk Owner		Responsible Committee			Operational Lead	Date Risk Identified	Target Delivery Date	
Tricia D’Orsi		Quality and Safety Committee			Rebecca Hulme	01/08/2018	30/09/24	
Risk Scores								
Unmitigated			Mitigated			Tolerated (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	5	20	4	5	20	3	4	12
Risk appetite					Risk tolerance			
Controls					Assurances on controls			
- Additional investment approved 2021. - Pre-diagnostic service commissioned to support families 2021/22. - Expressions of Interest for National Spending Review funding have been successful with the aim of easing demand and impact of long waits. - Non-recurrent £1m investment 2023/24 waiting list initiative. - Identified as priority workstream within Children and Young People’s System Collaborative - Choice Policy and guidance in place - NDD included as priority in Joint Forward plan for 2024/25 - Successful bid for funding of for Partnerships for Inclusion of Neurodiversity in Schools					Internal: Quality and Safety Committee, and progress reporting to Senior Management Team when required. ICB Performance Committee (from Jan24). External: Bi-monthly reports on waiting times to NAPB Diagnosis working group and Norfolk HOSC, CYP System Collaborative priority for 2024/25.			
Gaps in controls or assurances								
- Poor quality of data. - Lack of understanding of waiting list process. - Lack of universal support for neurodiverse families in the system leads to over-medicalisation. - Insufficiency within the education offer to accommodate the learning needs of neurodiverse CYP. - NDS does not sit within suite of pathways eligible for pathway recovery programmes which results in reduced system oversight and scrutiny. - Long term impact of COVID pandemic and cost of living issues suggests investment to address backlog will take longer to impact families. - Worsening mental health cannot be support by existing mental health services, families report difficulties accessing services whilst awaiting diagnosis - Increase in requests for assessment leading to waiting list growing								
Updates on actions and progress								
Date opened	Action / update						BRA G	Target completion
May 24	Provider framework is live on the procurement portal. Right to choose guidance and advice for those seeking private assessments has been updated. Suffolk HOSC briefing submitted.						B	Complete
June 24	Service review underway with request to providers for recovery plan						G	30/08/24
June 24	System Collaborative Neurodiversity Working Group established and case for change in development.						G	30/08/24

	Update 28.08.24 Draft case for change to be presented to Executive Steering Group 29.08.24.											
June 24	Executive membership of System Collaborative providing challenge, assurance and oversight to work programme.										G	30/08/24
June 24	Provider Framework procurement almost complete. Will provide some additional capacity for choice an any waiting list activity. Update 28.08.24 Provider framework procurement complete – provides opportunity to increase capacity – work underway to finalise contracts.										G	30/08/24
August 24	We continue to see an increase in enquiries from parent, carers and primary care regarding long waiting times and right to choose assessments. Work is underway to develop updated comms for the system to describe the various options available to families.										G	30/09/24
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	20	20	20	20	20							
Change	➔	➔	➔	➔	➔							

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BORR11 (Inphase ref 00000023)

Risk Title		The resilience of general practice								
Risk Description		- There is a risk to the resilience of general practice due to several factors including workforce pressures and increasing workload (including workload associated with secondary care interface issues). - There is also evidence of increasing poor behaviour from patients towards practice staff, leading to retention and recruitment issues. - There is an increasing risk of industrial action following the BMA referendum where the GP contract and associated uplift was rejected. - The national GP contract price uplift does not cover the required increase in meeting the minimum wage. - The LMC has written to practices to cease un-commissioned work associated with MGUS monitoring and Advice and Guidance. Further communications are likely. - Individual practices could see their ability to deliver care to patients impacted through lack of capacity and the infrastructure to provide safe and responsive services will be compromised. - This will have a wider impact as neighbouring practices and other health service partners take on additional workload which in turn affects their resilience. - This may lead to delays in accessing care, increased clinical harm because of delays in accessing services, failure to deliver the recovery of services adversely affected, and poor outcomes for patients due to pressured general practice services.								
		Risk Owner		Responsible Committee		Operational Lead	Date Risk Identified	Target Delivery Date		
		Mark Burgis		Primary Care		Sadie Parker	01/09/2020	31/03/2026		
		Risk Scores								
		Unmitigated			Mitigated			Tolerated (Target in 12 months)		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total		
5	4	20	4	4	16	3	4	12		
Risk appetite						Risk tolerance				
Controls					Assurances on controls					
- Locality teams and strategic primary care teams structured around supporting the resilience of general practice.—All practices have previously been supported to review business continuity plans. - PCN ARRS (additional roles reimbursement scheme) funding has provided additional capacity but has not grown in this contract year. - Primary care workforce and training team working closely with locality teams to ensure training available to support practices and PCNs in setting up and maintaining services. - System interface group with representation from primary, community and secondary care system partners established. - Standard contract requirements on interface – gap analysis and action plans, including monitoring being reviewed by contracts team. New national requirement for providers to self-assess using national toolkit 6-monthly - Commencement of LMC General Practice Alert System sitreps					Internal: Executive Management Team, workforce steering group, primary care strategic planning meetings, establishment of new general practice and community pharmacy delivery group, Primary Care Commissioning Committee, risk is on the Board Assurance Framework External: NHS England via delegation agreement and assurance framework, Health Education England, Norfolk and Waveney Local Medical Committee, Health Overview and Scrutiny Committee meetings					
Gaps in controls or assurances										
- Practice visit programme, CQC inspections focused on where there is a significant risk or concern. - Significant number of vacancies within primary care commissioning, workforce, quality, and locality teams impacts the level of support which can be provided to practices. Organisational change is impacting on										

support available due to vacancy controls.

- Continued reports of poor patient behaviour across practices, decrease in patient satisfaction with general practice through GP patient survey, consistent with national position.
- Progress on interface action planning process across Trusts impacted by ongoing pressures and national strike action.
- Reporting process for inappropriate transfers of workload from community and secondary care providers to general practice not fully utilised by practices, leading to under-reporting of issues. Alternative approaches being considered with the LMC.
- 50% overall response rate to LMC General Practice Alert System, meaning full picture is not available.
- Workforce and capacity shortages across community pharmacy and dental practices, and ongoing drug shortages, are having an impact on general practice and the rest of the system.
- Pressure on and unavailability of primary care budgets due to the ICB's financial position impacting on our ability to support resilience and transformation in general practice.
- Resilience policy in development, which will link into any bids for section 96 support.
- Five-year Primary Care Strategy has expired, new strategic framework in development.
- Primary care dashboard/ delivery report remains in development, leading to a lack of integrated performance oversight.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
May 24	• All provider trusts completed the new interface monitoring tool and this was submitted to NHS England. National data appears to be in line with our local reporting. • The new ICB interface manager role is currently being advertised internally. This role will provide additional capacity into the system to develop the work programme and coordinate work across the system. • The BMA is going out to ballot for industrial action with a closing date of 29 July. We are modelling the potential impact of this on the system. It is thought interface areas (nationally thought to make up 20% of practice workload) will form part of the action. • 8 vacancies in the primary care commissioning team are currently being internally advertised as part of the ICB's restructure process. This will bring in valuable additional capacity to the team. • The issue of private referrals to Trusts has now been agreed and the Trusts' joint access policy updated. Trusts are working through the implementation of this policy update, noting this has been raised as an issue by the LMC for some years, due to the associated workload for GPs in having to pass on the referrals. • ICE ordering of tests for non-medical staff has been implemented in QEH and has been agreed in principle in JPUH and NNUH, which are now working through an implementation plan. Funding the additional capacity required is a particular issue to work through. The LMC has provided significant support to the task and finish group in this area.	B	Complete
Jun 24	• The ICB has successfully recruited to the vacant interface manager role and some other vacancies within the team have also been filled. Unfortunately some roles will have to go to external advert, which will take time. • A draft MGUS specification has been shared with the LMC and comments received, with the proposal having to go through the ICB's new prioritisation and triple lock processes. There is no identified budget to fund the service if it is approved.	B	Complete

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	- Work to develop a vision and set of principles for our primary care strategic framework is progressing well, with wide engagement across primary care. - The BMA has published potential areas for industrial action – the GP practice survival toolkit detailing these can be see on their website - https://www.bma.org.uk/our-campaigns/gp-campaigns/contracts/gp-contract-202425-changes											
Jul 24	- All but 2 roles in the primary care team have been filled, the remaining two are being externally advertised. There is continued risk from the long-term absence of the head of strategic planning post, with some part time resource mitigation internally. - LMC has escalated concerns about mental health crisis support to the ICB and the Trust. - DDRB and any pay increase timetable currently unknown. - ICB has included potential for GP collective action in its system control response with weekly meetings commencing 23 July. National and regional assurance reporting framework expected imminently. Modelling of impact has been undertaken. Medical director has written to all Trust medical directors asking them to prepare.	A	30/09/24									
Aug 24	1 remaining vacancy out to external advert. Most roles will have commenced during September. There is continued risk from the long-term absence of the head of strategic planning post, with some part time resource internally until the end of September. An application is being made to extend this through the triple lock process. - NHSE has confirmed a further uplift to the global sum. While this is welcome it will not impact the ongoing collective action. - Internal EPRR structure in place around collective action. As yet no significant impact has been felt, but this is expected to grow as practices agree what action they will take heading into the autumn. - MGUS specification is in the final stages of discussion with the LMC, funding approval has been received through the triple lock process with governance now in progress. - Interface work programme and System Group Terms of Reference due to be reviewed in September and October. Trusts have been reminded of need to undertake further self-assessments in September and NHSE is expected to write to systems in early September.	A	30/11/24									
Visual Risk Score Tracker – 2024/25												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score	16	16	16	16	16	16						
Change	➔	➔	➔	➔	➔	➔						

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Agenda item: 14

Subject:	Governance Handbook - Proposed Changes
Presented by:	Karen Barker, Executive Director of Corporate Affairs and ICS Development
Prepared by:	Amanda Brown, Associate Director of Corporate Governance
Submitted to:	ICB Board
Date:	25 September 2024

Purpose of paper:

The ICB Board is being asked to approve amendments to the Governance Handbook's Scheme of Reservation and Delegation, committee's terms of reference and a new section 13 about the process for submitting questions to the Board.

Executive Summary:

Introduction

The Governance Handbook is designed to support and supplement the ICB Constitution. It sets out a framework which demonstrates the ICB's governance arrangements for exercising its duties and functions. In this respect, whilst it is not a legal requirement to have a Governance Handbook, it supports the ICB to build a consistent corporate approach and form part of the corporate memory.

The document library contains updated sections of the NHS Norfolk and Waveney Integrated Care Board (ICB) Governance Handbook in track for Board approval. Members of the public are able to access this upon request to the ICB.

Section 5 – Scheme of Reservation and Delegation (SoRD)

The 'Decisions and functions delegated by the board to ICB committees' section has been updated with proposed changes to Committees terms of reference where the changes concern the remit and/or responsibilities of the committee.

New Section 13

A new section 13 has been added which is a Protocol for members of the public when submitting questions to the ICB Board.

Committee Terms of Reference

The following committees are proposing changes to their terms of reference. The majority of changes are to clarify wording, correct typos or formatting etc. The changes are set out

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below and can be seen in the track changes documents which can be accessed via the document library.

- **Appendix D – Patients and Communities Committee**

A sentence has been added for clarity that if the Chair is unable to attend the meeting, then the deputy chair will chair the meeting or if unavailable the members will choose a Chair from amongst themselves.

Membership of the Committee has been clarified by setting out those that are members and those that are attendees.

Quoracy has been reduced to 5 members (from 8) and it currently provides that this needs to include at least the Chair or Deputy Chair and one ICB Executive.

- **Appendix E – Finance Committee**

The remit and responsibilities for the committee have been refreshed taking account of the list prepared by the Health Care Financial Management Association. The Finance Committee priorities these in light of the financial circumstances.

Amendments include confirming where progress reports and assurances will be received from and that the Committee will monitor double-lock and triple-lock.

- **Appendix G – Quality and Safety Committee**

The proposed wording under the Chair and Vice Chair section sets out chairing arrangements in the event that the Chair is unavailable. If neither the Chair or Deputy Chair is available to attend the meeting this would not meet the quorum requirements. Wording has been added that another Non-Executive will chair the meeting and depends on an additional NEM being available.

The requirement for a member from a local authority has been removed noting that there is provision for two local authority attendees to attend the meeting. It is suggested that this membership is reviewed in 6 months' time or as part of the next terms of reference refresh.

With respect to the second group of people, I have deleted the word 'members' as they are not included in the quoracy requirements but can still attend meetings, receive papers, and be able to contribute to discussions, but would not vote in the rare circumstances that one is required.

- **Appendix H – Commissioning & Performance Committee**

Terms of reference have been updated to note that if the Chair is unable to attend a meeting or has a conflict of interest then the members will agree among themselves who will Chair the meeting.

Role titles have been updated and the list of attendees has been expanded including adding representatives from NHS England. Oversight and assurance of the Joint Forward Plan and Clinical Strategy has been added as a responsibility of the Committee.

- **Appendix I – Conflicts of Interest Sub-Committee**

Amendments to this Committee's terms of reference included correcting job titles and general tidy up. In addition, section 6 was amended so that the committee would meet at least twice a year.

For information, Membership of Committees by Board members is set out below:

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Committee	Board Member
Integrated Care Partnership	Rt Hon Patricia Hewitt Tracey Bleakley
Audit and Risk Committee	David Holt (Chair) Cathy Armor Emma Ratzer
Finance Committee	Hein van den Wildenberg (Chair) Cathy Armor Steven Course
Remuneration, People and Culture Committee	Cathy Armor (Chair) Hein van den Wildenberg Aliona Derrett Patricia D'Orsi
Quality and Safety Committee	Aliona Derrett (Chair) Cathy Armor Patricia D'Orsi Dr Frankie Swords Dr Hilary Byrne
Primary Care Commissioning Committee	Debbie Bartlett (Chair) Hein van den Wildenberg Steven Course Patricia D'Orsi
Patients and Communities Committee	Aliona Derrett (Chair) Cathy Armor Emma Ratzer Dr Frankie Swords
Commissioning and Performance Committee	Dr Hilary Byrne Hein van den Wildenberg Dr Frankie Swords Patricia D'Orsi Steven Course
Conflicts of Interest Sub Committee	David Holt (Chair) Hein van den Wildenberg Dr Frankie Swords Steven Course

The Board approved version of this document will become version 8 of the Governance Handbook.

Recommendation to the Board:

The Board is asked to approve the amendments to the ICB Governance Handbook as detailed in this paper.

Key Risks	
Clinical and Quality:	
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	Ensuring that the ICB has appropriate governance processes in place is a key part of maintaining it's reputation.
Legal:	Ensuring that the ICB is compliant with statutory requirements.
Information Governance:	N/A
Resource Required:	
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	

Governance

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

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Norfolk and Waveney
Integrated Care Board

**NHS NORFOLK & WAVENEY
INTEGRATED CARE BOARD
GOVERNANCE HANDBOOK**

Version 7

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Revision History

Document Control Sheet

Revision Date	Summary of changes	Author(s)	Version Number
December 2022 to March 2023	Amendments made to committee terms of reference: Integrated Care Partnership, Performance Committee, Audit and Risk Committee, Quality and Safety Committee, Remuneration, People and Culture Committee, Finance Committee, Conflicts of Interest Committee—additional attendees included: Finance Committee, clarification of Part 1 attendees roles. Updates to Conflicts of Interest Policy, Standards of Business Conduct Policy.	Corporate Affairs	1.2
February 2023	Amendments made to PCCC Terms of Reference and ICB SoRD to reflect delegation of POD which were approved at February 2023 Board		1.3
March 2023	Included v10 of People Approach		2
May 2023	Revised terms of reference: Patient and Communities Committee and Performance Committee		3
July 2023	Updated the SoRD re 'decisions and functions delegated by the board to individual board members' by including 'Downs syndrome Board lead' and Learning Disability and Autism Board lead' to the Director of Nursing's responsibilities		4
November 2023	Updated Appendix A, Integrated Care Partnership ToR and updated Audit and Risk Committee ToR with respect to membership		5
January 2024	Revised Performance Committee ToR and established Commissioning and Performance Committee ToR		6
March 2024	Updates to SoRD to reflect delegation of 59 services of Specialised Commissioning from NHSE to the ICB and amendments to the PCCC Terms of Reference		7

Approvals

This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	NHS England	Corporate Affairs	1
28 March 2023	ICB Board	Corporate Affairs	2
30 May 2023	ICB Board	Corporate Affairs	3
18 July 2023	ICB Board	Corporate Affairs	4
28 Nov 2023	ICB Board	Corporate Affairs	5
23 Jan 2024	ICB Board	Corporate Affairs	6
26 March 2024	ICB Board	Corporate Affairs	7

Document Control Sheet

Policy title	Governance Handbook
Policy area	This Policy has been prepared and reviewed by the Corporate Affairs team.
Who is it aimed at and which settings?	All staff whether temporary, fixed term, or under consultancy, contract for services or agency arrangements, Governing Body and Committee members, ICB clinical advisors and anyone else undertaking work for the ICB.
Approved by	ICB Board
Effective date	1 July 2022
Review date	Annually

Contents

~~Section 1 — Introduction~~
~~Section 2 — Governance Structure~~
~~Section 3 — Functions and Decisions Map~~
~~Section 4 — Delegation Arrangements~~
~~Section 5 — Scheme of Reservation and Delegation~~
~~Section 6 — Standing Financial Instructions~~
~~Section 7 — People and Communities Approach~~
~~Section 8 — Conflicts of Interest Policy~~
~~Section 9 — Standards of Business Conduct Policy~~
~~Section 10 — Petitions Policy~~
~~Section 11 — Eligible nominating PMS (GMS/APMS) Providers~~
~~Section 12 — Working with Voluntary, Community and Social Enterprise~~

Appendices

~~Terms of Reference:~~

- ~~A. Integrated Care Partnership — statutory committee of both the ICB and Norfolk County Council and Suffolk County Council~~
- ~~B. Audit and Risk Committee~~
- ~~C. Remuneration, People and Culture Committee~~
- ~~D. Patients, and Communities Committee~~
- ~~E. Finance Committee~~
- ~~F. Primary Care Commissioning Committee~~
- ~~G. Quality and Safety Committee~~
- ~~H. Commissioning and Performance Committee~~
- ~~I. Conflicts of Interest Sub-Committee of the Audit and Risk Committee~~

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SECTION 1

Introduction

Introduction to the Governance Handbook

The purpose of this document is to bring together a range of corporate statutory documents into one place and is described as the NHS Norfolk and Waveney Integrated Care Board Governance Handbook (the "Governance Handbook").

The Governance Handbook is designed to support and supplement the ICB's Constitution. It sets out a framework which demonstrates the ICB's governance arrangements for exercising its duties and functions. In this respect, whilst it is not a legal requirement to have a Governance Handbook, it supports the ICB to build a consistent corporate approach and form part of the corporate memory.

The Governance Handbook sets out how the general public can inform decision making (see in particular section 7 on people and communities approach) and who makes decisions (see the ICB's functions and decision map at section 3.) The general public can always find out what is happening at the ICB via our website at www.improvinglivesnw.org.uk or by attending one of our meetings held in public.

Accordingly, the Governance Handbook will be published on the ICB website for transparency and ease of access and will be updated regularly as a matter of routine.

The Governance Handbook includes:

- Introduction
- Governance Structure
- Functions and Decisions Map
- Scheme of Reservation and Delegation (including delegation arrangements)
- Standing Financial Instructions
- People and Communities Approach
- Conflicts of Interest Policy
- Standards of Business Conduct Policy
- Petitions Policy
- Eligible nominating PMS (GMS/APMS) Providers
- Working with Voluntary, Community and Social Enterprise

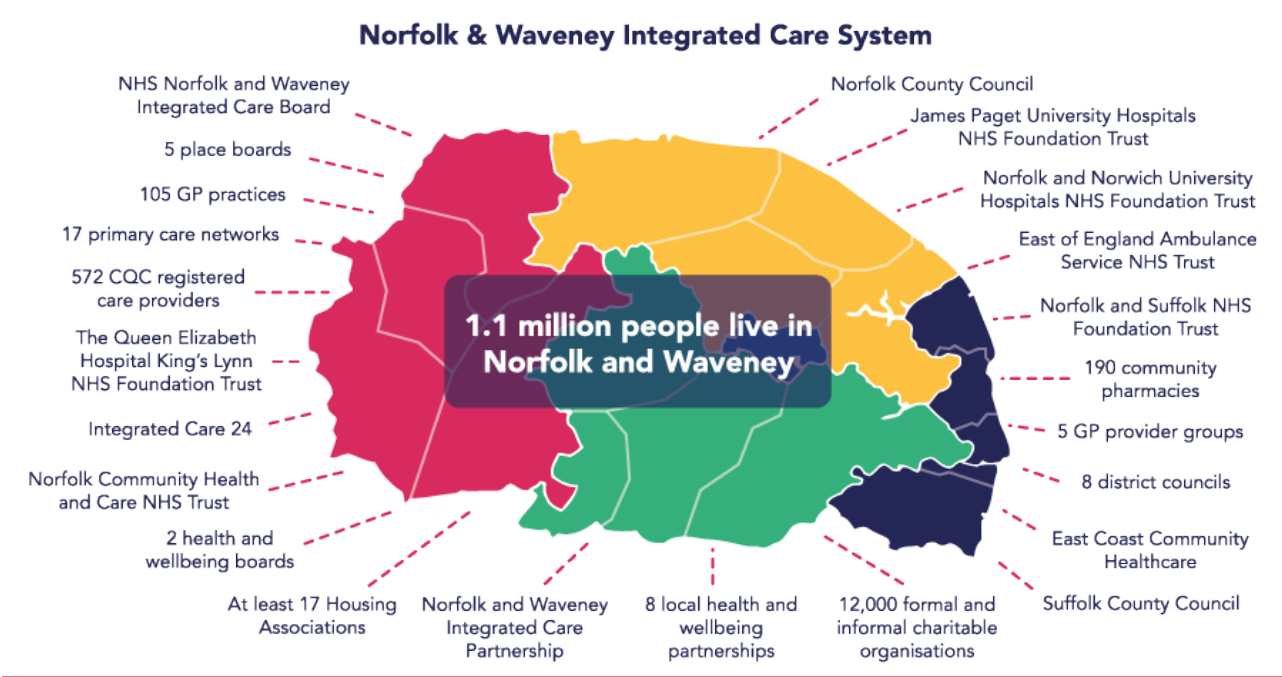
The Terms of Reference for the ICB's Committees and also the statutory committee of the Integrated Care Partnership are contained in the appendices

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SECTION 2

Governance Structure

Integrated Care Systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. This diagram shows the wide range of organisations that form the Norfolk and Waveney Integrated Care System:



The mission of our ICS is: To help the people of Norfolk and Waveney to live longer, healthier and happier lives.

Like all Integrated Care Systems in England, we will work to:

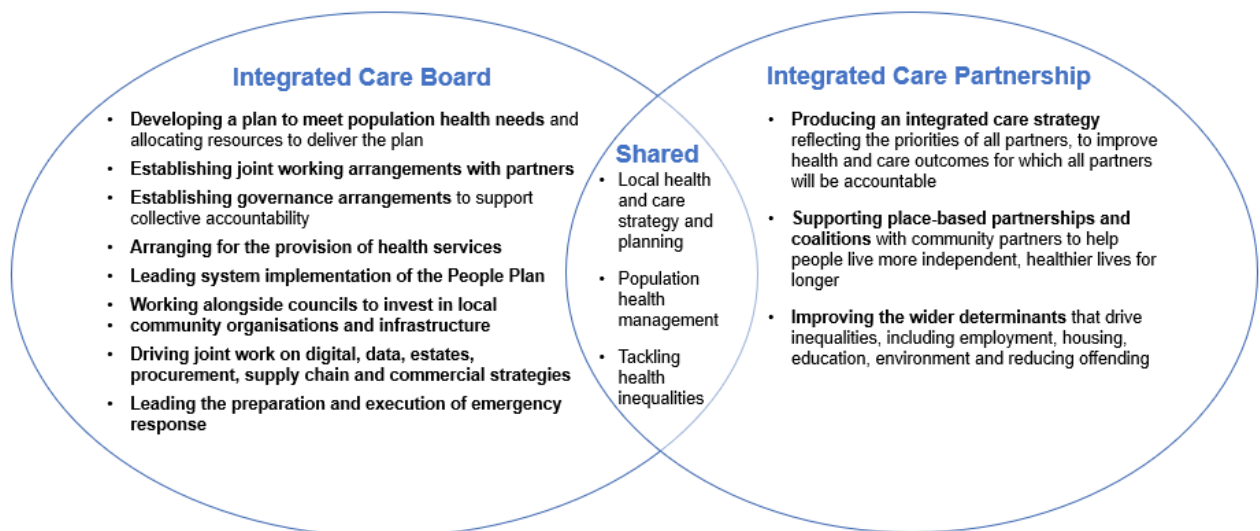


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Each ICS must include an Integrated Care Board and an Integrated Care Partnership:

- **NHS Norfolk and Waveney Integrated Care Board (ICB)** is accountable for the overall performance and finances of the NHS in Norfolk and Waveney. The ICB was established on 1 July 2022, following the dissolution of NHS Norfolk and Waveney Clinical Commissioning Group on 30 June 2022. However the ICB has a very different role to the CCG—helping to bring organisations together, working collaboratively, removing traditional barriers and more.
- **Norfolk and Waveney Integrated Care Partnership (ICP)** is responsible for agreeing an integrated care strategy for improving the health care, social care and public health across the whole population. It works to address the wider determinants of health, such as employment and housing. The partnership is established locally and jointly by the Suffolk and Norfolk county councils and the ICB.

The ICP and ICB are of equal importance. Unlike the ICB, the ICP is a statutory committee of the ICS, not a statutory body, and as such its members can come together to take decisions on an integrated care strategy, but it does not take on functions from other parts of the system. The diagram below shows the different roles of the ICB and the ICP:



ICB Constitution

The ICB Constitution is based on the model constitution produced by NHS England (NHSE). The ICB model constitution is based on the Health and Care Act and NHSE policy as well as legal requirements that must be included in the Constitution. The ICB Constitution has been approved by NHSE and by the ICB Board. Applications for changes to the Constitution are made to NHSE following approval by the Board. The ICB Constitution is published on the ICB website www.improvinglivesnw.org.uk.

The Board of the ICB

The Board of the ICB is a unitary Board that meets in public every other month. Details of meeting dates and times as well as papers can be found on the ICB website. The purpose of the Board is to govern effectively and in doing so, build patient, public and stakeholder confidence that their healthcare is in safe hands. The Board is responsible for:

- Formulating strategy for the organisation (taking into account the ICP's Integrated Care Strategy)
- Holding the organisation to account for delivery of the strategy

- Being accountable for ensuring the organisation operates effectively and with openness, transparency and candour and by seeking assurance that systems of control are robust and reliable
- Shaping a healthy culture for the organisation and the wider ICS partnership.

The Board remains accountable for all the ICB's functions, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation.

The members of the Board of the ICB Board can be viewed on the website www.improvinglivesnw.org.uk.

ICB Committees

The following committees support the work of the Board:

Name of Committee	Remit	Chair
Audit and Risk Committee	The Audit and Risk Committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.	Non-Executive Member for Audit and Risk
Remuneration, People and Culture Committee	This Committee's statutory purpose is to confirm the ICB Pay Policy, but the committee will also have a remit with regard to organisational development and ensuring work is developed on culture and for our staff.	Non-Executive Member for Remuneration, People and Culture
Patients, and Communities Committee	The purpose of this committee is to ensure that there is rigour and challenge with regard to the ICB's ambitious transformation objectives.	Non-Executive Member
Finance Committee	This Committee provides oversight of financial matters bringing external and impartial rigour and challenge to the management of the ICB's finances.	Non-Executive Member for Finance
Primary Care Commissioning Committee	The Committee enables collective decisions on the review, planning and procurement of primary care services in Norfolk & Waveney.	Local Authority Partner Member from ICB Board
Quality and Safety Committee	The Committee is responsible for the oversight and development of the ICB's Quality Strategy, which sets out its plan for quality and safety improvement.	Non-Executive Member
Commissioning and Performance Committee	The committee will ensure oversight of the delivery of key performance standards by commissioned providers, performance of the system against the NHS Outcomes Framework and progress with improving wider outcome measures of population health.	ICB Board Partner Member, Primary Medical Services
Conflicts of Interest Committee (sub-committee)	The sub-Committee is authorised to make decisions on behalf of the ICB with regard to issues which cannot be decided by the Board due to the Board not being quorate as a result of conflicts of interest.	Non-Executive Member for Audit and Risk

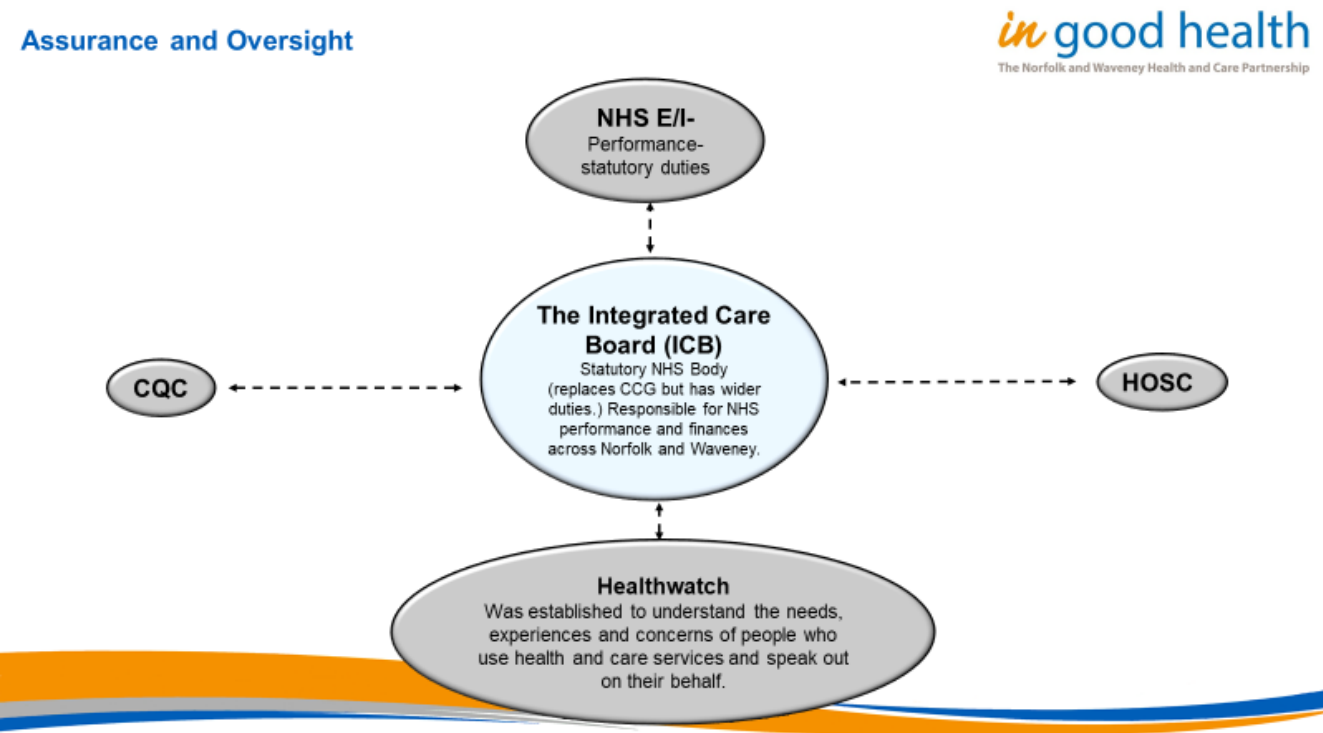
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In addition, the Norfolk and Waveney Integrated Care Partnership, as a statutory committee jointly formed between the Norfolk and Waveney Integrated Care Board and Norfolk County Council and Suffolk County Council.

Name of Statutory Committee	Remit	Chair
Integrated Care Partnership	The Integrated Care Partnership brings 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.	Cabinet member for Adult Social Care, Public Health and Prevention, Norfolk County Council

Assurance and Oversight

The diagram below sets out the system for assurance and oversight of the ICB.



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SECTION 3

Functions and Decision Map

As prescribed by the ICB’s Constitution and legislative requirements, the ICB must publish within its Governance Handbook a Functions and Decision Map.

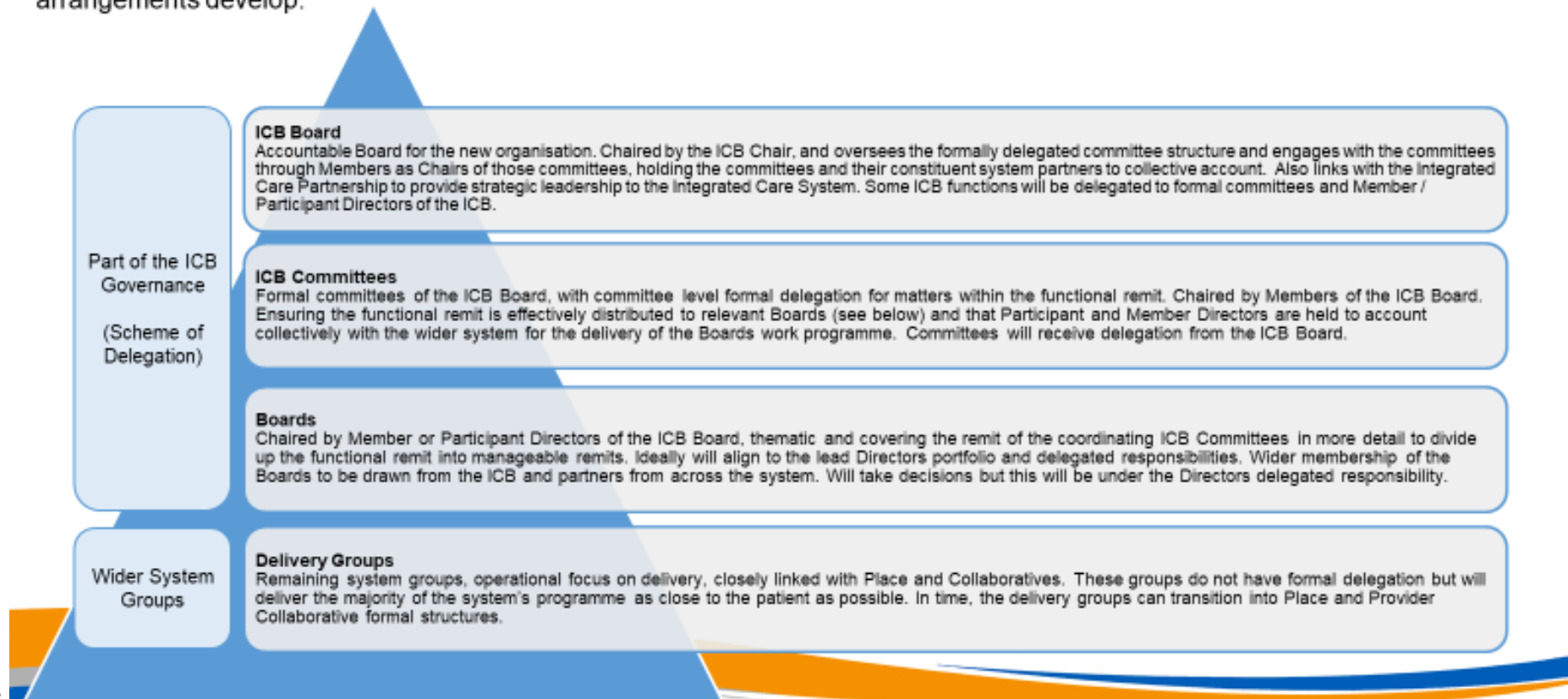
The purpose of a Functions and Decision Map is to provide a high-level structural chart that sets out which decisions are delegated and taken by which parts of the system.

Our Functions and Decisions Map is based on a framework made up of tiered model which allows delegation to different levels. The tiered delegated model can be seen below.

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A tiered delegated model

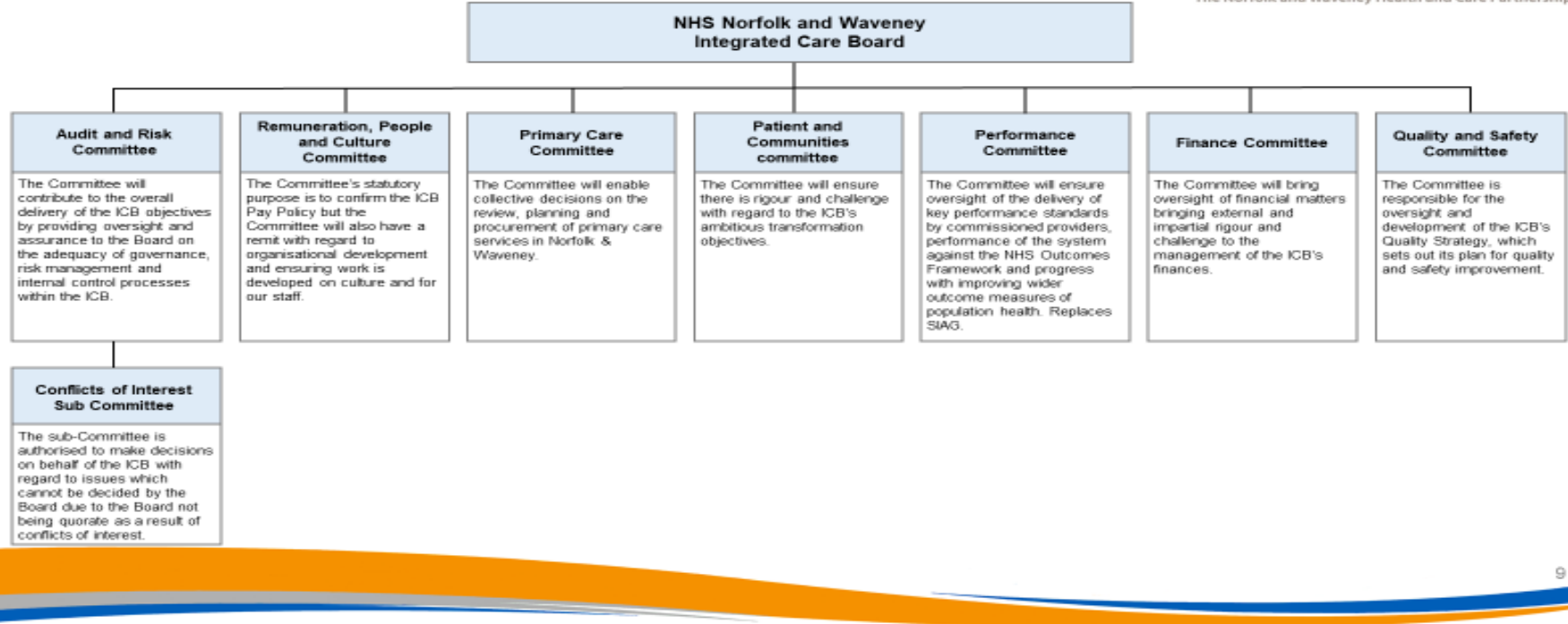
A tiered delegation model is proposed, that will receive c200 functions from the CCG but will preserve the partnership approach to delivery and improvement and form the basis of a model that can more easily evolve as Place and Provider Collaborative arrangements develop.



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Committee structure

ICB Board and Committee Structure
(formal delegation)



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SECTION 4

Delegation Agreements

This section sets out the Delegation arrangements for all instances where ICB functions are delegated in accordance with section 65Z5 of the 2006 Act to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.

Delegations under this section are set out in the ICB's Scheme of Reservation and Delegation that can be found in section 5 of this document.

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SECTION 5

NHS Norfolk and Waveney Integrated Care Board Scheme of Reservation and Delegation (SoRD)

Decisions and functions delegated by the board to ICB committees

Committee	Decisions and functions delegated to the committee	Reference
Audit and Risk Committee	Standing Orders: Reporting of non-compliance with the standing Orders of the ICB	Section 3.6 Standing Orders, Constitution
Audit and Risk Committee	Standing Orders: Reporting of urgent decisions taken by the Board for review	Section 4.9.6 of the Standing orders, Constitution
Audit and Risk Committee	Annual report and Accounts: To ensure that financial systems and governance are established which facilitate compliance with DHSC's Group Accounting Manual.	ToR
Audit and Risk Committee	Annual report and Accounts: To review the annual report and financial statements (including accounting policies) before submission to the Board	ToR
Audit and Risk Committee	Risk and Internal Control: To review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of the ICB's objectives, the effectiveness of the management of principal risks.	ToR

Audit and Risk Committee	Risk and Internal Control: To have oversight of system risks where they relate to the achievement of the ICB's objectives.	ToR
Audit and Risk Committee	Risk and Internal Control: To seek reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.	ToR
Audit and Risk Committee	Risk and Internal Control: To identify opportunities to improve governance, risk management and internal control processes across the ICB.	ToR
Audit and Risk Committee	Internal Audit: Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework. Considering the major findings of internal audit work, including the Head of Internal Audit Opinion, (and management's response), and ensure coordination between the internal and external auditors to optimise the use of audit resources. Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation; and Monitoring the effectiveness of internal audit and carrying out an annual review. Recommend appointment of internal auditors.	ToR
Audit and Risk Committee	External Audit: Reviewing all external audit reports, including to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses. The Audit panel will be formed to recommend the appointment of External Auditors.	ToR
Audit and Risk Committee	Counter Fraud: Approve the ICB's Counter Fraud arrangements.	ToR
Audit and Risk Committee	Counter Fraud: To ensure that the counter fraud service provides appropriate progress reports and that these are scrutinised and challenged where appropriate.	ToR

Audit and Risk Committee	Freedom to Speak Up: To review the adequacy and security of the ICB's arrangements for its employees, contractors, and external parties to raise concerns, in confidence, in relation to financial, clinical management, or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.	ToR
Audit and Risk Committee	Conflicts of Interest: The Committee shall satisfy itself that the ICB's policy, systems, and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.	ToR
Audit and Risk Committee	Finance: To monitor the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance.	ToR
Audit and Risk Committee	Finance: To ensure consistency that the ICB acts consistently with the principles and guidance established in HMT's Managing Public Money.	ToR
Audit and Risk Committee	Finance: Review of ICB risk sharing or risk pooling arrangements	ToR
Audit and Risk Committee	Finance: Approval the ICB's banking arrangements	ToR
Audit and Risk Committee	IG: To provide assurance to the Board that there is an effective framework in place for the management of risks associated with information governance.	ToR
Audit and Risk Committee	IG: Approval of the arrangements for ensuring the appropriate safekeeping and confidentiality of records and for the storage management and transfer of information and data	ToR

Remuneration, people and culture committee	For the Chief Executive, Members of the Board and other Very Senior Managers- Determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, pensions and cars.	s. 8.1.6 of the Constitution
Remuneration, people and culture committee	For the Chief Executive, Members of the Board and other Very Senior Managers - Determine arrangements for termination of employment and other contractual terms and non-contractual terms.	s. 8.1.6 of the Constitution
Remuneration, people and culture committee	Approval of the nominations and appointments process for Board members.	ToR
Remuneration, people and culture committee	Oversight of executive board member performance	ToR
Remuneration, people and culture committee	For all ICB staff -Determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change) including staff on very senior managers grade, including all board members, excluding the Chair and Non-Executive Members.	s. 8.1.6 of the Constitution ToR
Remuneration, people and culture committee	For all ICB Staff- Oversee contractual arrangements.	s. 8.1.6 of the Constitution
Remuneration, people and culture committee	For all ICB Staff -Determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.	s. 8.1.6 of the Constitution
Remuneration, people and culture committee	For Speciality Advisors- Determine ICB pay policy and oversee contractual arrangements.	s. 8.1.6 of the Constitution
Remuneration, people and culture committee	Oversee the development of an ICB culture and Organisational Development plan, taking into account national People and OD frameworks, and recognising the changing needs of our people to ensure the ICB is best place to work	ToR

Remuneration, people and culture committee	Assurance as to succession planning for the Board.	ToR
Remuneration, people and culture committee	Assurance in relation to ICB statutory duties relating to people such as compliance with employment legislation including such as Fit and proper person regulation (FPPR).	ToR
Remuneration, people and culture committee	Approve human resources policies for employees and for other persons working on behalf of the ICB.	ToR
Remuneration, people and culture committee	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to promote education and training for persons who are employed or are considering becoming employed in an activity which is connected with the health service.	ToR
Finance committee	To set the strategic financial framework of the ICB and ICS and monitor performance against it.	Terms of Reference
Finance committee	To develop the system financial information systems and processes to be used to make recommendations to the Board on financial planning in line with the strategy and national guidance	Terms of Reference
Finance committee	To work with ICS partners to identify and allocate resources where appropriate to address financial performance, quality and safety related issues that may arise and to ensure Value for Money in that resource allocation	Terms of Reference
Finance committee	To work with ICS partners to consider major investment/disinvestment business cases for material service change or efficiency schemes (smaller of 3% of organisational	Terms of Reference

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	~~annual expenditure and £5m with a de-minimis level of £1m) and to agree a process for sign-off where system funding is required~~ <u>to receive progress reports and assurance from the Strategic Capital and Estates Board, and its work with ICS partners to consider major investment/disinvestment business cases for material service change or efficiency schemes.</u>	
Finance committee	To articulate the financial position and financial impacts (both short and long-term) to support decision-making	Terms of Reference
Finance committee	To develop a medium- and long-term financial plan, consistent with strategic and operational plans	Terms of Reference
<u>Finance committee</u>	<u>To monitor the impact of the so-called double-lock and triple-lock, as appropriate, on the finance management in the system</u>	<u>Terms of Reference</u>
Finance committee	To oversee the management of the system financial target and the ICB's own financial targets	Terms of Reference
Finance committee	To monitor and report to the board overall financial performance against national and local metrics, highlighting areas of concern	Terms of Reference
Finance committee	To monitor and report to the board key service performance which should be taken into account in assessing the financial position	Terms of Reference
Finance committee	To develop the system estates strategy and plan to ensure it properly balances clinical, strategic and affordability drivers (if not covered by separate strategic estates forum)	Terms of Reference
Finance committee	To monitor the system capital programme against the capital envelope and take action to ensure that it is appropriately and completely used	Terms of Reference
Finance committee	To gain assurance that the estates, digital and clinical strategic plans are built into system financial plans and strategy to ensure effective oversight of future prioritisation and capital funding bids	Terms of Reference

Conflicts of Interest Committee	Where decisions are required to be made on behalf of the ICB but cannot ~~due~~ be decided by the Board ~~due~~ s to the Board not being quorate as a result of conflicts of interest decisions are to be taken by the conflicts of interest committee. The Sub Committee has authority to act in accordance with the ICB's Constitution, Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation and its terms of reference.	Terms of Reference
Conflicts of Interest Committee	Responsibility for overseeing the ICB's policies and procedures with regard to conflicts of interest	Terms of Reference
Patients and Communities Committee	Approve the ICB's arrangements for handling complaints.	Terms of Reference
Patients and Communities Committee	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to have regard to the need to reduce inequalities and use population health management approaches to help achieve this.	Terms of Reference
Patients and Communities Committee	Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to promote the involvement of patients, their carers and representatives in decisions about their healthcare.	Terms of Reference
Patients and Communities Committee	Review and approve arrangements as to the delegations to place boards or place Directors.	Terms of Reference
Quality and Safety Committee	Be assured that there are robust processes in place for the effective management of quality • Scrutinise structures in place to support quality planning, control and improvement, to be assured that the structures operate effectively, and timely action is taken to address areas of concern • Agree and put forward the key quality priorities that are included within the ICB strategy/ annual plan, including priorities to address variation/ inequalities in care	Terms of Reference

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	Oversee and monitor delivery of the ICB key statutory requirements <u>for quality and safety</u>	
Quality and Safety Committee	Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner	Terms of Reference
Quality and Safety Committee	Approve arrangements including supporting policies to minimise clinical risk maximise patient safety and to secure continuous improvement in quality and patient outcomes	Terms of Reference
Quality and Safety Committee	Approval of the arrangements for discharging the CCG's statutory duty associated with its commissioning functions to act with a view to securing continuous improvements to the quality of services.	Terms of Reference
Quality and Safety Committee	- Oversee and scrutinise the ICB's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSE and other regulatory bodies / external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained - Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the ICB that these are disseminated and implemented across all sites - Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes - Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place - Receive assurance that the ICB identifies lessons learned from all relevant sources, including, incidents, never events, complaints and claims and ensures that learning is disseminated and embedded - Receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and PFD report)	Terms of Reference

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	• To be assured that people drawing on services are systematically and effectively involved as equal partners in quality activities • Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children • Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control • Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people drawing on services • Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety. • Receive assurance that the ICB has effective and transparent mechanisms in place to monitor the quality of Children, Maternity and Neonatal care. • Have oversight of and approve the Terms of Reference and work programmes for the groups reporting into the Quality and Safety Committee (e.g., System Quality Group, <u>ICB Infection Prevention and Control and Antimicrobial Stewardship Partnership and ICS Learning from Deaths Forum, Safeguarding Boards / Hubs etc.</u>).	
Commissioning and Performance Committee	<u>Strategic Commissioning</u> <u>The Committee will be the formal point of engagement for the ICB with the East of England Specialised Services Joint Commissioning Committee or equivalent committee and will oversee the ICB's relationship with the regional specialised services commissioning team and will consider specialised services matters on behalf of the ICB.</u> <u>Performance</u> The Committee shall conduct and lead oversight of both NHS system and commissioned provider performance, including evaluation of health services, provider resilience and failure and performance review and management.	

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	• Hold the system to account and provide challenge to the system where this is required to address opportunities to improve performance and outcomes. • Determine where a peer review or 'deep dive' approach is required to support improvement in the system; overseeing the subsequent review and ensuring the learning is implemented. • Direct improvement resources when required in the system, including defining the parameters of any new improvement plans, peer review of existing plans where expected outcomes are not delivered and coordinating with regulators where formal improvement or intervention support is required. • Approve the KPIs and outcome metrics for use across the system and negotiate any metrics or improvement trajectories with NHSE where relevant to NOF segmentation or the Recovery Support Programme (RSP), as may be required from time to time. • Take into account the duty of the ICB to harness innovation, best practice and the use of evidence and evaluation in commissioning decisions, to ensure this is consistently adopted across the system. • Agree and coordinate any support and intervention carried out by NHSE, other than in exceptional circumstances. Procurement The Committee shall approve the application of the Provider Selection Regime process for the procurement of any business cases that it approves under its delegation as set out above.	
Primary Care Commissioning Committee	NHS England has delegated to the ICB authority to exercise the primary care commissioning and dental functions in accordance with section 13Z of the NHS Act and as set out in Schedule 2 of the Delegation Agreement as follows: Schedule 2A: Primary medical services • decisions in relation to the commissioning and management of Primary Medical Services;	Terms of Reference

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Davey, Heidi 19/09/2024 14:02:47	• planning Primary Medical Services in the Area, including carrying out needs assessments; • undertaking reviews of Primary Medical Services in respect of the Area; • management of the Delegated Funds in the Area; • co-ordinating a common approach to the commissioning and delivery of Primary Medical Services with other health and social care bodies in respect of the Area where appropriate; and • such other ancillary activities that are necessary in order to exercise the Delegated Functions. Schedule 2B: Primary dental services and prescribed dental services • decisions in relation to the commissioning and management of Primary Dental, Services; for clarity this includes primary care, community care/special care dental services and secondary care dental services; • planning Primary Dental Services in the Area, including carrying out needs assessments; • undertaking reviews of Primary Dental Services in the Area; • management of the Delegated Funds in the Area; • co-ordinating a common approach to the commissioning and delivery of Primary Dental Services with other health and social care bodies in respect of the Area where appropriate; and • such other ancillary activities that are necessary in order to exercise the Delegated Functions. Schedule 2C: Primary ophthalmic services Ophthalmic services are hosted by Hertfordshire and West Essex Integrated Care Board (H&WE ICB) on behalf of the ICB. In accordance with the Memorandum of Understanding with HWE ICB and other ICBs in the East of England region H&WE ICB will report general optometry services matters to the Committee including information to support decision making as and when matters arise. The ICB remains responsible and accountable for the provision of this service.	

	• decisions in relation to the management of Primary Ophthalmic Services; • undertaking reviews of Primary Ophthalmic Services in the Area; • management of the Delegated Funds in the Area; • co-ordinating a common approach to the commissioning of Primary Ophthalmic Services with other commissioners in the Area where appropriate; and • such other ancillary activities that are necessary in order to exercise the Delegated Functions.	

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	Schedule 2D: Pharmaceutical services and local pharmaceutical services Pharmaceutical services are hosted by HWE ICB on behalf of the ICB. NHS England has established mandated local committees to be known as Pharmaceutical Services Regulations Committees (PSRC). The PSRC is an ICB committee with representatives from all East of England ICBs attending. NHS England has delegated decision making to each PSRC in relation to matters under the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 as amended. H&WE ICB will coordinate and host the PSRC to agreed Terms of Reference as set out in the NHS England Pharmacy Manual (https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-manual/). In accordance with the Memorandum of Understanding with HWE ICB and other ICBs in the East of England region H&WE ICB will provide quarterly reports to the Committee on decisions made at the PSRC. Applications and Notifications will be made by H&WE ICB on behalf of the ICB to the PSRC for determination. The ICB remains responsible and accountable for the provision of this service. To support the delivery of these functions the PCCC has established a Primary Medical Services Delivery Group and a Dental Services Delivery Group. The Primary Care Commissioning Committee Scheme of Delegation (attached at Section 4a) sets out where decisions are made.	
Integrated Partnership Committee (ICP) statutory joint committee of ICB and Norfolk and	Production and approval of an integrated care strategy for Norfolk and Waveney	Statutory

Suffolk County Councils		

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SECTION 13

Protocol for submitting questions to the ICB Board

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

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

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

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

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

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

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

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

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

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APPENDIX D

Norfolk and Waveney Integrated Care Board Patients and Communities Committee Terms of Reference

Revision History

Revision Date	Summary of changes	Author(s)	Version Number
10 March 2023	Tweaks to the Terms of Reference following the meeting held on 23 January 2023	Paul Hemingway	1.1
13 April 2023	Tweaks to the Terms of Reference following the meeting held on 27 March 2023	Paul Hemingway	1.2
28 April 2023	Update to membership	Mark Burgis	1.3
10 May 2023	Changes made to quoracy	Mark Burgis	1.4
16 May 2023	Update to membership	Mark Burgis	1.5
19 July 2024	Tweaks to Terms of Reference following a committee development session	Mark Burgis	1.6

Approvals

This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	ICB Board		1
30 May 2023	ICB Board		2

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1. CONSTITUTION

The Patients and Communities Committee (“the Committee”) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a committee of the Board and its members are bound by the Standing Orders and other policies of the ICB.

2. PURPOSE OF THE COMMITTEE

The Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that meets the needs of patients and communities, that is based on engagement and feedback from local people and groups, and that takes account of and reduces the health inequalities experienced by individuals and communities.

The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care.

The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

3. DELEGATED AUTHORITY

The Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

The Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

4. MEMBERSHIP AND ATTENDANCE

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than four members of the Committee, including one who is a Non-Executive Member of the Board (from the ICB). Other attendees of the Committee need not be members of the Board, but they may be.

When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Conflicts of Interest

The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

Chair and Deputy chair

If a Chair has a conflict of interest then the ~~Deputy~~ Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

In the event that the Chair is unable to attend a meeting, then the deputy Chair will chair the meeting or if unavailable the members will choose a Chair from amongst themselves.

Members

The Members attending Part 1 and Part 2 meetings of the Committee are as follows:

- Non-Executive Member of the ICB Board (Chair)
- Non- Executive Member of the ICB Board (Deputy Chair)
- VCSE Board Member on the ICB Board
- Executive Director Patients and Communities, NHS Norfolk and Waveney ICB or nominated deputy
- Executive Medical Director, Norfolk and Waveney ICB or nominated deputy
- Executive Nursing Director, Norfolk and Waveney ICB or nominated deputy
- The following are invited to attend meetings of the Committee:
 - A representative from Commissioning (ICB/NCC)
 - A primary care representative
 - Senior Public Health Officer Norfolk County Council
 - A representative from the Place Boards
 - A representative from the Health and Wellbeing Partnerships
 - A representative from Healthwatch Norfolk
 - A representative from Healthwatch Suffolk
 - Lived Experience Representatives
 - Health Inequalities advisor

5. MEETING QUORACY AND DECISIONS

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The Committee shall meet at least on a bi-monthly basis. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

Quoracy

The quorum for the meeting will be a minimum of eight five members including at least ~~one the~~ Chair or Deputy Chair, and one ICB Executive Director ~~and at least six additional committee members~~.

Where members are unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate on their behalf. For the avoidance of doubt the deputy will be counted as part of the quorum.

If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. If an urgent decision is required, the process set out below may be followed.

Decision making and voting

Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee or their nominated deputy may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

Urgent decisions

In the event that an urgent decision is required, if it is not possible for the Committee to meet virtually an urgent decision may be exercised by the Committee Chair and relevant lead director subject to every effort having been made to consult with as many members as possible in the given circumstances (minimum one other member).

The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification and noted in the minutes.

6. RESPONSIBILITIES OF THE COMMITTEE

The Committee will hold a Part 1 meeting to cover system-wide issues and a Part 2 meeting to consider issues internal to the ICB or that are of a nature where it is not appropriate to discuss in a public forum e.g. sensitive patient specific detail, or contractual issues.

The responsibilities of the Committee will be authorised by the ICB Board. It is expected that the Committee will:

Complaints

- Approve the ICB's arrangements for handling complaints
- Receive regular reports about complaints received by the ICB and performance against the organisation's Complaints Policy.
- Oversee the sharing of lessons learnt from complaints received by the ICB across the organisation and the Integrated Care System.
- Provide assurance to the ICB Board regarding the organisation's performance against its Complaints Policy and processes.

Listening to, engaging and working with people and communities

- Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to promote the involvement of patients, their carers and representatives in decisions about their healthcare.
- Approve annual changes to the Norfolk and Waveney People and Communities Approach that sets out how the ICB and wider ICS will deliver on the system wide approach to working with people and communities in Norfolk and Waveney.
- Receive regular reports setting-out the ICB's implementation of its annual communications and engagement plan and the organisation's contribution to delivering the Integrated Care System's approach to working with people and communities in Norfolk and Waveney.
- Consider how the ICB and the Integrated Care System could improve how we listen to, engage and work with people and communities.
- Oversee the sharing of insight gained from engagement with people and communities across the ICB and the Integrated Care System.
- Provide assurance to the ICB Board regarding the effectiveness of the organisation's approach to listening to, engaging and working with people and communities.

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- The Patients and Communities Committee will receive and approve any substantial departure from the Norfolk and Waveney People and Communities Approach and national guidance for working with People and Communities, published by NHS England.

Using Population Health Management Approaches and addressing health inequalities

- Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to have regard to the need to reduce inequalities and use population health management approaches to help achieve this.
- The Committee will receive regular reports from the Norfolk and Waveney Health Inequalities Oversight Group about the Integrated Care System's work to reduce health inequalities.
- Consider how the ICB and the Integrated Care System could improve its work to address health inequalities.
- Provide assurance to the ICB Board regarding the effectiveness of the organisation's work to address health inequalities.

Integration with the voluntary, community and social enterprise sector

- Receive regular reports about the work of the ICB and the Integrated Care System to improve integration between the statutory and voluntary, community and social enterprise sectors.
- Consider how the ICB and the Integrated Care System could improve integration between the statutory and voluntary, community and social enterprise sectors.

Development funding

- Agree how the ICB should use development funding received from NHS England.
- Agree how the ICB should use any funding received by the ICB as a result of bids to external bodies with regard to health inequalities or patient engagement.

Place

- Review and approve arrangements as to the delegations to place boards or place Directors.

7 ACCOUNTABILITY and REPORTING ARRANGEMENTS

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The Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded. The Chair of the Committee shall report to the Board (public session) after each meeting and provide a written report on assurances received, escalating any concerns where necessary.

The Committee will receive scheduled assurance reports from any delegated groups. Any delegated groups would need to be agreed by the ICB Board.

8. BEHAVIOURS AND CONDUCT

ICB values

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

9. DECLARATIONS OF INTEREST

All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

10. SECRETARIAT AND ADMINISTRATION

The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Attendance of those invited to each meeting is monitored highlighting to the Chair those that do not meet the minimum requirements;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken in accordance with the Standing Orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept;
- The Chair is supported to prepare and deliver reports to the Board;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments;
- Action points are taken forward between meetings and progress against those actions is monitored.

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11. REVIEW

The Committee will review its effectiveness at least annually and complete an annual report submitted to the Board.

These terms of reference will be reviewed at least annually from the date the latest version was approved and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Date of approval: 30 May 2023

Date of review:

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APPENDIX E

Finance Committee Terms of Reference

NHS Norfolk and Waveney Integrated Care Board

Version~~3~~-2

ICB Board approval ~~28 March 2023~~DATE

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2. Purpose

The Finance Committee is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

Its main purpose is to contribute to the overall delivery of the ICS objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan and strategy, consistent with the ICS Strategic Plan and its operational deliverables.

The Finance Committee will be run in two separate parts (with differing core membership for each element), this includes:

- Financial performance of NHS organisations within the formal ICS footprint – system control total (Part 1)
- Financial performance of the ICB (Part 2)

3. Authority

The Finance Committee is authorised by the Board to:

- 3.1 investigate any activity within its terms of reference
- 3.2 seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) as outlined in these terms of reference
- 3.3 commission any reports it deems necessary to help fulfil its obligations
- 3.4 obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice
- 3.5 create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, Standing Orders and Scheme of Reservation and Delegation (SoRD) but may not delegate any decisions to such groups
- 3.6 Advise the Board and / or any of its committees of findings and insights it considers are relevant for noting or discussion

4 Remit and Responsibilities

The list of responsibilities and duties in the section have been taken from a list prepared by the Health Care Financial Management Association (HFMA). The Finance Committee prioritises these in light of the financial circumstances. Any mention of ICS refers to NHS organisations in the Norfolk and Waveney ICS, unless specified differently.

The Committee will hold a part 1 meeting to cover system wide issues and a part 2 meeting to consider issues internal to the ICB. In executing its remit and responsibilities,

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the Finance Committee will receive progress reports and assurances from other boards, committees, etc.

This may include the Financial Recovery Board, and the Strategic Capital and Estates Board.

The Committee's duties are as follows:

System financial management framework

- 4.1 to set the strategic financial framework of the ICB and ICS and monitor performance against it
- 4.2 to develop the system financial information systems and processes to be used to make recommendations to the Board on financial planning in line with the strategy and national guidance
- 4.3 to ensure health and social inequalities implications are taken into account in financial decision-making

Resource allocation (revenue)

- 4.4 to develop an approach to distribute the resource allocation through commissioning and direct allocation to drive agreed change based on the ICS strategy
- 4.5 to advise on the process regarding the deployment of system wide transformation funding and monitor the financial impact of transformation initiatives
- 4.6 to work with ICS partners to identify and allocate resources where appropriate to address financial performance, quality and safety related issues that may arise and to ensure Value for Money in that resource allocation
- 4.7 to receive progress reports and assurance from the Strategic Capital and Estates Board, and its work with ICS partners to consider major investment/disinvestment business cases for material service change or efficiency schemes. work with ICS partners to consider major investment/disinvestment business cases for material service change or efficiency schemes (smaller of 3% of organisational annual expenditure and £5m with a de-minimus level of £1m) and to agree a process for sign-off where system funding is required

National framework

- 4.8 to advise the ICS member organisations on any changes to NHS and non-NHS funding regimes and consider how the funding available to the ICS can be best used within the system to achieve the best outcomes for the local population
- 4.9 to oversee national ICB and ICS level financial submissions
- 4.10 to ensure the required preparatory work is scheduled to meet national planning timelines

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Financial monitoring information

- 4.11 to develop a reporting framework for the ICB (using the chart of accounts devised by NHS England and the integrated single financial environment (ISFE)) and the ICS as a system of bodies
- 4.12 to articulate the financial position and financial impacts (both short and long-term) to support decision-making
- 4.13 to work with ICS partners to agree common approaches across the system such as financial reporting, estimates and judgements
- 4.14 to work with ICS partners to seek assurance over the financial reports from system bodies and providing feedback to them
- 4.15 to oversee the development of financial and activity modelling to support the ICB and ICS priority areas
- 4.16 to develop a medium- and long-term financial plan, consistent with strategic and operational plans
- 4.17 to develop an understanding of expenditure run rates across a system, system cost drivers and the impacts of service change on costs
- 4.18 to ensure appropriate information is available to challenge and manage financial issues, risks and opportunities across the ICS
- 4.19 to manage financial and associated risks by developing and monitoring a finance risk register
- 4.20 to leverage the use of non-financial data to triangulate against financial insights, and vice versa
- 4.21 to monitor the impact of the so-called double-lock and triple-lock, as appropriate, on the finance management in the system
- 4.204.22 to gain deeper understanding of all system partners in the ICS, seen through a financial lens

Financial Performance

- 4.214.23 to oversee the management of the system financial target and the ICB's own financial targets
- 4.224.24 to agree key outcomes to assess delivery of the ICS financial plan and strategy
- 4.234.25 to monitor and report to the board overall financial performance against national and local metrics, highlighting areas of concern
- 4.244.26 to monitor and report to the board key service performance which should be taken into account in assessing the financial position

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System efficiencies

- [4.254.27](#) to ensure system efficiencies are identified and monitored across the ICS, in particular opportunities at system level where the scale of the ICS partners together and the ability to work across organisations can be leveraged
- [4.264.28](#) to ensure financial resources are used in an efficient way to deliver the objectives of the ICS and to monitor and support resource utilisation that is consistent with long term financial sustainability
- [4.29](#) to review exception reports on any material breaches of the delivery of agreed efficiency improvement plan including the adequacy of proposed remedial action plans
- [4.274.30](#) to review progress reports and gain assurance from the ICS Financial Recovery Board (co-chaired by the Executive Director of Finance) progress on the delivery of transformational improvement plans to support the correction of the ICB and ICS Underlying Deficit

Communication

- [4.284.31](#) to co-ordinate and manage communications on financial governance with stakeholders internally and externally
- [4.294.32](#) to develop an approach with partners, including the ICS health and care partnership, to ensure the relationship between cost, performance, quality and environment sustainability are understood

People

- [4.30](#) to develop a system finance staff development strategy to ensure excellence by attracting and retaining the best finance talent
- [4.314.33](#) ~~to ensure that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements~~

Capital

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[4.324.34](#) to develop the system estates strategy and plan to ensure it properly balances clinical, strategic and affordability drivers (if not covered by separate strategic estates forum)

[4.334.35](#) to monitor the system capital programme against the capital envelope and take action to ensure that it is appropriately and completely used

[4.344.36](#) to gain assurance that the estates, digital and clinical strategic plans are built into system financial plans and strategy to ensure effective oversight of future prioritisation and capital funding bids

Committee Development

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[4.354.37](#) to provide a programme of development to ensure Committee members are able to fulfil their committee duties, through a combination of training, education and information sharing sessions

5 Accountability and Reporting

- 5.1 The Finance Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities
- 5.2 The Chair will provide assurance reports to the Board after each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require Board action
- 5.3 The Committee will provide an annual report to the Board to describe how it has fulfilled its terms of reference and give details on progress and a summary of key achievements in the delivery of its responsibilities

6 Membership

- 6.1 The Finance Committee members shall be appointed by the Board in accordance with the ICB Constitution
- 6.2 When determining the membership of the Finance Committee active consideration will be made to diversity and equality. Members of the committee may be co-opted to ensure diversity of thinking in decision making
- 6.3 The board will appoint no fewer than four members of the Committee including one who is an Non-Executive Member of the Board. Other members of the committee need not be members of the board but may be
- 6.4 Members should possess between them knowledge, skills and experience in accounting, risk management and technical or specialist issues pertinent to the ICB's business.
- 6.5 The members of the Committee are as follows:
 - Non-Executive member with the lead for Finance (Chair)
 - Non-Executive ([Vice Chair](#))
 - [Executive](#) Director of Finance
 - [Executive](#) Director of ~~Performance, Transformation and~~ Strategy

The following members attend the Committee for Part 1 only and bring their own delegation (where applicable from their own organisations.)

- Acute Chief Finance Officer (a serving Norfolk & Waveney Chief Finance Officer with current experience in an acute NHS provider setting)
- Non-acute Chief Finance Officer (a serving Norfolk & Waveney Chief Finance Officer with current experience in a non-acute NHS provider setting)
- Non-Executive Director (from NHS provider organisation)

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- A clinical person with primary care experience.
- ~~A clinical person from a provider, active within the Norfolk & Waveney locality~~
- A finance lead from Local Authority
- A person with financial expertise from the VCSE or wider community.

- 6.6 There will be a standing invitation to a finance representative from the NHS England regional team. They will not have voting rights at the meeting
- 6.7 Where a conflict of interest is deemed to exist, the Chair (or vice-Chair) can ask the member not to attend the meeting (or part thereof) or allow the member to attend but not vote
- 6.8 Meetings will take place on a minimum of ~~8~~¹⁰ occasions throughout any given financial year
- 6.9 Members should make reasonable endeavours to attend meetings and are expected to attend at least 90% of meetings held each year to ensure consistency, unless agreed with the chair in extenuating circumstances.
- 6.10 Where a member is unable to attend, efforts should be made to ensure a suitable representative attends, as nominated by the member and agreed with the Chair

Chair and Vice Chair

- 6.11 In accordance with the constitution, the Committee will be chaired by an Independent Non-Executive Member of the Board appointed on account of their specific knowledge, skills and experience making them suitable to chair the Committee
- 6.12 The Chair of the Committee shall be independent
- 6.13 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number Chair the meeting
- 6.14 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference

Attendees

- 6.15 Only members of the Finance Committee have the right to attend meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the committee. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with discussions on any particular matter
- 6.16 The Chair may ask any or all of those who normally attend, but are not members, to withdraw to facilitate open and frank discussion on particular matters
- 6.17 The Chair of the ICB may also be invited to attend one meeting a year in order to gain an understanding of the committee's operations

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7 Secretary and Administration

7.1 The Finance Committee shall be supported with a secretariat function, led by the ICB Director of Commissioning Finance, which will ensure that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead
- Records of members' appointments and renewal dates and the Committee is prompted to renew membership and identify new members where necessary
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept
- The Chair is supported to prepare and deliver reports to the Board
- The Finance Committee is updated on pertinent issues/ areas of interest/ policy developments
- Action points are taken forward between meetings and progress against those is monitored
- Attendance of those invited to each meeting is monitored and the Chair is made aware as soon as possible of those meetings that do not meet the minimum quoracy requirements

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8 Meeting Quoracy and Decision

- 8.1 For a meeting to be quorate a minimum of 50% voting members are required, including the Chair or Vice Chair
- 8.2 If any member of the Committee has been disqualified from participating on item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum
- 8.3 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken

Decision Making and Voting

- 8.4 Decisions will be taken in according with the Standing Orders. The Finance Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote
- 8.5 Only members of the Finance Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter
- 8.6 Where there is a split vote, with no clear majority, the Chair of the Finance Committee will hold the casting vote
- 8.7 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication. Where such action has been taken between meetings, then these will be reported to the next meeting

9 Conduct of the Finance Committee

Benchmarking and Guidance

- 9.1 The Finance Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations

Conflict of Interest

- 9.2 In discharging duties transparently, conflicts of interest must be considered, recorded and managed. Members should have regard to the NHS guidance on managing conflicts of interest
- 9.3 All conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Chair and

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submitted to the Board. If a conflict of interest arises, the Chair may require the affected member to withdraw at the relevant point

ICB Values

- 9.4 Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB
- 9.5 Members of, and those attending, the Finance Committee shall behave in accordance with the ICB’s constitution, Standing Orders, and Standards of Business Conduct Policy

Equality, Diversity and Inclusion

- 1.1 Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make

10 Review

- 10.1 The Finance Committee will review on an annual basis its own performance and effectiveness including membership and terms of reference. The ICB Board will approve any resulting changes to the terms of reference or membership

Date Approved:	28 March 2023DATE
Next Review:	March June 20254

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APPENDIX G

Norfolk and Waveney Integrated Care Board

Quality and Safety Committee

Terms of Reference DRAFT v2.10.4

Revision History

Revision Date	Summary of changes	Author(s)	Version Number
21/10/2022	Side by side review against SNEE and C&P terms. Membership queries highlighted.	KW & EK	v0.7 & v0.8
08/11/2022	Review against final version in ICB Governance Handbook. Changes to membership and quoracy. Meeting to confirm changes with Corporate.	EK & AB	v0.9
09/11/2022	Version for Committee review.	EK & AB	v0.10
11/01/2023	Final version for Committee review. Highlighted all amends to the version approved by Board.	EK	v0.11
August 2024	Annual review and refresh.	AB & EK	2.1

Approvals

This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number
1 July 2022	ICB Board		1
28 March 2023	ICB Board		2

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CONSTITUTION

The Quality and Safety Committee (“the Committee”) is established by the Integrated Care Board (“the Board” or ICB) as a Committee of the Board in accordance with its Constitution.

These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a non-executive chaired committee of the Board and its members are bound by the Standing Orders and other policies of the ICB.

PURPOSE OF THE COMMITTEE

The Quality and Safety Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out by the National Quality Board ‘Shared Commitment to Quality’ and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care.

The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, of an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care. The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

See the appendix to these terms for an overview of Committee objectives for 2024-2025.

DELEGATED AUTHORITY

The Quality and Safety Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time. The Quality and Safety Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

MEMBERSHIP AND ATTENDANCE

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than four members of the Committee including two who are Non-Executive Members of the Board (from the ICB). Other attendees of the Committee need not be members of the Board, but they may be.

When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion and the voice of clinical the workforce.

The Chair may ask any or all attendees, who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Chair and Vice Chair

The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest. If a Chair has a conflict of interest, then the Deputy Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

If the Chair is unable to attend the meeting then the Deputy Chair will Chair the meeting. In the event that neither the Chair nor Deputy Chair is able to attend the meeting another Non-Executive will chair the meeting.

Members

The Members attending Part 1 and Part 2 meetings of the Committee are as follows (please see Section 6 below with regard to Part 1 and Part 2 meetings):

- Non-Executive ~~Director-Member~~ (Chair)
- Non-Executive ~~Member~~Director (Deputy Chair)
- ICB ~~Executive~~ Director of Nursing or nominated deputy
- ICB ~~Executive~~ Medical Director or nominated deputy
- ICB Primary Medical Services Partner Member
- ~~ICB Local Authority Partner Member~~

The following ~~Members~~ attend the Committee for Part 1 only and bring their own delegation (where applicable from their own organisations):

- ~~Acute, Community, Mental Health and Ambulance Service Chief Nurses or nominated deputies~~1 Acute Provider ~~attendee~~Member
- ~~1 Community Provider Member~~attendee
- ~~1 Mental Health attendee~~Member
- 2 Local Authority ~~attendee~~Members (Norfolk and Suffolk)
- 1 VCSE Assembly ~~attendee~~Member
- 1 Independent Provider Partner
- 1 Hospice Provider Partner

Additional attendees will be called upon by the Chair as required and will include representation from ~~the regional NHS England Team the Urgent & Emergency Care system~~ as well as the local voluntary sector and other providers and provider collaboratives. The ICB Chief Executive Officer is routinely invited to attend.

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MEETING QUORACY AND DECISIONS

The Quality and Safety Committee shall meet on a monthly basis. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

Quoracy

There will be a minimum of one Non-Executive Member, plus at least the Executive Director of Nursing or Executive Medical Director. Where members are unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate on their behalf.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. If an urgent decision is required, the process set out below may be followed.

Decision Making and Voting

Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote. Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis using telephone, email or other electronic communication.

RESPONSIBILITIES OF THE COMMITTEE

The Committee will hold a Part 1 meeting to cover system wide issues and a Part 2 meeting to consider issues internal to the ICB.

The responsibilities of the Quality and Safety Committee are authorised by the ICB. It is expected that the Quality and Safety Committee will:

- Be assured that there are robust processes in place for the effective management of quality.
- Scrutinise structures in place to support quality planning, research, control and improvement, to be assured that the structures operate effectively and timely action is taken to address areas of concern.
- Agree and put forward the key quality priorities that are included within the ICB strategy and annual plan, including priorities to address variation and inequalities in care.
- Oversee and monitor delivery of the ICB key statutory requirements for quality and safety.

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- Review and monitor those risks on the Board Assurance Framework and Corporate Risk Register which relate to quality, and high-risk operational risks which could impact on care. Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner.
- Oversee and scrutinise the ICB's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSE and other regulatory bodies and external agencies (e.g., CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained.
- Maintain an overview of changes in the methodology employed by regulators and changes in legislation and regulation and assure the ICB that these are disseminated and implemented across all ICB sites.
- Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes.
- Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place.
- Ensure that patient outcomes from care are collected and measured, to inform outcomes-based commissioning for quality.
- Receive assurance that the ICB identifies lessons learned from all relevant sources, including, incidents, never events, complaints and claims and ensures that learning is disseminated and embedded.
- Receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from deaths (including coronial inquests and Reports to Prevent Future Deaths).
- Receive assurance that the ICB has effective and transparent mechanisms in place to monitor the quality of Children, Maternity and Neonatal care.
- To be assured that people drawing on services are systematically and effectively involved as equal partners in quality activities.
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children.
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control.
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for research and evaluation.

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- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people drawing on services.
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety.
- Have oversight of and approve the Terms of Reference and work programmes for the groups reporting into the Quality and Safety Committee (e.g., System Quality Group, [and ICS Infection Prevention and Control](#) [and Antimicrobial Stewardship Partnership and ICS Learning from Deaths Forum](#)).
- Approve ICB arrangements including supporting policies to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality research and patient outcomes.
- Approval of the arrangements for discharging the ICB's statutory duty associated with its commissioning functions to act with a view to securing continuous improvements to the quality of services.

ACCOUNTABILITY and REPORTING ARRANGEMENTS

The Quality and Safety Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded. The Chair of the Committee shall report to the Board (public session) after each meeting and provide a report on assurances received, escalating any concerns where necessary.

The Committee will advise the Audit and Risk Committee on the adequacy of assurances available and contribute to the Annual Governance Statement.

The Committee will receive scheduled assurance report from its delegated groups. Any delegated groups would need to be agreed by the ICB Board.

BEHAVIOURS AND CONDUCT

ICB Values

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and Diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

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DECLARATIONS OF INTEREST

All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

SECRETARIAT AND ADMINISTRATION

The Committee shall be supported with a secretariat function, which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant Executive lead;
- Attendance of those invited to each meeting is monitored and that those that do not meet the minimum requirements are highlighted to the Chair;
- Member appointments and renewal dates are recorded, and the Board is prompted to renew membership and identify new members where necessary;
- Minutes are taken in accordance with the Standing Orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are maintained;
- The complete agenda pack will be circulated at least five calendar days before the date of the meeting. The draft minutes and action log will be shared with all Committee members within five calendar days following the meeting.
- The Chair is supported to prepare and deliver a report of each Committee meeting to the Board;
- The Committee is updated on pertinent issues, areas of interest and policy developments;
- Action points are taken forward between meetings and progress against those actions is monitored.

REVIEW

The Committee will review its effectiveness at least annually and complete an annual report submitted to the Board.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

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The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Date of approval:

Date of review:

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APPENDIX: Committee Objectives for 2024-2025

- To have oversight of the ICS Quality Strategy and to be part of its continuous development and monitoring of impact.
- To seek assurance that the Norfolk and Waveney system has a unified approach to quality governance and internal controls that support it to effectively deliver its strategic objectives and provide sustainable, high-quality care and to have oversight of local implementation of the NHS National Patient Safety Strategy.
- To be assured that these structures operate effectively, that timely action is taken to address areas of concern, and to respond to lessons learned from all relevant sources including national standards, regulatory changes, and best practice.
- To oversee and monitor delivery of the ICB key statutory requirements, including scrutiny of the robustness and effectiveness of its arrangements for safeguarding adults and children, infection prevention and control, medicines optimisation and safety, research and evaluation and equality and diversity. To ensure that patient outcomes from care are collected and measured, to inform outcomes-based commissioning for quality.
- To review and monitor those risks on the Board Assurance Framework and Corporate Risk Register which relate to quality, and the delivery of safe, timely, effective and equitable care. To consider the effectiveness of proposed mitigations and to escalate concerns to risk owners and operational leads/forums as agreed by Committee Members.
- To approve ICB arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and secure continuous improvement in quality. To seek assurance that commissioning functions act with a view to supporting quality improvement; developing local services that promote wellbeing and prevent adverse health outcomes, equitably, across all patients and communities in Norfolk and Waveney.

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Norfolk and Waveney Integrated Care Board (ICB)
ICB Commissioning and Performance Committee
Terms of Reference

Revision History

Revision Date	Summary of changes	Author(s)	Version Number
04/07/2024	ICB Executive Director of Nursing -added as a member. ICB Executive Medical Director and ICB Executive Director of Performance, Transformation and Strategy job title corrected. ICB Associate Director of PHM and NHSE representation added to attendees. Performance added to the Purpose and Oversight sections. The process for how to appoint another Chair if the usual chair is not available has been changed to be consistent with all other sub-committees. Reference to the Joint Forward Plan and Clinical Strategy added to section 6.8. Amendment to wording in section 5 to reflect Part 1 and Part 2 format of the meeting. Removal of previous paragraphs 6.8 and 6.9 and re-numbering.	LJ	2

Approvals

This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number
23.01.24	Governing Body Board	KB	1

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1. INTRODUCTION

The Commissioning and Performance Committee is a meeting established by the Norfolk and Waveney ICB to provide assurance to the ICB Board as to the matters set out below and make decisions within these terms of reference.

These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a committee of the Board and its members are bound by the Standing Orders and other policies of the ICB.

2. PURPOSE OF THE COMMITTEE

The Committee exists to provide assurance and oversight and make decisions (within its delegations) on the commissioning and performance of services to ensure better outcomes for the population of Norfolk and Waveney. It will also consider the management of risk in all its work.

The Committee will provide regular assurance updates to the ICB Board in relation to activities and items within its remit.

3. DELEGATED AUTHORITY

The Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

The Committee holds only those powers as delegated in the Scheme of Reservation and Delegation and set out in these Terms of Reference as determined by the ICB Board.

4. MEMBERSHIP AND ATTENDANCE

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than ten members of the Committee including at least two who are Non-Executive or Partner Members of the Board of the ICB. Other attendees of the Committee need not be members of the Board, but they may be.

When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Chair ~~of the Meeting and Deputy chair~~

If a Chair has a conflict of interest, or is unable to attend a meeting for whatever reason, then the members will agree between themselves who will chair the meeting and be deputy chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

Members

- Partner Member for Primary Care (Chair)
 - One non-executive (Deputy Chair)
 - ICB Executive Director of Commissioning and Performance
 - ICB Executive Medical Director
 - ICB Executive Director of Nursing
 - ~~ICB Executive Director of Finance~~
 - ~~ICB Executive Director of Performance, Transformation and Strategy and Transformation and Deputy Chief Executive~~
 - One member from the Norfolk and Waveney Acute Trust Collaborative
 - One member from community services
 - One member from mental health services and
 - One member from local authorities
-
- ~~NHS England Regional Director of Finance or nominated Deputy (Investment Oversight Panel only.)~~

Attendees

Other individuals including;

- Representatives from NHS England regional team
- Head of Acute Commissioning, East of England Specialised Commissioning Team (or deputy)
- Chief Executives from within the system
- Representatives from Local Authorities
- Representatives from primary care
- Representatives from the VCSE sector
- Representatives from community providers

- Representatives from secondary providers
- ICB Associate Director of Population Health Management / Deputy Director of Public Health NCC (joint role)
- System senior responsible officers for any programme

may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter.

5. MEETING QUORACY AND DECISIONS

The Committee shall meet on at least a monthly basis. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

In accordance with the Standing Orders, the Committee will normally meet virtually unless face to face meeting is deemed necessary.

A public notice of the time and place of meetings to be held in public and how to access the meeting shall be given electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.

The Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

The usual format of the meeting will be:

Part 1: Private session

Part 2: Public session

Quoracy

The quorum for the meeting will be five Members. This must include:

- at least one of either the Chair or deputy Chair,
- at least two ICB Executive Directors.
- At least one non-ICB member

Where members are unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate on their behalf. For the avoidance of doubt the deputy will be counted as part of the quorum.

If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. If an urgent decision is required, the process set out below on urgent decisions may be followed.

Decision making and voting

Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee or their nominated deputy may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

Urgent decisions

In the event that an urgent decision is required, if it is not possible for the Committee to meet virtually an urgent decision may be exercised by the Committee Chair and relevant lead ICB director subject to every effort having been made to consult with as many members as possible in the given circumstances (minimum two other members).

The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification and noted in the minutes.

6. RESPONSIBILITIES OF THE COMMITTEE

The responsibilities of the Committee will be authorised by the ICB Board.

Decision Making/Recommendations:

The Committee shall:

6.1 Make decisions on the whole value of a business case for Commissioning and Decommissioning (outside of the financial plan) under £1,000,000, (except where matters are delegated to Primary Care Commissioning Committee).

6.2 Make recommendations to Chief Executive/CFO or the Board on business cases over £1,000,000 which are outside of the financial plan as per the ICB's financial limits. Any business case brought under sections 6.1 or 6.2 above must be approved by the Director who is responsible for the portfolio to which the proposal relates and also include comments on finance before it is presented to the Committee.

6.3 Consider and make decisions on clinical policies as recommended by the Clinical Policy Development Group.

6.4 Consider and make decisions on recommendations from the medicines optimisation programme board.

Oversight and Assurance

6.5 Provide oversight and seek assurance that the operational arrangements in place across the ICB to support the commissioning and performance of services/care to the local population are in line with the agreed system and place strategic plans. In particular to gain assurance as to the projects that were agreed as part of the financial plan to ensure they are on track.

Ensure relevant stakeholders are appropriately briefed as committee business is undertaken, including any applicable briefing for HOSCs.

6.6 Oversee the process for any further delegation of commissioning functions to the ICB from NHS England.

6.7 Provide oversight to the Individual Funding Request panels.

6.8 Provide oversight and assurance of the Joint Forward Plan and Clinical Strategy.

~~**Investment Oversight Panel- Only applicable when the system or any part of it is subject to financial special measures.**~~

~~**6.8** The Committee shall also serve as an Investment Oversight Panel. Accordingly any part of the system that is proposing expenditure of over £50,000 (double lock) or the system in aggregate that is proposing expenditure of over £100,000 that will exceed the budget and/or the approved plan (triple lock) will be required to present its case to the Investment Oversight Panel. This process will apply even where additional funding is being provided to support the change, to ensure that expenditure increase is minimised.~~

~~**6.9** In approving or rejecting the case the panel will have consideration to the items in appendix 1 to these terms of reference~~

Strategic Commissioning

Provide the health oversight and assurance needed to support the delivery of the joint commissioning agenda with Local Government. For the avoidance of doubt the committee is not accountable or responsible in any way for any Local Government finances.

Provide oversight and seek assurance that the commissioning arrangements in place across the ICB to deliver delegated or joint services with NHS England are delivering in line with agreed principles.

The Committee will be the formal point of engagement for the ICB with the East of England Specialised Services Joint Commissioning Committee or equivalent committee, and will oversee the ICB's relationship with the regional specialised services commissioning team and will consider specialised services matters on behalf of the ICB.

The Committee will oversee and support the development of future models of collaborative commissioning with Provider Collaboratives and Alliances.

Performance

The Committee shall:

Conduct and lead oversight of both NHS system and commissioned provider performance, including evaluation of health services, provider resilience and failure and performance review and management.

Hold the system to account and provide challenge to the system where this is required to address opportunities to improve performance and outcomes.

Determine where a peer review or 'deep dive' approach is required to support improvement in the system; overseeing the subsequent review and ensuring the learning is implemented.

Direct improvement resources when required in the system, including defining the parameters of any new improvement plans, peer review of existing plans where expected outcomes are not delivered and coordinating with regulators where formal improvement or intervention support is required.

Approve the KPIs and outcome metrics for use across the system and negotiate any metrics or improvement trajectories with NHSE where relevant to NOF segmentation or the Recovery Support Programme (RSP), as may be required from time to time.

Take into account the duty of the ICB to harness innovation, best practice and the use of evidence and evaluation in commissioning decisions, to ensure this is consistently adopted across the system.

Agree and coordinate any support and intervention carried out by NHSE, other than in exceptional circumstances.

Procurement

The Committee shall approve the application of the Provider Selection Regime process for the procurement of any business cases that it approves under its delegation as set out above.

7. ACCOUNTABILITY and REPORTING ARRANGEMENTS

The Committee is directly accountable to the ICB Board. The minutes of meetings shall be formally recorded. The Chair of the Committee shall report to the Board (public session) after each meeting and provide a written report on assurances received, escalating any concerns where necessary.

The Committee will receive scheduled assurance reports from any programme boards which report into it and also the deliberation prioritisation panel.

8. BEHAVIOURS AND CONDUCT

ICB values

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

Members must demonstrate that they have considered the equality and diversity implications of decisions they make.

9. DECLARATIONS OF INTEREST

All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

10. SECRETARIAT AND ADMINISTRATION

The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Attendance of those invited to each meeting is monitored highlighting to the Chair those that do not meet the minimum requirements;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken in accordance with the Standing Orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept;

- The Chair is supported to prepare and deliver reports to the Board;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments;
- Action points are taken forward between meetings and progress against those actions is monitored.

11. REVIEW

The Committee will review its effectiveness at least annually.

These terms of reference will be reviewed at least annually and more frequently if required. The Committee shall undertake a review of its effectiveness and terms of reference at six months from establishment. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Appendix 1:

- The priority ranking of investments proposed, for which a scoring matrix can be used to help with consistency;
- The operational and clinical risks associated with not making the proposed investment, and how/whether these risks can be mitigated if the investment is not approved;
- Any other risks relevant to the decision;
- What alternatives have been explored to the proposed investment, such as a lower level of expenditure, and/or alternatives leveraging the wider system;
- Whether invest to save proposals have a sufficiently detailed and persuasive case to proceed including the likely return and the risk of successful delivery;
- Investments that are proposed to be funded with non-system resources are at least fully funded and do not present a future risk to the system's financial position; and
- The system's financial position and ability to absorb the proposed investment within the system's agreed financial plan.
- The equality, diversity and inclusion implications of the proposal.

Date of approval: ~~September 2024~~ January 2024

Date of review: ~~March~~ September January 2025 ~~??~~

APPENDIX I

Norfolk and Waveney Integrated Care Board

Conflict of Interest Sub Committee

Terms of Reference

Revision History

Revision Date	Summary of changes	Author(s)	Version Number
27 January 2023	Amendments to references and roles and responsibilities of the Committee	M.Fitt	2
13 August 2024		M. Fitt	3

Approvals

This document has been approved by:

Approval Date	Approval Body	Author(s)	Version Number

Davey Heidi
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Conflict of Interest Sub Committee - Terms of Reference

1. Introduction

- 1.1 The Conflicts of Interest Committee (Committee') is a Sub Committee of the Board of the NHS Norfolk and Waveney Integrated Care Board ("the ICB").
- 1.2 The Committee is established in accordance with the ICB's Constitution. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee.
- 1.3 The committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Audit and Risk Committee on the adequacy and effectiveness of conflict of interest processes within the ICB.

2 Membership

The Committee members shall be appointed by the board in accordance with the ICB's Constitution.

Members of the Committee are:

- 2.1.1 Non-Executive Member (Chair)
- 2.1.2 At least one further Non Executive Member from the Board
- 2.1.3 Executive Director of Finance (Deputy Chair)
- 2.1.4 Executive Medical Director
- 2.2 The Chair of the Committee shall be the Non-Executive Member who Chairs the Audit and Risk Committee.
- 2.3 In the absence of the Chair the Executive Director of Finance will preside.
- 2.4 A Committee member shall cease to hold office if:
 - 2.4.1 He/she ceases to meet the eligibility criteria for their role as set out in the Constitution;
 - 2.5.1 Only members of the Committee have the right to attend committee meetings. However, meetings of the Committee will also be attended by the following individuals who are not members of the Committee

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- Associate Executive Director Head of Governance Corporate Affairs
- Governance Corporate Affairs Manager
- Any individual required to present matters to the Committee for consideration if called upon by the Committee Chair

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

2.6.1 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), Secondary and Community Providers

3 Secretary

3.5 The Executive Director of Corporate Affairs and ICS Development shall be secretary to the Committee and will provide administrative support and advice. The duties of the secretary in this regard shall include but are not limited to:

3.5.1 Supporting the Chair in management of the Committee's business;

3.5.2 Agreement of the agenda with the chair of the Committee together with the collation of connected papers;

3.5.3 Ensuring that ~~Taking of the~~ minutes and ~~keeping a~~ records of matters arising and issues to be carried forward are kept;

3.5.4 Advising the Committee as appropriate on best practice, national guidance and other relevant documents.

4 Quorum

4.5 A quorum shall be one Non-Executive Members and one of the Executive Directors (Director of Finance or Medical Director).

5 Decision Making

5.5 Committee members may participate in meetings by the use of telephone, video conferencing facilities and/or webcam where such facilities are available (subject to the

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approval of the Chair). Participation via remote technology as described above shall be deemed as presence in person at the meeting.

- 5.6 Generally it is expected that the Committee's decisions will be reached by consensus. Should this not be possible then a vote of members will be required, the process for which is set out below:

5.6.1 **Eligibility** – Each member as provided in section 2 who is physically present at the meeting or present in accordance with section 5.2 above is entitled to one vote;

5.6.2 **Majority necessary to confirm a decision** – Each question put to the vote at a meeting shall be determined by a majority of votes of those members voting on the question;

5.6.3 **Casting vote** - In the case of an equal vote, the Chair of the meeting shall have an additional and casting vote;

5.6.4 **Dissenting views** – Should a vote be taken, the outcome of the vote, along with any dissenting views, must be recorded in the minutes of the meeting.

6 Frequency and notice of meetings

- 6.5 Meetings will be held as and when required as matters arise, but will meet at least twice a year to review and discuss the strategic vision relating to conflicts of interest.

6.6 Items of business to be transacted and all supporting papers for such items for inclusion on the agenda need to be notified to the Chair of the meeting wherever possible at least one week before the meeting takes place.

6.7 The agenda and supporting papers will be circulated wherever possible at least one week before the date the meeting will take place.

6.8 With the agreement of the Chair, items of urgent business may be added to the agenda after circulation of papers to members.

7 Remit and responsibilities of the Sub Committee

- 7.5 The Committee is authorised to make decisions on behalf of the ICB with regard to issues which cannot be decided by the Board due to the Board not being quorate as a result of conflicts of interest.

7.6 The Committee has the responsibility for overseeing the ICB's policies and procedures with regard to conflicts of interest. This includes, but is not limited to, receiving reports and making decisions on potential breaches of policy.

7.7 The Committee has authority to act in accordance with the ICB's Constitution, Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation.

7.8 The Committee is authorised by the Board to commission any reports or surveys it deems necessary to help it fulfil its obligations.

7.9 The Committee shall conduct regular 'deep dives' into key themes and monitor the ICB's compliance with conflicts of interest as a matter of routine business.

7.10 The Committee must review its terms of reference on an annual basis.

7.87.11 At each meeting the Committee will be submitted with an operational paper setting out the ICB's compliance with national guidance and against its policy. It will also receive regular assurance and the outcome as regard to internal audit.

8 Relationship with the Board

8.5 The minutes of Committee meetings shall be formally recorded by the Secretary of the Committee. A report of the Committee's work will be submitted to the Audit and Risk Committee following each meeting. The Committee shall however act independently of the Board.

8.6 The ICB's annual report shall include a section describing the work of the Committee in discharging its responsibilities.

9 Policy and best practice

The Committee will apply best practice in the decision-making process for example by following Conflicts of Interest guidance published by NHS England. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions

10 .Conduct of the Committee

10.5 The Committee will conduct its business in accordance with national guidance and relevant codes of conduct and good governance practice, including the Nolan Principles.

10.6 Declarations of interest will be a standing item on all meeting agendas.

10.7 Members who have any direct/indirect financial or personal interest in a specific agenda item will declare their interest. The Chair of the meeting will decide the course of action required, which may include exclusion from participation in the discussion and decision making.

10.8 All declarations of interest and actions taken in mitigation will be recorded in the minutes.

10.9 The Committee will assess its performance, membership and terms of reference annually and draw up its own plans for improvement. The Board will approve any subsequent amendment to the terms of reference.

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Agenda item: 15

Subject:	Research and Evaluation Team report Annual report April 2023- March 2024
Presented by:	Dr Clara Yates
Prepared by:	The Research and Innovation Team
Submitted to:	NHS Norfolk and Waveney ICB Board
Date:	25 September 2024

Purpose of paper:

To present the NWICB Research and Evaluation Team annual report April 2023-March 2024

Executive Summary:

Research and Evaluation Team Report for Norfolk and Waveney ICB April 2023-March 2024

The Annual Report details the achievements of the team through three main workstreams: Research, Evidence and Evaluation and Innovation. Community engagement and public and patient involvement is threaded throughout each workstream. Key highlights are detailed below:

Research

Research Development: the team supported thirty-three research projects ranging from providing advice and drafting NHS costs to proposal development. Twenty-one were submitted with NWICB as the NHS host organisation. Six NWICB-hosted NIHR applications, worth a total of £9,008,064, were funded in the financial year 23-24 in addition to the nine which are currently active. The ICB receives Research Capability Funding (RCF) as a result of hosting NIHR grants, in 23/24 this total award was £535,047. RCF was used to cover staff salaries and a significant portion is invested in the development of further research grant applications aligned to the health and care priorities of the ICS. These include smoking cessation, medicine adherence and deprescribing, reducing inequalities in health and social care. Evidence briefings are also produced by researchers, examples include: Exploring barriers and enablers to uptake in Diabetes Prevention Programmes (DPPs) for UK ethnic minorities and people living in deprived areas; Prediction of gastrointestinal malignancy in patients with iron deficiency; Investigating Pharmacogenomics (PGx)

David Yates
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Testing into the Community Pharmacy Delivered New Medicines Service (NMS) for Depression.

Research Management: the team works in partnership with the Cambridgeshire and Peterborough ICB Research Office and Clinical Research Network (CRN) EoE to provide a central point of coordination and management for primary care research and research into wider community settings (such as care homes, schools and hospices). We also support research at Norfolk Community Health & Care (NCH&C) and East Coast Community Healthcare CIC (ECCH). We provide expert advice, ensuring research is undertaken in line with all governance and legal requirements. We reviewed and assured/confirmed 77 new studies, a 31% increase compared with the previous year.

In total, 91 of 105 practices (87%) in Norfolk and Waveney were involved in research in 2023/24, recruiting one or more participants to nationally important research.

Overall 8,763 participants were recruited to 22 NIHR Portfolio studies. The Measuring Loneliness Study, an online survey to measure the extent that individuals are feeling lonely and/or socially isolated, was the highest recruiting study with 4,278 participants. We maintained our position as the highest recruiter in Primary Care in the Eastern region. At Primary Care Network (PCN) level, the top three recruiting networks were:

- Norwich PCN: 2,843
- Lowestoft PCN: 1,558
- Breckland Surgeries PCN: 1,266

Evidence and Evaluation

The Evidence and Evaluation (EE) Hub supports the ICB with its statutory duty to use evidence in decision making. It is a quasi-independent, data-led team and is dedicated to identifying the best outcomes for our population. Initially set up as a two-year pilot, the Hub now has a permanent role in the ICB, with a core team of four staff and supports many projects and programmes.

This year, the EE Hub has been involved in 15 active evaluation projects, produced two evidence briefings and completed 10 evaluations. The Hub was also approached for initial discussion about 28 potential projects and provided advice and support on 23 projects.

Completed evaluations include: Cancer Pathways: Personalised Care; Health Connect; Legacy Mentor Service; Hydration Pilot phase 1; Digital wearable in care homes; Virtual Ward.

The team also provide advice, support and training to ICB staff, including logic modelling to support a systematic framework to service development.

Innovation

In response to our statutory duty to promote innovation and in line with ICS Joint Forward Plan ambitions for 2023 and 2024 as well as the Research and Innovation strategy we appointed a Head of Innovation in October 2023. This is a jointly funded with Health Innovation East (HIE).

We successfully applied to become one of 18 NHS England funded Innovation Sites (InSites), working on behalf of the ICS. The InSites programme aims to align processes, share intelligence on implementation of innovations and build capability within the InSites. This programme commenced in December 2023, and we have been awarded £200k to accelerate our innovation objectives. So far, we have used the funding to support project management capacity, elements of our innovation

David Smith
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culture and networking activities and we will allocate a limited budget for implementing innovation projects.

Working across the ICS through the newly established Innovation Network we have developed four core innovation objectives:

- raise the profile of innovation across ICS partners and emphasise the importance of embedding innovation.
- develop systematic processes for the identification, selection, and governance of innovation/s to meet N&W population healthcare needs and clinical challenges.
- promote healthcare equality and equity through supporting the sharing, scale-up, spread and sustainability of impactful innovations across N&W ICS.
- promote an innovation culture and grow an innovation, aware, capable, and competent workforce.

We have also mapped out the wider innovation ecosystem across N&W including councils, higher education institutes (e.g., UEA) and the Norwich Research Park. We are actively liaising with these institutions to consider how we can collaborate to optimise the integration of innovation to benefit the health of the N&W population.

Community Engagement:

We have undertaken several initiatives this year to increase community involvement and engagement in research. We have secured £150k of NHSE Research Engagement Network (REN) funding to recruit, train and support individuals through 16 VCSE organisations to have conversations with their communities about barriers and facilitators to taking part in research. The approach taken was inclusive and flexible as demonstrated by the charity Opening Doors, a user led organisation run by people with learning disabilities. Experts by experience re-designed and tested the questions provided by the REN team so they were more easily understood by the community. We also supported the successful application to NHS England for REN 3, led by Dr Caroline Barry, to explore the barriers to research participation for those at end of life.

2024-25

As a team we will focus on these key areas

- community engagement and involvement in research, working with CRN, VCSE and UEA colleagues across Norfolk and Waveney, with a focus on seldom heard groups
- embedding a culture of evidence use and evaluations in service design, transformation and service delivery, supporting quality across the ICS
- facilitating the delivery of high-quality research in out of hospital settings, including supporting primary care to increase commercial research activity
- working with local, regional and national colleagues to explore the most effective way of ensuring the results of research are used to improve health and care
- developing an innovation culture across the ICS.

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Recommendation to the Committee:

The report is provided for information and discussion

Key Risks	
Clinical and Quality:	R&D risks are mitigated through adherence to the DHSC Research Policy Framework for Health and Social Care and review / approval of research projects by Health Research Authority (HRA). Collaborative working between CRN team, general practice and researchers reduces clinical risk. Patient access to potentially new treatments and therapies.
Finance and Performance:	Close performance monitoring ensures the flow of research monies to practices and the Research Office, ensures delivery against contracts and SLAs, and increases opportunities for patients and the public.
Impact Assessment (environmental and equalities):	Any adverse impact on equality and diversity is minimised by HRA and ethical review.
Reputation:	Achievement of targets and patient recruitment is essential for good research delivery and achievement of funding from CRN East of England. Achievement of research grants hosted by the ICB enhances ICB reputation and generates additional income in the form of RCF. R&D assessment and review ensures appropriate approvals, facilitating timely set up of studies to minimise the risks to the patient, the study, the host organisation and the reputation of primary & community care research in Norfolk & Suffolk.
Legal:	Robust performance monitoring mitigates legal risks associated with research activity. Sponsors and permission givers (GP practices) take legal responsibility for research. HRA takes responsibility for the review it conducts, and indemnity arrangements for research is assessed as part of this review
Information Governance:	All research work is compliant with information governance rules associated with data handling and research. Robust processes are in place at all stages of research from review by HRA and Ethics to management and roll out of studies locally and dissemination and assessment of impacts. Evaluations are planned and carried out in consultation with ICB IG team.
Resource Required:	R&E Team is fund through a variety of sources including CRN East of England, DHSC held research grants and RCF and through SLA arrangements with Suffolk, Norfolk Community Health and Care and East Coast. Research monies are managed in line with NIHR and DHSC rules and financial governance frameworks

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Reference document(s):	ICS Research and Innovation Strategy, May 2023 ICB Duty to facilitate or otherwise promote research, evidence use and innovation, Health and Care Act 2022 UK Research Strategy -Best Research for Best Health, May 2021 NHS Long Term Plan, January 2019 UK Policy Framework for Health and Social Care Research, 2017.
NHS Constitution:	NHS Commitment to the promotion, conduct and use of research.
Conflicts of Interest:	Any conflicts have been managed in line with Norfolk and Waveney ICB policy
Reference to relevant risk on the Board Assurance Framework	Current there are no risks on the GBAF. The team have a risk register in line with corporate governance requirements and research governance standards

Governance

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

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Research and Evaluation Team

Annual report April 2023- March 2024

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1. Introduction

Research in the NHS and across the wider health and care system is vital. It provides the evidence needed for new and improved treatments, services and care pathways. Evaluating how well those improvements work means we are constantly learning to ensure we spend our limited NHS and care budget efficiently and effectively. The Research and Evaluation team support this aim through our three main workstreams:

- Research
- Evidence and Evaluation
- Innovation

We are committed to ensuring that opportunities to engage with, and participate in, research are provided across Norfolk and Waveney and public involvement and community engagement is threaded throughout our workstreams.

Members of the team also influence national and regional initiatives including chairing two national R&D Forum working groups (Primary Care & Commissioning; ICB Research Leads), acting as one of two Research Champions for the Health Research Authority on behalf of the East of England and engaging with UKRD, a community of senior R&D Leaders in the NHS.

The team's achievements have been made possible by the strength of our collaborative relationships with our academic partners (primarily the University of East Anglia (UEA), provider organisations, clinical and care professionals, primary care practices and Primary Care Networks (PCNs), the voluntary, community and social enterprise (VCSE) sector, the National Institute of Health and Care Research (NIHR) Clinical Research Network East of England (CRN EoE), Health Innovation East (HIE), local authorities, UEA Health and Social Care Partners (UEAHSCP), UEA Citizen's Academy and the Norfolk Institute for Coastal and Rural Health Equalities (NICHE) Anchor Institute at UEA.

2. Research and Innovation Strategy

As a team we coordinated the development of, and wrote, the Norfolk and Waveney Integrated Care System (ICS) Research and Innovation strategy¹ for 2023-2028, published in May 2023. A system wide leadership group, meeting every 6 months, was established in September 2023 to oversee the delivery of the strategy.

The four strategy principles state that research and innovation in Norfolk and Waveney will be:

¹ <https://improvinglivesnw.org.uk/the-first-research-and-innovation-strategy-for-norfolk-and-waveney/>

1. Focused on our communities
2. Driven by a confident and capable workforce
3. Collaborative and co-ordinated
4. Embedded in everything we do as a system.

The leadership group appointed workstream leads for each strategy principle to conduct further in depth conversations with partners and to develop recommendations for how we implement the strategy. These took place between December 2023 and March 2024 and a report detailing the recommendations will be published in May 2024.

3. Research

We support research across the whole research lifecycle from development of ideas, through to funding application, set-up, delivery, completion and ensuring the results are shared and used, if appropriate. This approach is illustrated in case study 1.

Case Study 1

Development and delivery of the Research for Patient Benefit (RFPB) funded “Improving the Quality and Experience of Care for Patients Prescribed Medicines with a Risk of Dependence or Withdrawal

Dr Jenny Seddon, University of Bedfordshire.

What was the problem?

Figures show that in 2019 a quarter of the adult population of England – 11.5 million people - were prescribed medicines, known to cause withdrawal symptoms or dependence. The longer you take the medicines, the more difficult it is to stop, and the evidence showed that 1.9m people were taking these medicines for a year or more.

The Research Development team began working with Dr Jenny Seddon in July 2019 and worked to support her research application for funding. Discussions and support focused on study screening, recruitment, and dissemination, as well as identifying and linking Dr Seddon with an academic at UEA, identifying and costing the relevant NHS costs of her research, and completing the Schedule of Events Costs Attribution Template (SoECAT). The stage one application was submitted in November 2019 and stage two in March 2020, with funding awarded in July 2020.

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What was the study about?

The 18-month study aimed to improve the quality and experience of care for patients prescribed benzodiazepines, Z-drugs, antidepressants, opioids and gabapentinoids. The study brought together patients and healthcare staff across five practices in Norfolk and Suffolk to develop understanding of current patient and staff experience; identify strategies and priorities to improve the experience and quality of care and, design and implement change, through a series of workshops.

Following funding, the Research Management Team worked with Dr Seddon to set up the relevant agreements for the study with University of Bedfordshire, as Sponsor and other named collaborators on the grant; oversaw the delivery of the study; worked with the Clinical Research Network (CRN) to identify and recruit practices to take part in the study and in collaboration and managed study finances and financial reporting. At the end of the study, we worked with Dr Seddon to collect some local impacts from practices who participated in the study.

Key findings

Patients and healthcare staff identified three main improvement priorities:

- Improved information and communication
- Improved continuity of care
- Alternatives to medication

Action points were identified for each priority area, and solutions to improve care were co-designed by patients and healthcare staff. Improvement initiatives were implemented within participating GP practices to improve the patient experience of care giving a direct benefit to those practices taking part.

Impacts collected from practices included a better understanding of these types of medicines; the importance of tailored support to patients, as well as the use of group consultations within the study providing an opportunity to improve the information provided to patients.

“The results of the study have informed and reinforced the approach to care within the clinic.”

Participating Practice

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“The study has highlighted the patient experience and need for more information at the point of prescription”

Participating Practice

Resources

A number of professionally designed materials were developed and can be found on the following website: <https://sites.google.com/brookes.ac.uk/medication-experience> (including a published paper, a summary report for patients/members of the public, an information guide for patients, an information guide for healthcare professionals, a policy brief, a short-animated video for patients, a webinar for health professionals).

Research Development

We drive the design and development of collaborative and nationally competitive research applications for the benefit of our population. We support the development of effective and meaningful patient, carer and public involvement and engagement in all health and social care projects.

We were involved in supporting 33 research projects, ranging from providing advice and drafting NHS costs to proposal development. Of these research applications, 21 were submitted with NWICB as the NHS contracting organisation.

These research projects were led by researchers from:

University of East Anglia	11 in School of Health Sciences 8 in School of Medicine
University of Leicester	7 in School of Healthcare
University of Essex	1 in School of Health and Social Care
King’s College London	1 in Faculty of Life Sciences & Medicine
University of Exeter	1 in School of Medical Health Sciences
Other	4 with Norfolk County Council, Norfolk & Norwich University Hospital, and Eastern Academic Health Science Network

Six NWICB-hosted NIHR applications, worth a total of £9,008,064, were funded in the financial year 23-24 in addition to the nine which are currently active (see section 3).

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NWICB-hosted NIHR research awarded in 2023/24

In progress:

- The InflAIM Project: Inflammation, nutrition, and the evolution of multiple long term conditions an AI-based analysis of intersectionality in longitudinal health data (£4,910,000)

In Set-up:

- SleepXacT: Feasibility and practicability of low-burden contactless sleep tracking devices to measure objective sleep quality in sleep interventions in patients with dementia and mild cognitive impairment (£142,000)
- MND Care Pathways - Optimising care pathways in Motor Neurone Disease for family carers: A realist evaluation (£799,000)
- IMAB-Qi: The Identification of Medication Adherence Barriers Questionnaire intervention (IMAB-Qi) NIHR 206808 (£2,768,000)

In Contracting:

- AISCs (£250,000)
- Swept under the carpet (£139,000)

Research Capability Funding

NIHR Research Capability Funding (RCF) is awarded to research-active NHS organisations. In 2023/24, in recognition of the work undertaken by hosting and contracting NIHR research grants, NWICB received £535,407. This success represents the significant work that the team undertake with academics and system partners to ensure robust, high-quality research applications are submitted for funding. Only nine ICBs across England currently receive grant-related RCF, and this award means that Norfolk and Waveney is now in receipt of the 3rd largest award of any ICB.

We invest a portion of RCF into the development of innovative research grant applications with our NHS and academic partners which are aligned to the health and care priorities of our ICS. In 2023/24, we made 17 RCF awards.

The awards cover a wide breadth of research, including

- smoking cessation
- medicine adherence and deprescribing
- addressing support needs
- rethinking care pathways

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- mental health
- reducing inequalities in health and social care

Involvement and engagement of our communities forms a fundamental part of these awards, which we support through our community engagement coordinator.

Recipients of RCF also produce a one-page evidence briefing summarising recent evidence in the field to help inform decision making by commissioners of services. Our library of evidence briefings is available on request; the box below details briefings that have been delivered in 2023/24.

RCF evidence briefings delivered in 2023/24

- Hearing Loss and Dementia Risk, Patients and Clinicians Perspectives
- Maternal and child outcomes from pregnancies after bariatric surgery: a CPRD feasibility study
- Can GP data be used to analyse the high BMI asthma phenotype in infancy?
- Exploring barriers and enablers to uptake in Diabetes Prevention Programmes (DPPs) for UK ethnic minorities and people living in deprived areas
- Prediction of gastrointestinal malignancy in patients with iron deficiency
- Investigating Pharmacogenomics (PGx) Testing into the Community Pharmacy Delivered New Medicines Service (NMS) for Depression
- The Support Needs Approach for Patients (SNAP). Planning future research to support SNAP in practice
- Designing a religiously informed culturally acceptable smoking cessation intervention for maintaining abstinence during and post Ramadan among UK-based Muslim Smokers
- Improving young carer support: developing a study to adapt the Carer Support Needs Assessment Tool Intervention (CSNAT-I) for use with Young Carers
- Ask what matters to me. Collecting meaningful and acceptable outcome measures with people from under-researched groups
- Primary care healthcare professionals supporting patients to discontinue antidepressants

In 2023/24, we also introduced two new uses of RCF: early career fellowships and PCN funding. Our collaboration with UEA has enabled us to use RCF to jointly fund an early career fellowship post at UEA. The fellow is employed by UEA for two years and the aim is to undertake grant development work that leads to an application to the NIHR for research funding. This is part of our approach to supporting early career researchers.

Alongside this, we also funded eight PCNs to set up a research network and engage with the Research and Innovation Team. We have presented at PCN meetings with all eight and have made new positive connections. Further conversations are ongoing to support PCNs and practices to develop their capacity and capability to undertake research.

Research Management

This Team works in partnership with the Cambridgeshire and Peterborough ICB Research Office and CRN EoE to provide a central point of coordination and management for primary care research and research into wider community settings (such as care homes, schools and hospices). We also support research at Norfolk Community Health & Care (NCH&C) and East Coast Community Healthcare CIC (ECCH).

We provide expert advice, ensuring research is undertaken in line with all governance and legal requirements.

We advise on local requirements, support the management and set-up of research, and confirm capacity and capability of sites to undertake research studies and provide assurance to primary care that all appropriate governance checks have been undertaken.

In the last year, the Research Management team:

- Reviewed and assured/confirmed 77 new studies, a 31% increase compared with the previous year (note - some studies took place in multiple settings e.g. primary and community care, so the total number of studies is higher than the number reviewed):
 - 48 assured for Primary Care
 - 22 confirmed for NCH&C
 - 5 confirmed for ECCH
 - 7 assured for Social Care/Non-NHS settings
 - 1 assured for pharmacies
- Supported 136 amendments to existing studies
- Supported adoption of 86% of studies onto the NIHR Portfolio
- Processed 31 Letters of Access for research
- Issued 3 Honorary Research Contracts for the academic leads on ICB hosted research grants.

A list of all active studies can be found in Appendix B: Studies active during 2023/24.

NWICB held research

NWICB directly hosted a total of 10 NIHR grants in 2023/24, worth a total of £14M, with a further two currently in set-up (total £1M) and 3 recommended for funding

(total £3M) which are now progressing to contracting. The team conducted the contracting process with the Department of Health and Social Care (DHSC) and supported study set-up, financial reporting and oversight. In addition to the six newly funded grants listed in section 2.3, we also continue to manage nine projects successfully funded in previous years:

NWICB held NIHR grants active in 2023/24

- Development of a trial to evaluate a theory of evidence-based medication adherence intervention to enhance structured medication reviews in primary care (IMAB-Qi PDG) (now complete)
- Improving patient recovery following hip fracture through caregiver support (JOINT SUPPORT)
- Complex intervention to prevent returning to smoking postpartum (BabyBreathe)
- Fighting fatigue in the NHS ambulance workforce (CATNAPS)
- Estimating the effectiveness and cost-effectiveness of a complex intervention to increase care-home staff influenza vaccination rates (FluCare)
- Improving the long-term care of patients who have had bariatric surgery (PROMISECARE)
- Decision support tool to optimise community-based tailored management of sleep for people living with dementia or mild cognitive impairment (TIMES)
- Social prescribing for people to live enjoyably with dementia/memory problems in daily life (SPLENDID)
- Outdoor mobility after hip fracture (Outdoor Mobility)
- Inflammation, nutrition and the evolution of multiple long-term conditions – an AI-based analysis of intersectionality in longitudinal health data – the InflAIM project

Supporting primary care research

We have a dedicated and passionate primary care workforce who recognise the importance of research for both their patients and their own professional development.

In total, 91 of 105 practices (87%) in Norfolk and Waveney were involved in research in 2023/24, recruiting one or more participants to nationally important research. 53 practices are on an RSI (Research Site Initiative) research contract with the NIHR CRN (either individually or part of a cluster) – these practices receive activity-based funding to develop and maintain their research infrastructure to better enable them to take on studies. 93% of all research participants were recruited within these RSI practices, with over 5800 participants (66%) coming from just ten RSI practices.

Overall Norfolk and Waveney practices recruited 8,763 participants to 22 NIHR Portfolio studies (Appendix B: Studies active during 2023/24 Figures 1 and 2), with the Measuring Loneliness Study (an online survey to measure the extent that individuals are feeling lonely and/or socially isolated) being the top recruiting study, followed by the Discover Me Study (Case Study 2). This maintained our position as the highest recruiter in Primary Care in the Eastern region. At Primary Care Network (PCN) level, the top three recruiting networks were:

- Norwich PCN: 2,843
- Lowestoft PCN: 1,558
- Breckland Surgeries PCN: 1,266

Supporting commercial research in primary care

Commercial research is research that is developed and funded by industry and is a growing area of importance both locally and nationally, particularly in the Primary Care setting which has been highlighted as *“a negligible provider of clinical trial activity, despite the opportunities it provides... and there is too much reliance on hospital settings for the delivery of trials”*²

We know that research funded by commercial companies increases access to new and innovative treatments, closer to home, which is what our community engagement work has told us people want. It can also provide an additional income stream for NHS organisations and contribute to workforce skill development.

In 2022/23, 18% of commercial recruitment in England (5,961 participants) was from 331 GPs, with a further 186 GPs acting as Participant Identification Centres, despite only 3.5% (43) of all recruiting commercial studies taking place in primary care³. Of the 22 recruiting studies in Norfolk and Waveney in 23/24, 5 (23%) were commercial, with 2,045 (23%) of recruits being attributed to commercial research – the majority of these being attributed to the Discover Me study (see **case study 2** below), which is an atypical commercial study. Most commercial studies recruit relatively small numbers of participants per practice (tens of participants rather than hundreds).

Alongside colleagues in the CRN, we have worked to understand the extent of commercial research taking place in primary care in Norfolk and Waveney and the barriers and facilitators to this. We know there are pockets of excellence, for example within Breckland Primary Care Network, and in 2023, 11 practices across the system were rewarded for their commercial research work by the Department of Health and Social Care, receiving £35k of additional funding as part of the RESET RCF programme. We want to learn from this success, share best practice across

² [Commercial clinical trials in the UK: the Lord O'Shaughnessy review - final report - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118037/commercial-clinical-trials-in-the-uk-the-lord-oshaughnessy-review-final-report.pdf)

³ Data taken from NIHR All Portfolio 2022-23 Annual Cut

the system and support more practices within the region to be able to undertake commercial work.

Case Study 2

The Discover Me Study



The Discover Me study, funded and sponsored by Omnigen Biodata Ltd, aims to recruit thousands of adults from GP practices across the UK from a broad and ethnically diverse population. With consent, researchers will integrate participants' health record data with newly collected genetic data (a saliva sample or mouth swab, for DNA extraction), to build models of disease risk and progression, and to help inform patient management in primary care. This will create a dynamic resource of demographic, health and genetic data to help better understand clinical disease progression in primary care and risk prediction.

Primary Care Involvement

Norfolk and Waveney GPs recruited 1,983 participants to the Discover Me in 2023/24 (3,379 to date since the study started in November 2019, representing 39% of the participants recruited in the EoE region). St Stephens Gate Medical Partnership is one of the top 10 recruiting practices nationally.

Why is this study important?

By collecting health and genetic information on thousands of people, Discover Me aims to find out why diseases may affect some people more than others. This could help transform healthcare.

As part of Discover Me, participants can learn more about their own health and ancestry, supporting them and their GP to make better decisions about health and care.

Local Activity

Our commercial activity locally is growing - in 2023-24 the Research Office reviewed and assured 13 commercial studies in Primary Care, four times the total in 2022-23, where 3 were assured. Dr Serge Engamba, at North Norfolk Primary Care is the Chief Investigator (UK lead) in two studies: the NASH study, which aims to detect non-alcoholic steatohepatitis-induced alterations using food flavours, and the OptiZest study, which is a prospective observational proof-of-concept study of Zestril dose optimisation protocol in patients with uncomplicated primary hypertension.

NCVR – Making it easier to take part in commercial research

The [National Contract Value Review \(NCVR\)](#) process is the UK's national approach to costing and contracting for commercial research. NCVR takes the burden of costing and contract negotiation away from research sites, enabling organisations to focus on opening the study to their patients quicker, whilst mandatory for Trusts, the scheme is voluntary for Primary Care but can make it easier to set-up commercial trials.

Alex Zhekova, ICB Research Manager, was appointed as a NCVR Champion for East of England and is working with the CRN, as well as individual GP practices, to provide knowledge and understanding of NCVR, and encourage practices to sign up to the scheme. At the time of writing, 27 GP practices across the East of England region have already signed up to NCVR, with 14 of these in the NHS Norfolk and Waveney region.

Practices are also working collaboratively with the Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH) on a number of commercial studies - NNUH is acting as a Patient Identification Centre (PIC) for the NASH study; whereas 3 practices (St Stephens Gate Medical Practice, the Breckland Alliance and North Norfolk Primary Care) are acting as PICs for the NNUH REIMAGINE 2 study trialling novel treatment for type 2 diabetes.

Supporting community care research

We support community research at NCH&C and ECCH via a Service Level Agreement (SLA) and work in collaboration with the Research Teams within these organisations to support the management and governance of research.

- In total, 278 participants were recruited to 20 community care NIHR Portfolio studies at NCH&C during 2023/24. Eight different studies recruited 10 or more participants (Appendix C - Figure 3). The top recruiting study was the Measuring of Loneliness Study- an online survey which aims to measure the extent that individuals are feeling lonely and/or socially isolated.
- ECCH recruited 23 participants to 3 studies, one of which recruited 17 participants (Appendix C - Figure 4).

4. Evidence and Evaluation

Evidence and Evaluation Hub

The Evidence and Evaluation (EE) Hub supports the ICB with its statutory duty to use evidence in decision making. It is a quasi-independent, data-led team and is dedicated to identifying the best outcomes for our population. Initially set up as a

two-year pilot, the Hub now has a permanent role in the ICB, with a core team of four staff and supports many projects and programmes.

This year, the EE Hub has been involved in 15 active evaluation projects, produced two evidence briefings and completed 10 evaluations. The Hub was also approached for initial discussion about 28 potential projects and provided advice and support on 23 projects.

Active evaluations

As in the previous year, our active evaluations have addressed a range of subject areas including evaluation of a hydration care intervention, of a wrap-around support service for individuals at risk of health deterioration or hospital readmission. EE Hub activity on these projects varied considerably and included:

- designing and conducting full evaluation (for example of the Health Connect service in Great Yarmouth and Waveney)
- conducting rapid evaluation (for example of the adoption of the Shared Care Record in a small sample of local organisations)
- conducting discrete components of a broader evaluation and providing additional methodological support (for example, of the Clinical and Care Professional Leadership programme).

Completed evaluations

The Hub completed the following evaluations during 2023/24:

- Cancer Pathways: Personalised Care (Norfolk and Waveney ICB Cancer Team)
- Health Connect (Great Yarmouth and Waveney Place – Pathway Redesign Team)
- Legacy Mentor Service (Norfolk and Waveney ICB Workforce Transformation Team)
- Hydration Pilot phase 1 (Norfolk and Waveney ICB Infection Prevention and Control Team; case study 3)
- Digital wearable in care homes (Norfolk and Waveney ICB Digital Care Homes and Social Care Team)
- Virtual Ward phase 1 (Norfolk and Waveney ICB Urgent and Emergency Care Team)
- Remote observations pilot (Norfolk and Waveney ICB Digital Care Homes and Social Care Team)
- Mental Health Crisis Alternatives (Norfolk and Waveney ICB Mental Health Strategic Commissioning Team)
- Research Engagement Network Development (REND Core Group)
- Cancer Care Navigators NNUH (Norfolk and Waveney ICB Cancer Team)

Evidence and evaluation advice, support and training

Our advice and support activity has continued to form a substantial part of our work and has enabled us to provide an educational function across the ICB regarding the use of evidence and evaluation.

We received fewer new approaches for support this year (28 this year compared with 39 in 2022/23), however, requests for support often required an in-depth response and at times substantial work such as engagement in activity to ensure evidence was incorporated into planning processes. The nature of new approaches reflected the diversity of the ICB's work and included:

- requests for advice on data collection tools (for example, questionnaire design)
- enquiries about support for specific evaluations
- broader discussions regarding inclusion of evaluation in the context of new programme development.

The Hub has provided advice on the use of evidence to many colleagues across the organisation. This includes advice on accessing evidence through bibliographic sources, on synthesising findings from available evidence and on using evidence to plan, deliver and evaluate projects and services. The two evidence briefings written by the Hub during this reporting period were:

- The outcomes of Electronic Patient Record (EPR) implementation in acute settings
- Urgent and emergency care in Norfolk and Waveney

We also delivered several interactive logic model sessions during the course of the year, enabling colleagues to explore how models can support the planning, implementation and evaluation of services. Feedback was very positive, with many participants commenting that a logic modelling approach would provide a robust systematic framework for service development.

We completed our first programme of "lunchtime learning" during 2023/24. This involved monthly sessions between May and December addressing topics such as "What is service evaluation?", "All about evidence", "Practical issues in conducting service evaluation" and "Using logic models to underpin service evaluation". These sessions aimed to provide informal introduction and discussion in relation to projects that were relevant to participants, and sessions were attended by between two and six ICB staff at a time. Although uptake of this offer has been relatively low, participants had an active role in sessions. Feedback has been positive, and we have extended our offer for the forthcoming year.

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Case Study 3

Evaluation of a hydration care pilot (year 1)

The EE Hub conducted an evaluation of year 1 of a hydration care pilot, which took place in eight residential care homes in Norfolk and Waveney. The pilot aimed to increase residents' hydration, reduce urinary tract infections (UTIs), and reduce antimicrobial prescribing by implementing a hydration care intervention.

The evaluation identified improvements in care home hydration practices, with care home staff reporting improvements in the health and alertness of residents, and in the wellbeing of staff themselves. The training delivered as part of the intervention provided knowledge, ideas and valuable networking opportunities for staff. Staff gained a better understanding of the links between dehydration, UTIs and falls.

A focus on implementation and impact set out to inform potential scalability of the pilot, with recommendations focused on training, funding, the Hydration Champion role, implementation support, and increasing education around the UTI checklist in primary and community care.

The pilot subsequently received funding to scale-up, with participation in year 2 (2024/25) of the pilot being offered to all care homes in Norfolk and Waveney. Implications for scalability identified in the evaluation helped inform changes to this phase of implementation.

5. Community Involvement and Engagement

We have undertaken several initiatives this year to increase community involvement and engagement. We:

- successfully bid for funding (£150k) from NHS England for a second phase development of a Research Engagement Network (REN). Working with our partners (Norfolk Community Foundation⁴, Suffolk Community Foundation⁵, NIHR Clinical Research Network and Community Voices⁶) we recruited, trained, and supported individuals through 16 VCSEs in under-served communities across Norfolk and Waveney to have conversations in their communities about the barriers and solutions to participating in research. Over 436 conversations were recorded and an evaluation of REN was completed and distributed in April. Our next steps will

⁴ [Norfolk Community Foundation | Together, Norfolk shines brighter \(norfolkfoundation.com\)](https://norfolkfoundation.com)

⁵ [Home page - Suffolk Community Foundation \(suffolkcf.org.uk\)](https://suffolkcf.org.uk)

⁶ [Community Voices - Norfolk and Waveney ICS \(improvinglivesnw.org.uk\)](https://improvinglivesnw.org.uk)

be guided by face-to-face meetings with our VCSE groups. An example of this work can be seen in Case Study 4.

- supported the successful application to NHS England for REN 3, led by Dr Caroline Barry, to explore the barriers to research participation for those at end of life.
- have built relationships with community groups to explore research engagement and dissemination of research information and resources.

Case Study 4

Engaging in community research conversations - Opening Doors*

Opening Doors is a user led organisation run by people with learning disabilities. It is run for people with learning disabilities and or autism to have their say and be more confident to speak up to make their own decisions and live the life they want to have. On joining REN, Opening Doors used their established model for gathering insights and hearing and understanding people's views from their communities, a different approach to other VCSEs in REN.

The experts by lived experience worked alongside advisers without learning disabilities to understand the questions the local REN team had developed – 'translating' them into concepts and phrasing and choosing words that people with learning disabilities would be able to understand. The experts by lived experience designed and tested the co-produced easy read documents and used them as printed books and A3 worksheets to have individual and group conversations. Participants chose then used individual 'character' stampers to record anonymously their opinions and ideas. The experts by lived experience who designed the easy read tools then delivered the workshops across Norfolk with support of people they trust. The conversations were supported in their local advocacy groups including one in a locked secure setting. Finally, they co-produced an easy read booklet summarising all the recorded conversations and feedback (with a hard copy) to all the Advocacy Groups.

The Opening Doors approach was inclusive and flexible, adapting to different needs – e.g. people in a secure unit, people with dementia and learning disability and with autism, people who prefer a different format for recording conversations in line with the 2016 Accessible Information Standard. The material they produced provided invaluable insight into the accessibility of research and research participation for people with learning disabilities. The resources Opening Doors have developed have been shared with all REN VCSEs locally and they have said they are an invaluable resource for starting conversations within their own communities.

***We are grateful to Opening Doors for working on this case study with the EE Hub.**

6. Innovation

In response to our statutory duty to promote innovation and in line with ICS Joint Forward Plan ambitions for 2023 and 2024 as well as the Research and Innovation strategy, we have undertaken several innovation activities. We appointed a Head of Innovation in October 2023, jointly funded by Health Innovation East (HIE). This will help to ensure the ICB meets the statutory duty to promote innovation across the ICS.

We have developed four core innovation objectives:

- raise the profile of innovation across ICS partners and emphasise the importance of embedding innovation.
- develop systematic processes for the identification, selection, and governance of innovation/s to meet N&W population healthcare needs and clinical challenges.
- promote healthcare equality and equity through supporting the sharing, scale-up, spread and sustainability of impactful innovations across N&W ICS.
- promote an innovation culture and grow an innovation, aware, capable, and competent workforce.

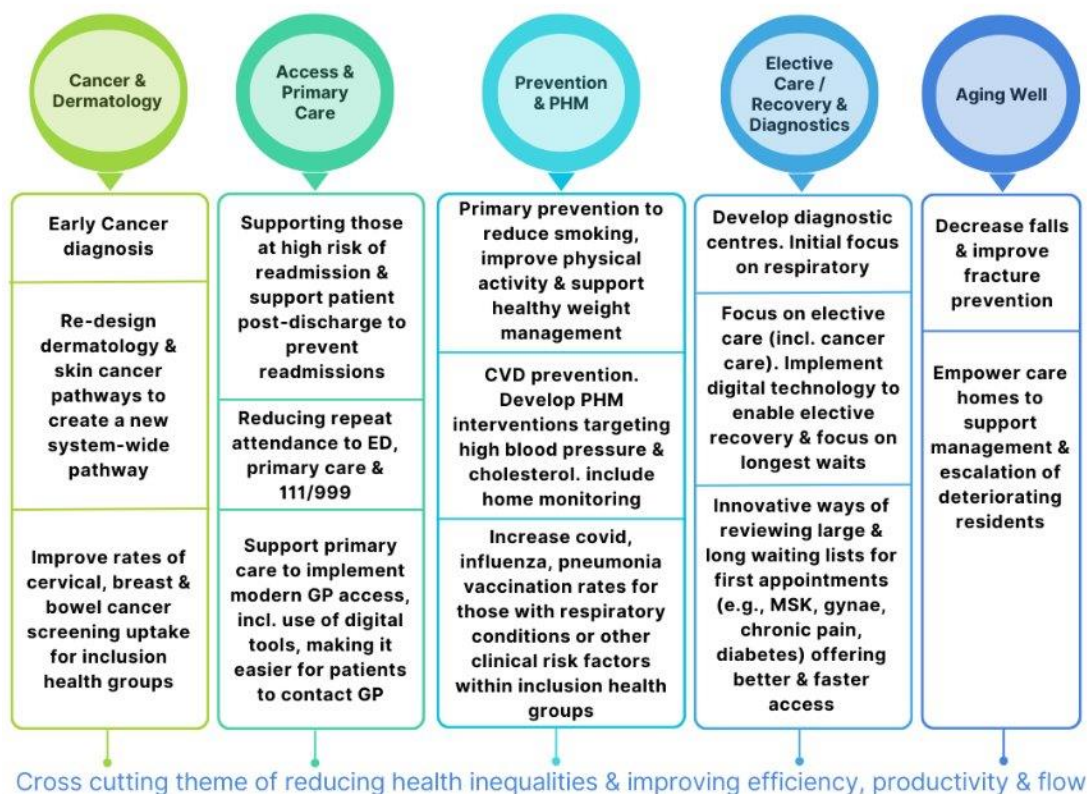
NHS Innovation Sites (InSites) programme

We successfully applied to become one of 18 NHS England funded Innovation Sites (InSites), working on behalf of the ICS. The InSites programme aims to align processes, share intelligence on implementation of innovations and build capability within the InSites. This programme commenced in December 2023, and we have been awarded £200k, to work with this programme to accelerate our innovation objectives. So far, we have used the funding to support project management capacity, elements of our innovation culture and networking activities and we will allocate a limited budget for implementing innovation projects.

Innovation system priorities

Innovation scoping, matching and implementation is primarily aligned to system agreed objectives and ambitions. We have used the Joint Forward Plan ambitions and clinical strategy objectives to develop an initial prioritised list of areas (see figure below) where innovation scoping and support has commenced. We have begun working proactively with programme teams and providers responsible for these innovation priority areas to explore innovation needs and if appropriate work with them to scope possible innovations.

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We have also worked with our Children and Young People’s Mental Health team to embed and evaluate a digital innovation to support children with anxiety difficulties (see Case Study 5).

Case Study 5

Working on Worries

We have worked with the ICB’s Children and Young People’s Mental Health team and local providers to establish a programme to implement and evaluate a new evidence-based parent-led Cognitive Behavioural Therapy (CBT) informed anxiety intervention, called Online Support Intervention (OSI). OSI is a digital intervention designed to guide parents/cares of children with anxiety difficulties through a CBT intervention. WoW has been training and supporting pastoral workers in primary schools and local clinicians to deliver this intervention to parents/carers. Evalaution to date suggests that this work is impactful and experienced positively. We have supported the project team to secure additional funding to continue this programme in to 2024/2025.

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Innovation network

We have established and convened the first ICS innovation network of over 90 representatives from across the ICB, NHS providers and VCSE organisations. The purpose is to bring together a community of professionals working within the N&W ICS whose job remit and/or professional interest are to lead, support and enable innovation. The Network offers the opportunity to work together, share best practice and create an integrated innovation culture based on learning from each other. The Network also works in partnership with local, regional, and national stakeholder organisations, such as Health Innovation East.

Innovation training and competency development

We have also developed a set of requirements for ICS wide innovation training and competency development. We have established our ICS innovation training needs across different levels and in 2024/2025 will be commissioning training / workshops for senior leaders and executives, all staff introductory training, and workshops aimed at those with a specific innovation remit or role across organisations.

Innovation Champions

As we have been working with ICS representatives in 2023/2024, we have identified that there are not many roles across organisations with a remit to develop, embed and implement innovation. We have therefore designed an 'Innovation Champions' programme which aims to identify those that have an interest or remit for growing innovation, providing them with either remuneration for 1-2 hours per week and/or CPD and learning opportunities, with the hope that a small group can collaboratively work together to enhance how we integrate innovation across the system.

Embedding as part of an ICS Innovation ecosystem

We have mapped out the wider innovation ecosystem across N&W including councils, higher education institutes (e.g., UEA) and the Norwich Research Park. We are actively liaising with these institutions to consider how we can collaborate to optimise the integration of innovation to benefit the health of the N&W population.

7. Next Year

This year will see us working with our system partners and stakeholders to drive the delivery of the ICS Research and Innovation strategy, based on the recommendations to be published in May 2024.

As a team we will focus on these key areas:

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- community engagement and involvement in research, working with CRN, VCSE and UEA colleagues across Norfolk and Waveney, with a focus on seldom heard groups
- embedding a culture of evidence use and evaluations in service design, transformation and service delivery, supporting quality across the ICS
- facilitating the delivery of high-quality research in out of hospital settings, including supporting primary care to increase commercial research activity
- working with local, regional and national colleagues to explore the most effective way of ensuring the results of research are used to improve health and care
- developing an innovation culture across the ICS.

Report compiled by the Research and Evaluation Team:

Dr Vicky Adams, Lane Binder, Dr Catherine Boyle, Margaret Brown, Sarah Chapman, Dr Tim Clarke, Emily Frost, Jack Hallworth, Dr Tessa Kasia, Gosia Majsak-Newman, Ria Markwell, Dr Gigi Moller, Lisa Osborne, Dr Rebecca Owens, Jacqueline Romero, Clare Symms, Dr Michael Twigg, Dr Matthew Whelband, Dr Clara Yates, Aleksandra Zhekova.

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Appendix A: Research and Evaluation Team income

Income for the Team is from a variety of sources and in 23/24 totalled £3.4m. Income is broken down as follows. Please note that much of this income is spend on projects through our project partners:

NIHR Clinical Research Network (East of England) funding:

- Partnership Agreement: £194,770 for 3.32 whole time equivalent posts
- Norfolk Community Foundation PPIE Project - £3,500
- Commercial Costing Funding: £1,000

NIHR Research Capability Funding (RCF):

- £535,407

NIHR RESET RCF (pass through monies for practices):

- £35,000

NIHR CRN Co-ordinating Centre

- NCVR Secondment - £2,135

NIHR Research awards:

- Babybreathe - £231,800
- CATNAPS - £92,839
- Flucare - £516,059
- Jennifer Seddon - £10,036
- JOINT SUPPORT- £130,000
- INFLAIM - £87,547
- Structured medication support - £6,296
- CHIPPS - £2,630
- OUTDOOR MOBILITY - £104,577
- PROMISECARE– £90,000
- SPLENDID - £539,947
- TIMES - £305,981
- TRIP - £15,000

NHS England Projects:

- Research Engagement Network Development (REN2): £150,000
- Research Engagement Network Development (REN3): £95,000
- Evaluation of hydration in care homes pilot: £17,500

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Insites Programme

- £200,000

Service level agreements:

- £30,504

Evaluation Monies

- Shared Care Record Evaluation - £27,406
- HCDA Evaluation - £27,406
- Cancer Transformation Evaluation - £23,000
- HTAAF - £50,000

Health Innovation East

- Part funding for Head of Innovation Post - £23,114

JPUH / NICHE Scholarships

- £4,600

NHS Excess Treatment Costs

- £48,532

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Appendix B: Studies active during 2023/24

Community Care

Project Short title	Project Summary	IRAS Number	Project Type	Project site status (April-2023)	Planned End Date
Parkinson's and Movement Disorders Families Project (PFP)	The study aims to identify new genes that predispose or cause Parkinson's Disease, Parkinsonism, and other movement disorders.	162268	Non-commercial portfolio	Open	01/01/2030
CORE-VNS	Comprehensive Outcomes Registry in Subjects with Epilepsy Treated with Vagus Nerve Stimulation Therapy®	242687	Commercial portfolio	Closed to recruitment - in follow up	31/12/2023
Trauma-AID	Intervention: To assess if general populations treatments would be effective or provide value for money when used with PwID. Eye movement desensitization and reprogramming (EMDR) is an effective treatment in the general adult population. The first stages of treatment psychoeducation and stabilisation (PES) and EMDR help PwID develop strategies to calm their turbulent emotions; the later EMDR stages involve focusing attention on past traumatic events while making controlled eye movements.	260514	Non-commercial portfolio	Open	30/06/2024
A Register for New Anti-Epileptic Drugs In ID/PDD populations	A register for collecting and measuring outcomes of licensed Anti-Epileptic drugs (AEDs) in patients with Epilepsy and Intellectual Disability (ID) and/or Pervasive Developmental Disorders (PDD)	160521	Non-commercial portfolio	Open	30/11/2024
RECREATE: a cluster randomised trial	This study is the fifth of five workstreams in a National Institute for Health Research funded seven-year research programme, which seeks to develop and evaluate strategies for reducing sedentary behaviour in people after stroke to improve outcomes. We are developing and evaluating a complex intervention to target sedentary behaviour after stroke.	271111	Non-commercial portfolio	Closed to recruitment - in follow up	31/08/2023
Can we use c-SIGHT for spatial neglect in stroke survivor's homes?	Spatial neglect is a common post-stroke condition, meaning people may not be aware of anything on one side. Currently, there is no effective treatment and widely used paper-and-pencil tests often under diagnose spatial neglect. Here, we will test if a new computerised therapy for neglect (c-SIGHT; computerised Spatial Inattention Grasping Home-based Therapy) can be self-administered at home, and how to carry out a large-scale clinical trial	275001	Non-commercial portfolio	Open	31/08/2023

Project Short title	Project Summary	IRAS Number	Project Type	Project site status (April-2023)	Planned End Date
STRATA	Anxiety is common in autistic adults and can be more disabling than the core features of autism. Medications for anxiety are often prescribed for autistic adults but their effectiveness or side effects in this population are not well known. Research findings in non-autistic populations may not apply to autistic adults. This study aims to find out whether the drug sertraline is an effective treatment for anxiety in adults with a diagnosis of autism.	270727	Non-commercial portfolio	Closed to recruitment - in follow up	30/11/2023
Vapeline	We recently completed a trial which showed e-cigarettes (EC) are more effective in helping smokers quit than nicotine replacement therapy (NRT), e.g. patches, chewing gum. EC and NRT were used within the specialist stop-smoking services (SSS) and accompanied by weekly support sessions. SSS are important; however, attendance requires time and effort and under 5% of smokers attend. Less intensive treatments may be less effective but can reach more smokers and thus help more people. This trial will show whether, and to what extent, EC can help smokers quit with less intensive or no support.	284500	Non-commercial portfolio	Closed to recruitment - in follow up	31/03/2024
Adult ONS trial	The aim of this study is to evaluate compliance, acceptability, gastrointestinal tolerance, nutrient intake, appetite, nutritional status, and safety of three new ready to drink ONS: 1) an energy dense (3.2kcal/ml) low-volume (125ml) ONS; 2) a juice-style ONS with increased protein content (12 g/200ml); and 3) a plant-based ONS. This is a prospective, 3-independent arm, longitudinal, 28-day intervention study with a 1-day baseline period. During the intervention period, patients will receive one of the three ONS for 28 days alongside their routine diet. The study is being conducted for Advisory Committee on Borderline Substances (ACBS) and General Medical	299055	Commercial portfolio	Open	01/08/2024
RCT of group CBT for men with IDD and harmful sexual behaviour	Some men who commit sex offences have learning disabilities or autism. However, these men often do not get any treatment. This project will offer men with learning disabilities and/or autism the same kind of treatment that non-disabled men get. The treatment has been specifically adapted for them and is called SOTSEC-ID. We will look at whether this is helpful for the men, in the way they feel and the way they behave.	291027	Non-commercial portfolio	Closed to recruitment - in follow up	31/03/2026
Feasibility Randomised-Controlled Trial of online stroke interventions	Many people experience difficulties with organising their behaviour and problem-solving (also known as executive functioning) after they have a stroke. This can have serious and wide-ranging consequences for their wellbeing and ability to regain independence. While the importance of applying these skills has been recognised, there is not enough research evidence to recommend any specific interventions for executive functioning after stroke. We want to design a treatment to help people who have had a stroke acquire organisational and problem-solving skills, to make it easier for them to set goals and achieve them, aiding them in adapting to everyday life.	305848	Non-commercial non-portfolio	Closed	15/09/2023

Project Short title	Project Summary	IRAS Number	Project Type	Project site status (April-2023)	Planned End Date
CHElsea II Trial	The CHElsea II trial is a cluster randomised trial comparing the standard mouthcare with Clinically Assisted Hydration (CAH) versus the standard of mouthcare only in patients who are in the last days of life.	313640	Non-commercial portfolio	Open	31/10/2024
The MELD Study: Stage 2	This research is about community-based services across England that support children with a LD and BtC, and their families. We want to find out if the way that services are structured and organised (known as "service models") has any effect on the outcomes of children with LD and BtC and their families, and what their experiences of services are.	310149	Non-commercial portfolio	Open	30/06/2025
Clinical and cost-effectiveness of alternative urinary catheter design	The 'Optitip' catheter is being increasingly used in the NHS despite lack of evidence and higher cost (compare to the 'Foley') was determined to have the most potential to reduce the UTI rates for long-term users as well as being cost-effective. Patients (aged 18 years or over) using an indwelling catheter long-term will be randomly allocated to one of two groups. One group will receive the standard 'Foley' catheter while the second group will receive the 'Optitip' catheter from their next planned catheter change for 12 months. We will assess the result of the study by recording the number of UTIs over 12 months based on antibiotics prescribed for UTI treatment and at least one of a list of UTI related symptoms.	316986	Non-commercial portfolio	Closed to recruitment - in follow up	30/09/2025
Biatain Silicone 3DFIT Study (BISIL Study)	This study (BISIL) will compare the Biatain® Silicone dressing to commonly used wound care products (Aquacel® EXTRA used with Mepilex® Border). All products used in this study are CE-marked medical devices which are already available in the UK. The main objective is to compare the reduction in wound area over four weeks between the two treatment groups. The study will also look at other aspects of wound healing and compare the costs of the dressings and the participants' quality of life during the study period. In a subgroup of participants, ultrasound will be used to assess the contact between the dressings and the wound.	315855	Commercial portfolio	Closed - follow up complete	31/12/2023
Transcutaneous Limb Recovery Post-Stroke (TRICEPS)	TRICEPS aims to determine whether Transcutaneous Vagus Nerve Stimulation (TVNS) paired with rehabilitation therapy of the affected arm post stroke improves motor function in participants with arm weakness following a stroke.	308254	Non-commercial portfolio	Open	31/01/2025
Wordless vaccine information for people with intellectual disabilities	The aim of our project is to develop a picture book for people with learning disabilities that explains in pictures about having an injection for the Coronavirus (COVID-19). There is already a lot of information on television, in the newspapers, on the internet and in hospitals and GP practices about the Coronavirus and the new vaccinations that have recently been developed. But this mostly involves a lot of words and sometimes in Easy Read – words and pictures. For some people, words are very hard to follow and to understand and remember.	296159	Non-commercial portfolio	Closed - follow up complete	31/07/2023

Project Short title	Project Summary	IRAS Number	Project Type	Project site status (April-2023)	Planned End Date
Investigating healthcare professionals' learning at work v.1	Most workplace learning occurs on the job, informally. However, our understanding of informal learning is de-contextualised, and we know little about how it takes place during times of adversity and macroturbulence. The unprecedented strain the Covid-19 pandemic has placed on healthcare professionals renders healthcare a compelling setting to examine how individuals learn informally during crises. The proposed study will achieve this aim by focusing on interpersonal interactions as they are deemed an inherent aspect of the healthcare context and a key source of informal learning. We propose an inductive research design, undertaking semi-structured interviews with healthcare professionals in two NHS Trusts. The collected data will be analysed using thematic analysis and Gioia et al.'s methodology, while the findings will be disseminated through submissions to top academic outlets, knowledge-transfer workshops and a policy document.	306754	Non-commercial portfolio	Closed	30/06/2023
Experiences of therapeutic relationships with health professionals	This study is looking at how adults with learning disabilities (LDs) experience therapeutic relationships with health staff.	321563	Academic/student	Closed	20/09/2024
LISTEN	The LISTEN project is developing, delivering and evaluating an intervention which is a package of self-management support, to see if this helps individuals with long Covid to live their normal lives. The intervention is co-designed with individuals living with long Covid and a large patient and public panel from diverse backgrounds to ensure that the intervention can be personalised to individual needs.	306220	Non-commercial portfolio	Closed to recruitment - in follow up	31/08/2023
WC-22-435 A study to compare dressings for venous leg ulcers	This study compares two different antimicrobial dressings that can be used to treat venous leg ulcers to see which one works best. Both dressings are currently available and routinely used in clinical practice. One dressing has chemicals that break apart the biofilms once they are formed. One dressing has chemicals that bind to the bacteria so that they can't form a biofilm. Both dressings reduce the number of bacteria in the leg ulcer and are used regularly in clinical practice.	326566	Commercial portfolio	Closed to recruitment - in follow up	01/06/2024
Nursing Entrepreneurship Competencies and NHS Innovation	The study aims to understand the impact of entrepreneurship competencies on innovative work behaviour amongst NHS nurses. NMC certified nurses will take part in a quantitative online survey, with a subset then taking part in a qualitative interview.	324315	Academic/student	Closed	31/08/2025
OUTDOOR	Only one in four people can go outdoors four months after breaking their hip. Helping people get back to going outdoors could lower their chances of new illness, loneliness, or needing more support from friends and family. This NIHR funded study wants to see if the NHS can better support people who break their hip to get back to going outdoors.	329085	Non-commercial portfolio	Open	30/10/2024

Project Short title	Project Summary	IRAS Number	Project Type	Project site status (April-2023)	Planned End Date
SPaCE	Support for Parent Carers in England- study aiming to map the current pathways through which parent carers experiencing mental health problems gain access to support or treatment in England	316051	Non-commercial portfolio	Closed	31/12/2023
How parents of young adults with ID experiences transition: version1.0	This study aims to learn about the experience of parents supporting their child with the move from an LD CAMHS to an adult community learning disability service (CLDT). This will help to know how we can help families with transition and how we can make services better	321907	Non-commercial non-portfolio	Open	01/10/2024
LOCOMOTION	The aim of this study is to produce a 'gold standard' for care by analysing what is happening to patients now, creating new systems of care and evaluating them to establish best practice. This research takes place in 10 UK-wide LC clinics treating 5000 patients and involves three parallel workstreams (WS1, WS2 and WS3). Working with health professionals and people with LC, we found that the key priorities are correct clinical assessment; advice and treatment; and help with returning to work and other roles.	303623	Non-commercial portfolio	Open	30/06/2024
Autistic adults experience social trauma	The study will use individual semi-structured interviews to collect data and gain lived experience of the participants.	322252	Academic/student	Closed	30/11/2023
Awareness Detection and Communication in Disorders of Consciousness	EEG based Awareness Detection and Communication in Prolonged Disorders of Consciousness and Physical Disability	136640	Non-commercial portfolio	Open	31/08/2026
Brain Training App for Cognition in People with Long Covid (BEACON)	The Reasoning Cognitive Training (ReaCT) brain training programme is available online and is known to help maintain brain health in older adults but has not yet been tested in people with Long-Covid. This study aims to establish the effectiveness and cost-effectiveness of the ReaCT brain training programme in adults with cognitive impairment following Covid-19.	327021	Non-commercial portfolio	Open	14/07/2024
The PETAL intervention	This cluster randomised controlled trial aims to investigate whether a new multi-component personalised psychosocial intervention is clinically and cost-effective to address aggression (e.g., improved health, better quality of life) in adults with intellectual disability. The PETAL intervention has been co-produced with family carers and adults with intellectual disability alongside researchers and clinicians in intellectual disability. This project will take place in community intellectual disability services across the UK (e.g., England, Scotland and Northern Ireland) delivering either: 1. the PETAL intervention alongside Treatment As Usual (TAU) or 2. TAU alone. That means that adults with intellectual disability will have access to care anyway. We will compare the outcomes for those in the two intervention groups.	316749	Non-commercial portfolio	Open	30/09/2025

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Project Short title	Project Summary	IRAS Number	Project Type	Project site status (April-2023)	Planned End Date
My Diabetes and Me	The clinical and cost-effectiveness of the DESMOND-ID education programme for adults with intellectual disability and Type 2 diabetes	318439	Non-commercial portfolio	Open	30/09/2024
Frailty and glycaemia in older adults with type 1 diabetes	This study will look at people over the age of 65 with Type 1 diabetes (T1DM). We suspect that older people with more changes associated with frailty are likely to have more fluctuations in their glucose levels and be at greater risk of hypoglycaemia. This has not yet been proven in a trial. In this study, a blood test will be used to assess insulin production. Frailty assessment will involve: quality of life and physical activity questionnaires; and physical tests such as grip strength and walking speed to assess for frailty.	325332	Non-commercial portfolio	Open	01/10/2025
Study investigating an upper-limb VR rehabilitation system for stroke	The NeuroVirt system is a new device that has been developed for people after stroke. It uses games that can be played within a virtual reality environment to encourage stroke survivors to carry out their exercises. We are aiming to find out whether NeuroVirt will be acceptable in people's own homes and whether this might motivate them to do their usual exercises more than people who are not using NeuroVirt.	330780	Non-commercial non-portfolio	Open	04/12/2023
Swallow Training with Biofeedback in Acute Post Stroke Dysphagia	About 50% of people who have a stroke experience difficulty swallowing. There is a growing evidence base showing that swallowing therapy can help to improve swallowing, but we don't know which type or how much therapy is most beneficial. We are further developing one particular intervention - swallow strength and skill training with biofeedback. This involves practicing strong or effortful swallows and practicing controlling the timing of swallowing using visual feedback on a screen showing the activity of the muscles involved in swallowing. We want to know whether trained clinicians are able to deliver this therapy in acute hospital settings early after stroke.	319969	Non-commercial portfolio	Open	20/09/2024
Clinical usability evaluation of an Adaptive Templates Fitting System for socket design	The principal objective of this study is to evaluate the clinical usability of the ATFS that combines Adaptive Templates technology with the experience and expertise of the clinician to provide optimal socket design support. Stage One of the study will explore the strengths and limitations of the in-clinic usability of the ATFS to inform its further development, and; Stage Two will assess the in-clinic usability of ATFS and verify the safety and efficiency of its use.	317901	Commercial portfolio		28/06/2024
Environmental factors on DFUs incidence - a mixed-mode survey	Diabetic foot ulcers (DFUs) pose a significant threat to the health and wellbeing of diabetic patients. Affecting around 1 in 10 people (NHS North-West Coast Strategic Clinical Networks, 2017) regardless of a diabetes type they often result in a drastically worsened quality of life. They can lead to severe consequences including leg amputations. This survey will help to understand what role various environmental factors have on the incidence, severity, and recurrence of DFUs. Results from this study will help healthcare professionals as well as patients to better understand various factors involved in DFU prevalence.	312284	Non-commercial portfolio	Open	15/02/2025

Project Short title	Project Summary	IRAS Number	Project Type	Project site status (April-2023)	Planned End Date
Long COVID and HRQoL v0.1	Background: Long COVID is estimated to affect 1.7 million people in the UK. One way of assessing the impact of long COVID is to measure quality-of-life through a standard questionnaire, which can then be used to understand the costs of long COVID to the NHS and wider economy. The impact of long COVID on these measures is not currently known. It is important to understand who is worst affected by long COVID and the cost to the NHS, so that strategies like booster vaccines can be prioritised to the right people. Aim: OpenPROMPT aims to understand the impact of long COVID on quality-of-life in adults in English primary care.	304354	Non-commercial portfolio	Open	31/07/2023
The ELSA study	The study to explore the feasibility and acceptability of a system for identifying children in the general population at risk of type 1 diabetes (T1D). The study aims to recruit 20,000 children aged 3-13 years, over a 3-year study period, and will compare the feasibility of different community recruitment strategies including online and social media, general practices, childhood immunisation programmes, and schools. We will undertake fingerstick antibody testing of 20,000 children aged 3-13years. Children at risk will be further risk stratified with oral glucose challenge testing. All children testing positive for diabetes antibodies will be invited to an education session with their family, to be informed about the signs and symptoms of T1D, monitoring programmes available for long-term follow-up, and trials their child may be eligible for to delay the onset of T1D.	309252	Non-commercial portfolio	Project site in setup	28/02/2025
Measuring Loneliness Study	Loneliness & social isolation are rising problems of society. This study aims to measure the extent that individuals are feeling lonely and/or socially isolated using a brief eSurvey.	305483	Non-commercial portfolio	Open	30/10/2024
Restorative Just Culture:implementation and effectiveness	In 2019, Northumbria University and Mersey Care NHS Foundation Trust developed a teaching and learning programme based on the principles and practices of Restorative Just Culture (RJC). Research Questions: What are the RJC interventions developed and implemented by NHS Trusts attending a training and learning programme?	331402	Non-commercial non-portfolio	Open	31/08/2024
APOLLO trial	A Proof-of-Concept Study for Vitamin A Nasal Drops in Post-Viral Olfactory Loss	294741	Non-commercial portfolio	Project site in setup	31/05/2024
Venus 6 Compression therapies for treatment of venous leg ulcers V1.0	A randomised controlled trial of compression therapies for the treatment of venous leg ulcers	280987	Non-commercial portfolio	Closed to recruitment - in follow up	31/08/2024

Project Short title	Project Summary	IRAS Number	Project Type	Project site status (April-2023)	Planned End Date
Cultural Humility in palliative care	'Cultural Humility' in palliative care: a practice amongst nurses to reduce social stigma towards older sexual and gender minority patients and their family of choice	N/a	Academic/student	Closed to recruitment - in follow up	01/03/2025
REDUCE Trial: Reducing the impact of DFUs (RCT)	Reducing the impact of diabetic foot ulcers (REDUCE): A effectiveness and cost-effectiveness Randomised Controlled Trial	274384	Non-commercial portfolio	Open	30/09/2025
ACCORD	Adhesive Capsulitis Corticosteroid and Dilation Randomised Controlled Trial: A Feasibility Study in Primary Care	314582	Non-commercial portfolio	Closed to recruitment - in follow up	30/03/2024
Reduction of Bacteriuria Cam-Cath-001	'A Prospective Multicentre Randomized Study to assess the impact of a catheter coating on clinical bacteriuria.'	283618	Commercial portfolio	Closed to recruitment - in follow up	31/12/2023

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Norfolk and Waveney Primary Care

All studies listed are adopted to NIHR Portfolio. Please note that some studies have now closed.

Project Short title	Project Full title	IRAS Number	Project Type	Project status	End Date
A new relief inhaler for mild Asthma	Randomised controlled trial of a new relief inhaler in mild asthma: the RELIEF trial	1006098	Non-commercial portfolio	Open to recruitment	
Active Brains Study	Active Brains Study	273507	Non-commercial portfolio	Closed to recruitment - in follow up	24/01/2024
Aspirin To Target Arterial Events In Chronic Kidney Disease (ATTACK)	Aspirin To Target Arterial Events in Chronic Kidney Disease	228831	Non-commercial portfolio	Closed to recruitment - in follow up	21/12/2023
AZD4604 (JAK1 inhibitor) in patients with moderate to severe uncontrolled asthma	A Phase 2a Randomised, Double-Blind, Placebo-Controlled, Parallel Arm, Multi-Centre Study to Evaluate the Efficacy and Safety of AZD4604 Twice Daily for Twelve Weeks in Adult Patients with Moderate to Severe Asthma Uncontrolled on Medium-High Dose ICS-LABA	1008584	Commercial portfolio	Open to recruitment	
Brain Training App for Cognition in People with Long Covid (BEACON)	Online brain training for people with cognitive impairment following SARS-CoV-2 infection: A randomised controlled clinical trial	327021	Non-commercial portfolio	Open to recruitment	
Broccoli Effect on glycated haemoglobin (HbA1c) - BETA study	Broccoli Effect on glycated haemoglobin (HbA1c) - BETA study A randomised double-blinded controlled trial	281010	Non-commercial portfolio	Closed to recruitment - in follow up	16/06/2023
C19 in care homes	The association between Covid-19 immune response amongst older Residential and Nursing Care Homes residents and all-cause mortality and hospital admissions – a prospective cohort study	284248	Non-commercial portfolio	Closed to recruitment - in follow up	09/08/2023

Project Short title	Project Full title	IRAS Number	Project Type	Project status	End Date
Comparing COVID-19 Vaccine Schedule Combinations in Adolescents	A single-blind, randomised, phase II multi-centre study to determine reactogenicity and immunogenicity of heterologous prime/boost COVID-19 vaccine schedules in adolescents (COM-COV3)	304450	Non-commercial portfolio	Closed to recruitment - in follow up	30/06/2023
DaRe2THINK	Preventing stroke, premature death and cognitive decline in a broader community of patients with atrial fibrillation using healthcare data for pragmatic research: A randomised controlled trial	290420	Non-commercial portfolio	Open to recruitment	
DIAMOND	Dietary Approaches to the Management Of type 2 Diabetes (DIAMOND) cluster randomised trial	307150	Non-commercial portfolio	Closed to recruitment - no follow up	31/12/2023
Discover Me	Discover Me	258424	Commercial portfolio	Open to recruitment	
Early Liver Disease Breath Detection	Breath detection of non-alcoholic steatohepatitis (NASH)-induced metabolic alterations using food flavors.	330252	Commercial portfolio	Open to recruitment	
Electronic Risk Assessment for Cancer (ERICA)_Version 1	A pragmatic cluster randomised controlled trial assessing the clinical effectiveness and cost effectiveness of electronic risk-assessment for cancer for patients in general practice (ERICA)	255955	Non-commercial portfolio	Open to recruitment	
Evaluating COVID-19 Vaccine Boosters (Cov-Boost)	A randomised phase II UK multi-centre study to determine reactogenicity and immunogenicity of booster vaccination against ancestral and novel variants of SARS-COV-2	299180	Non-commercial portfolio	Open to recruitment	
Evaluation of aid to diagnosis for DDH in general practice, Version 1	Evaluation of an aid to diagnosis for congenital dysplasia of the hip in general practice: controlled trial randomised by practice	259615	Non-commercial portfolio	Open to recruitment	
Exploring perceptions of a GP Decision Support System for diagnosis	Exploring provider and patient perceptions of a Decision Support System for diagnosis	286789	Non-commercial portfolio	Closed to recruitment - no follow up	31/07/2023

Project Short title	Project Full title	IRAS Number	Project Type	Project status	End Date
Immune Defence Study	Reducing recurrent respiratory infections in primary care: The Immune Defence Study	288431	Non-commercial portfolio	Closed to recruitment - in follow up	07/04/2023
Intensive ARI surveillance: focus on RSV	Intensive surveillance of acute respiratory infections (ARI) in primary care with a focus on respiratory syncytial virus (RSV): prospective sentinel network observational study	329790	Commercial portfolio	Open to recruitment	
Interpretation of SPIROMetry +/- AI decision support tool (SPIRO-AID)	A randomized controlled trial comparing SPIROMetric diagnostic performance of primary care clinicians with or without Artificial Intelligence Decision support software	323361	Non-commercial portfolio	Open to recruitment	
Lifestyle discussions in UK primary care: an analysis of consultations	Addressing lifestyle behaviours in the management of diabetes and hypertension: an analysis of recorded primary care consultations	293284	Non-commercial portfolio	Open to recruitment	
Live Well with Parkinson's RCT	Live Well with Parkinson's (as part of the program Personalised care for people with Parkinson's Disease: PD-Care WP4)	294372	Non-commercial portfolio	Closed to recruitment - in follow up	11/07/2023
Long COVID and HRQoL v0.1	Quality-of-life in patients with long COVID: harnessing the scale of big data to quantify the health and economic costs	304354	Non-commercial portfolio	Closed to recruitment - no follow up	31/07/2023
Measuring Loneliness Study	Identifying the Prevalence of Social Isolation & Loneliness in the Community Setting Across England	305483	Non-commercial portfolio	Open to recruitment	
MultiCath	A non-inferiority randomised controlled trial to compare mixed (multi/single-use) catheter management with single-use catheter management by intermittent catheter users over 12 months	252496	Non-commercial portfolio	Closed to recruitment - in follow up	15/06/2023
Next Generation Propellant	A Randomized, Double-Blind, 12-Week, Multi-Center Study to Assess the Safety of Budesonide, Glycopyrronium, and Formoterol Delivered by BGF MDI HFO Compared with	1006119	Commercial portfolio	Closed to recruitment - in follow up	19/05/2023

Project Short title	Project Full title	IRAS Number	Project Type	Project status	End Date
	BGF MDI HFA In Participants with Moderate to Very Severe Chronic Obstructive Pulmonary Disease				
NOAR	The Norfolk Arthritis Register.	0	Non-commercial portfolio	Open to recruitment	
NOAR2	Norfolk Arthritis Register 2	166048	Non-commercial portfolio	Closed - follow up complete	31/07/2023
Observational study in atrial fibrillation (AF) patients at high risk	A Global prospective observationAI study of Real-world managemEnt of patieNts with atrlal fibrillAtion at high risk of stroke (GARDENIA)	316317	Commercial portfolio	Open to recruitment	
Operational failures in general practice: An observational study	Operational failures in general practice: An observational study of what general practitioners do and what gets in the way of doing it	233512	Non-commercial portfolio	Suspended	
OPTIMISE2	Optimising Prescription of Treatment In older patients with Mild hypertension at Increased risk of Serious adverse Events	1006598	Non-commercial portfolio	Open to recruitment	
OptiZest V1.0	Personalised Dose Optimisation of Zestril supported by the Digital Blood Pressure Diary in a Primary Care Environment in England: Pragmatic Observational Pilot Study for Remote Hypertension Treatment (OptiZest)	339990	Commercial portfolio	Open to recruitment	
PANORAMIC	Platform Adaptive trial of NOvel antiViRals for eArly treatMent of covid-19 In the Community	1004274	Non-commercial portfolio	Closed to recruitment - in follow up	28/03/2024
Pragmatic evaluation of a QI programme for modifiable high-risk COPD	A 3-year cluster randomised controlled trial of the impact of a quality improvement and clinical decision support package versus usual care for patients with modifiable high-risk chronic obstructive pulmonary disease with or without a current diagnosis.	295908	Commercial portfolio	Closed to recruitment - in follow up	16/08/2023

Project Short title	Project Full title	IRAS Number	Project Type	Project status	End Date
Primary care responses to mental distress (DeStress-2), Version 1	Implementing effective primary care responses to poverty-related mental distress	303179	Non-commercial portfolio	Closed to recruitment - no follow up	31/12/2023
PRODEMOS	Prevention of Dementia using Mobile phone Applications (PRODEMOS): A randomised implementation trial	257091		Project in Setup	
RAPTOR C-19	Expanding national RAPid community Test evaluation capacity fOR COVID-19	284320	Non-commercial portfolio	Open to recruitment	
RECORD: REported Outcomes in COPD with Trixeo in Real world	A non-interventional, multi-centre study to investigate the change in clinical and patient-reported outcomes in moderate to severe COPD patients treated with TRIxEO (Budesonide / Glycopyrronium / Formoterol) under real-life conditions	308176	Commercial portfolio	Closed to recruitment - in follow up	31/07/2023
Reduction of Bacteriuria Cam-Cath-001	'A Prospective Multicentre Randomized Study to assess the impact of a catheter coating on clinical bacteriuria.'	283618	Commercial portfolio	Open to recruitment	
REIMAGINE 2:	REIMAGINE 2: A research study to see how well CagriSema compared to semaglutide, cagrilintide and placebo lowers blood sugar and body weight in people with type 2 diabetes treated with metformin with or without an SGLT2 inhibitor	1008115	Commercial portfolio	Open to recruitment	
RESTORE	Pharmanovia Trial - Investigating Chloral Hydrate for Severe Insomnia	1007757	Commercial portfolio	Open to recruitment	
SAFER Trial	The SAFER Trial: Screening for Atrial Fibrillation with ECG to Reduce stroke - a randomised controlled trial	272184	Non-commercial portfolio	Closed to recruitment - in follow up	31/01/2024
SAFER Wearables Study	A study of the acceptability and performance of wearables for atrial fibrillation screening in older adults	283812	Non-commercial portfolio	Open to recruitment	

Project Short title	Project Full title	IRAS Number	Project Type	Project status	End Date
SMR-3858	A phase 2B, multicenter, randomized, double-blind, placebo-controlled, dose-finding, efficacy and safety study of HRO350 in subjects with mild to moderate psoriasis (the 'HeROPA' study).	1006508	Commercial portfolio	Open to recruitment	
Stopping Aminosalicylate Therapy in Inactive Crohn's Disease (STATIC)	STopping Aminosalicylate Therapy in Inactive Crohn's Disease (STATIC) Study: A Randomized, Open-label, Non-inferiority Trial	245233	Non-commercial portfolio	Closed to recruitment - in follow up	12/02/2024
Tallored ManagEment of Sleep (TIMES)	Tailored Management of Sleep (TIMES) for people living with dementia or mild cognitive impairment (MCI) in the community who experience sleep difficulties.	313504	Non-commercial portfolio	Closed to recruitment - no follow up	01/12/2023
The COPING-ID study	COPING-ID: a CO-produced Psychosocial INtervention delivered by GPs for young people who self-harm (COPING)-Intervention Development (ID) study	294180	Non-commercial portfolio	Closed to recruitment - no follow up	31/07/2023
The Stream Trial	Eat well, feel well, stay well (the STREAM Trial)	263245	Non-commercial portfolio	Closed to recruitment - in follow up	31/01/2024
Time and Motion (T&M) Study of Hexavalent Vaccines	Time and Motion (T&M) Study of Hexavalent Vaccines (Vaxelis vs. Infanrix Hexa) in a General Practitioner (GP) SurgerySetting in the United Kingdom (UK)	317645		Closed to recruitment - no follow up	
Vapeline	Do e-cigarettes help smokers quit when not accompanied by intensive behavioural support?	284500	Non-commercial portfolio	Closed to recruitment - in follow up	15/11/2023

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Appendix C: Recruitment performance in 2023/24

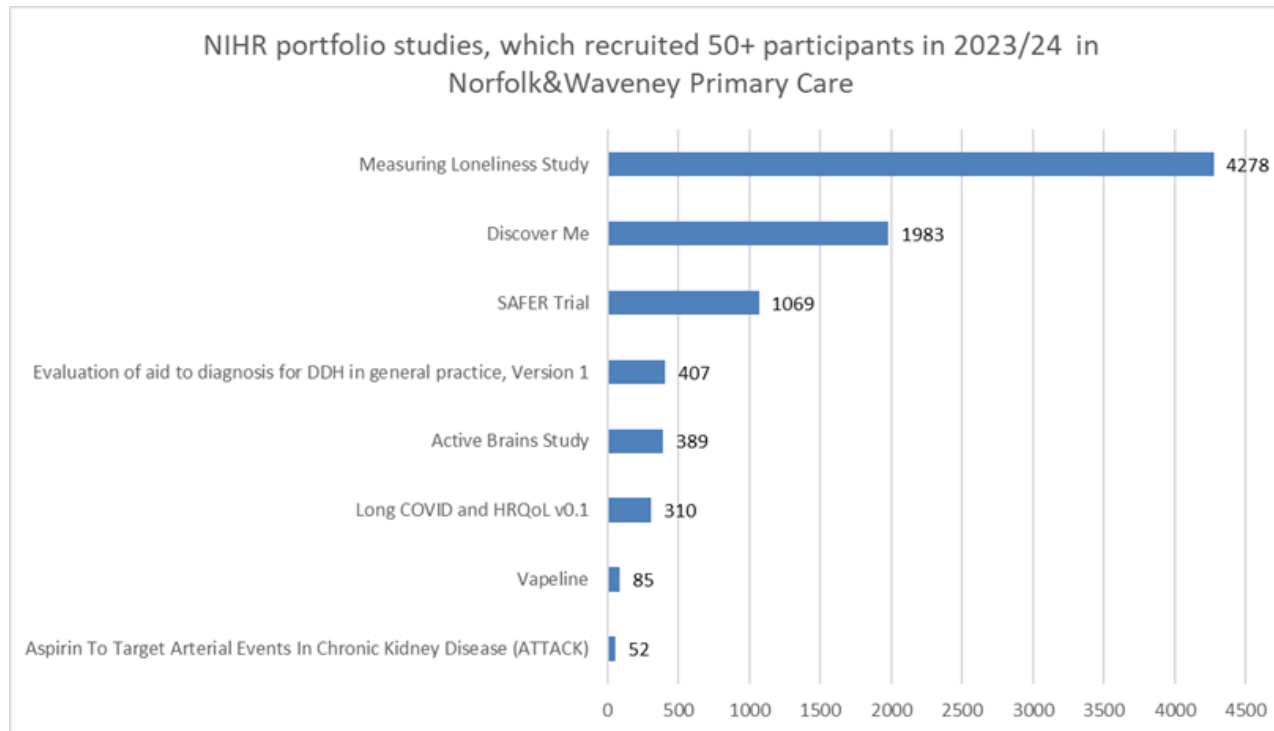


FIGURE 1 – STUDIES WITH 50+ RECRUITS AT NORFOLK AND WAVENEY GP SITES. AN ADDITIONAL 14 STUDIES HAD FEWER THAN 50 RECRUITS

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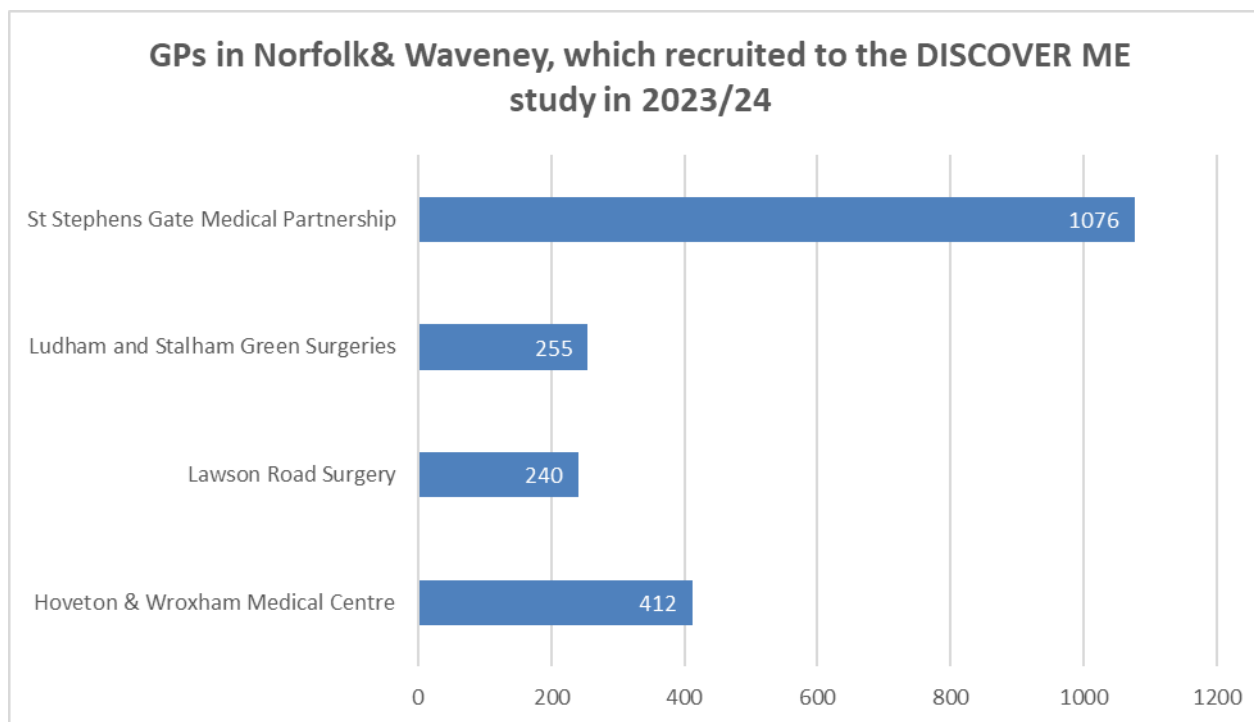


FIGURE 2 – NUMBER OF DISCOVER ME PARTICIPANTS, RECRUITED BY GENERAL PRACTICES IN NORFOLK AND WAVENEY DURING 2022/23

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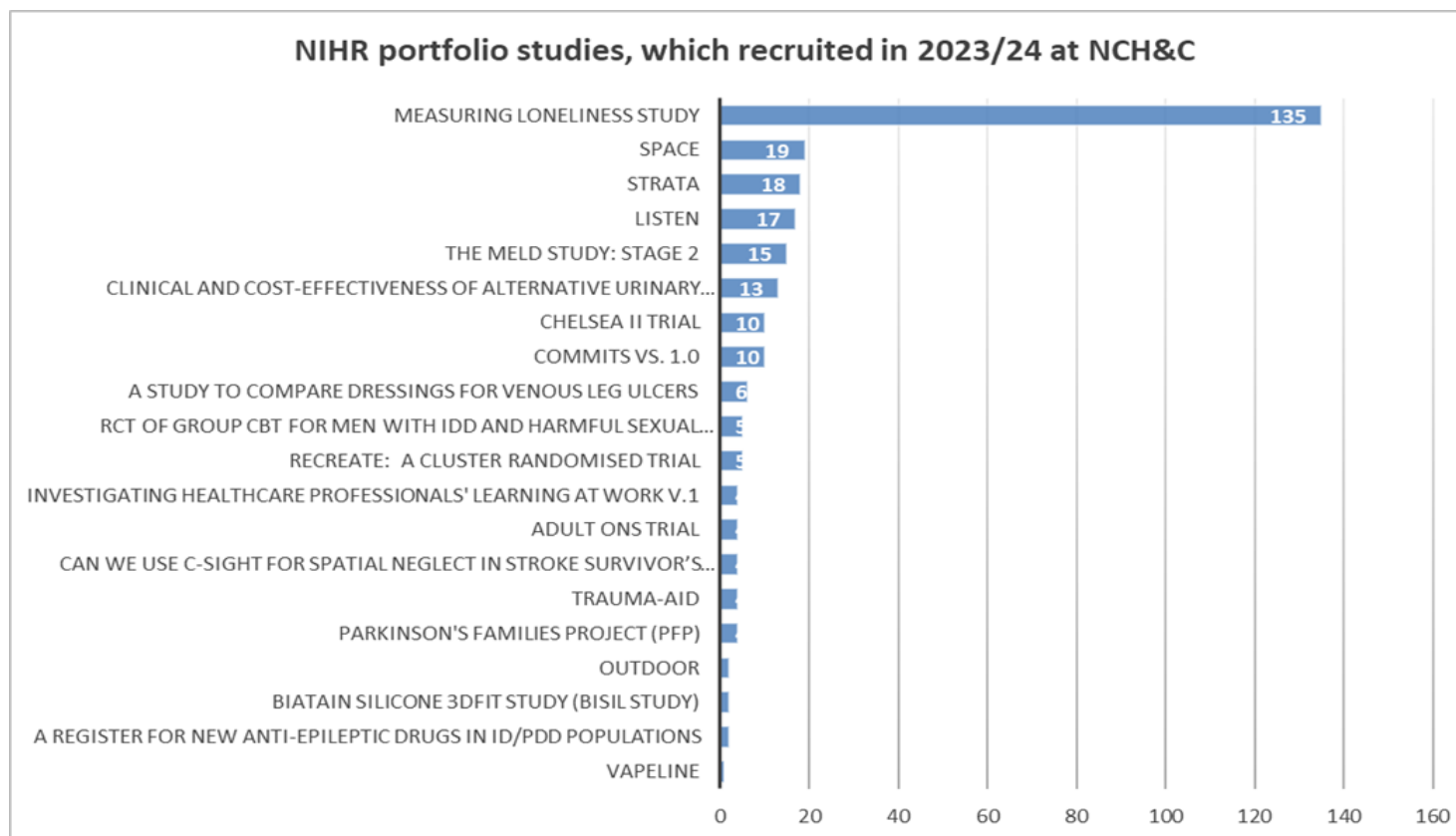


FIGURE 3 – NUMBER OF PARTICIPANTS, RECRUITED TO NIHR PORTFOLIO STUDIES AT NCH&C DURING 2023/24

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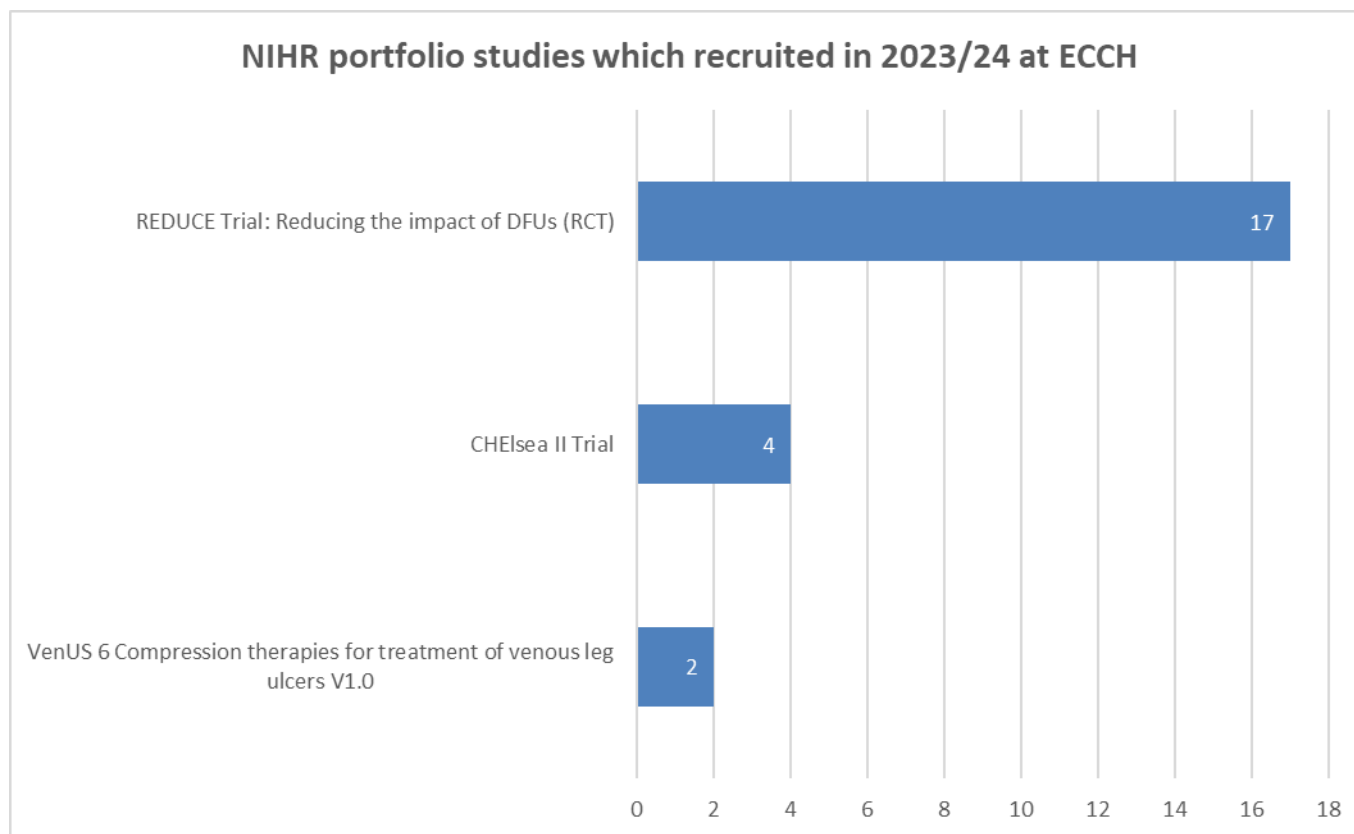


FIGURE 4 – NUMBER OF PARTICIPANTS, RECRUITED TO NIHR PORTFOLIO STUDIES AT ECCH DURING 2023/24

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Improving lives **together**

Norfolk and Waveney Integrated Care System

Integrated Care Board Finance Report

August 2024

(Month 5 2024/25)

ICB Board – Part One: 25th September 2024

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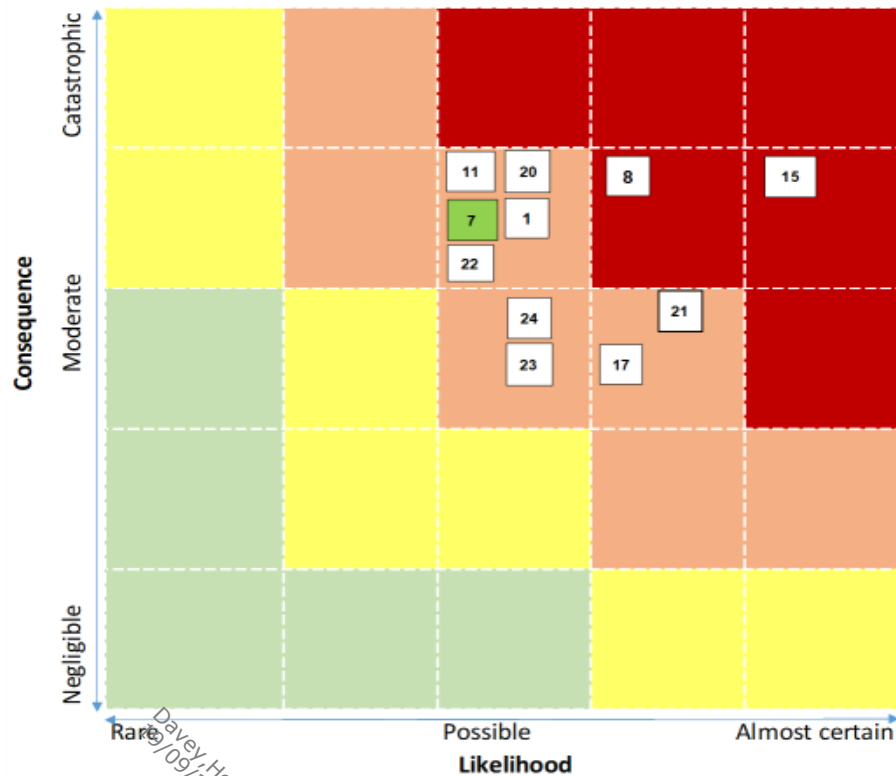
1. Executive Highlights

- The following report is based on the financial plan submitted to NHSE on 12 June 2024, which included a planned £387k surplus position.
- This report represents the **M05 August 2024** year-to-date position of the ICB as part of the 2024/25 Financial Year.
- The ICB has reported an **on plan year-to-date position of £0.16m Surplus**,
- The ICB has reported a **on plan Forecast out-turn position of £0.39m Surplus**, but includes offsetting variances and other forecast assumptions, the major items being:
 - The assumed delivery of the Non-Recurrent Unidentified Efficiencies of £14.8m. The ICB had identified potential mitigations which if delivered would cover the M05 year-to-date assumed Unidentified Efficiencies but would not, as at M05, cover the full year £14.8m risk.
 - £(14.3)m of Continuing HealthCare (CHC) Recurrent operational pressures resulting from ongoing increases in High-Cost Learning Disability and Childrens packages, and High-Volume Fast Track packages.
 - £(3.5)m of slippage on identified efficiency delivery within the Prescribing portfolio, and
 - £20.5m of Non-Recurrent mitigations arising from Prior-Year benefits, slowing of project expenditure and withholding of allocations.
- The **2024/25 Financial Plan included £51.3m of unmitigated risks** in-line with NHSE guidance relating to efficiency delivery, investment slippage, service demand, inflationary pressures beyond funding and corporate pay costs for the Re-Organisation. 
- As at M05 £51.3m net planning risks were reassessed to £30.7m, which is excluded from the forecast. **Total net risks, including new risks in addition to planning risks, total £32.65m.**
- The M05 **underlying deficit is £122.3m**, a deterioration against the planned deficit of £101.8m. This arises from the full year effect of Recurrent CHC packages and the removal of the Non-Recurrent in-year savings being used to deliver the 2024/25 Financial Position.

2. Strategic Financial Risk Register

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

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



Financial Strategic Risks	Ref.	Details	Tolerated Risk appetite	Jun-24	Jul-24	Aug-24
Achievement of Plan	1	Achieve the 2023/24 financial plan (BAF 11)	12	12	12	12
	15	Underlying deficit position (BAF 11A)	12	20	20	20
	17	Inflationary pressures	9	12	12	12
	20	Impact of new prescribing guidance	8	12	12	12
	21	Impact of Direct Commissioning transfer	9	12	12	12
	22	Re-Organisation: Running Costs Reduction, Increased Pay Costs and Cost of Delivery	9	12	12	12
	23	Debt and Working Capital Management (NCC)	6	9	9	9
Demand and Capacity	7	Continuing Health Care demand growth	9	16	16	12
	11	ERF: RTT backlog and Acute demand management	9	12	12	12
	24	Patient Choice (Learning Disabilities & Autism)	9	9	9	9
Efficiency	8	Efficiency, transformation development/delivery	8	16	16	16
			Extreme	3	3	2
			High	8	8	9
			Moderate	0	0	0
			Low	0	0	0
			Total Risks	11	11	11

As at M05 (August), 11 Key Financial Risks remain open of which 2 are considered Extreme relating to the ICB Underlying Deficit and delivery against the Efficiency programme.

Against M04 (July), one risk has improved being Ref 7 CHC moving from an Extreme risk of 16, to a High risk of 12. This reduction in risk recognises the increase in the forecast taken into M05 financial position for the additional costs of demand and acuity. The remaining risk is therefore considered reduced over and above this already recognised risk.

3. Statement of Financial Position (SOFP)

The Statement of Financial Position presents the aggregate closing position of the ICB as at 31st August 2024.

Non Current assets
IFRS16 was implemented in April 2022. The non-current assets balance includes the right of use assets for the lease of the premises at King's Lynn and Norfolk County Council. Corresponding entries are also included in both current and non-current Lease Liabilities.

Current assets
Total current assets have increased since March 2024. The £23.6m balance is made up of aged debtors of £2.9m (including ECCH £2m & NHSE £0.4m), net of a provision against this balance of £0.4m, prepayments & accrued income of £5.7m and dental under delivery of £15.4m. Trade debtors are subject to a quarterly review of bad debt for provision or write off, which are presented to the Audit Committee.

Current liabilities
Total current liabilities has decreased by £23m since March 2024, driven principally by ICB and system invoice accrual timing. The £154m balance is made up of trade creditors of £5m, Prescription Pricing Authority accruals of £22m, dental accruals of £4m, payroll costs including GP pensions of £3m, deferred income of £6m, prior year accruals of £36m and ICB and system invoice accruals of £78m. Provisions include redundancy, legal claims, estates, standard staffing costs and elective recovery funding conditions. There has been an in-year part release against these provisions as costs are being incurred.

As part of the improvement in working capital with Norfolk County Council, outstanding non-PO transactions stand at £9.1m. All invoices raised outside of the contractual conditions against which the ICB made a full and final settlement on remain on-hold.

Long Term liabilities
The non-current payables balance is the deferred income relating to research & development which are funded in advance.

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

NHS NORFOLK & WAVENEY ICB STATEMENT OF FINANCIAL POSITION	Position as at 31/03/24	Position as at 31/07/24	Position as at 31/08/24
ASSETS EMPLOYED			
Non-Current assets			
Right-of-use Assets	1,005	1,005	1,005
Accumulated Depreciation	(332)	(396)	(412)
Total non-current assets	673	609	593
Current assets			
Trade and Other Receivables	23,673	23,506	23,623
Cash and Cash Equivalents	376	2,922	1,681
Total current assets	24,049	26,428	25,304
Current liabilities			
Trade and Other Payables	(174,924)	(160,295)	(154,136)
Lease Liabilities	(218)	(192)	(193)
Provisions for liabilities and charges (including non-current)	(12,786)	(11,630)	(10,717)
Total current liabilities	(187,928)	(172,117)	(165,046)
Long Term liabilities			
Non-Current Payables	(820)	(422)	(422)
Non-Current Lease Liabilities	(472)	(415)	(375)
Total non-current liabilities	(1,292)	(837)	(797)
Net assets employed	(164,498)	(145,917)	(139,946)
FINANCED BY TAXPAYERS EQUITY			
General fund	(164,498)	(145,917)	(139,946)
Total taxpayers equity	(164,498)	(145,917)	(139,946)

4.1. ICS Financial Summary: Revenue

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

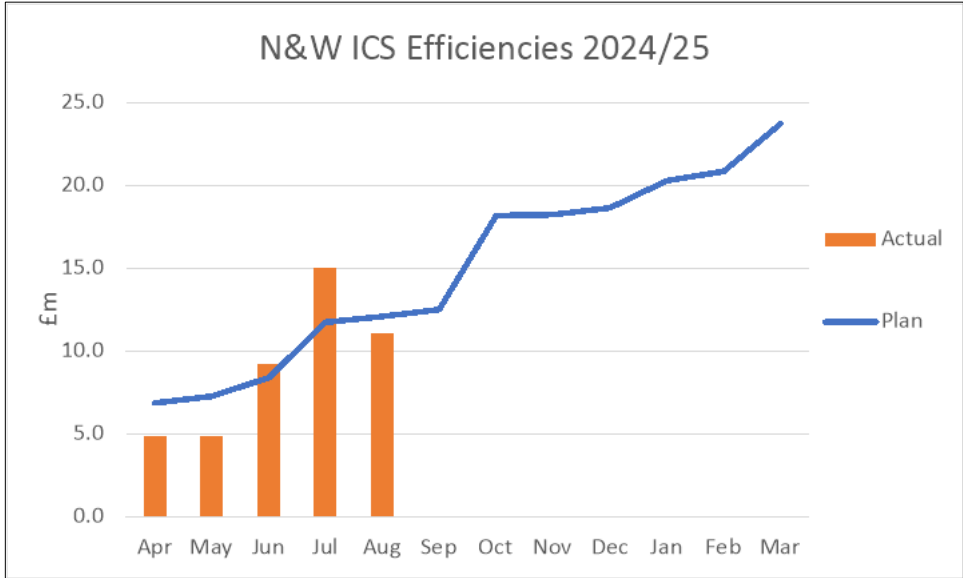
Revenue surplus/(deficit) £m	Month 5 YTD			Forecast Outturn		
Organisation	Plan	Actual	Variance	Plan	Actual	Variance
JPUH	(7.4)	(10.0)	(2.6)	(13.4)	(13.4)	0.0
NNUH	(4.1)	(10.1)	(5.9)	0.0	0.0	0.0
QEH	(9.7)	(17.3)	(7.7)	(9.5)	(9.5)	0.0
NSFT	0.8	(0.6)	(1.5)	0.0	0.0	0.0
NCH&C	(0.0)	0.0	0.0	1.5	1.5	0.0
Provider Subtotal	(20.4)	(38.0)	(17.6)	(21.4)	(21.4)	0.0
ICB	0.1	0.1	0.0	0.4	0.4	0.0
N&W System Total	(20.2)	(37.8)	(17.6)	(21.0)	(21.0)	0.0

- The position M5 YTD is a £37.8m deficit, which is £17.6m adverse against plan.
- Forecast outturn for the system is per plan, a £21.0m deficit.

5. ICS Financial Summary: Efficiency & Transformation

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

System Efficiencies £m				Month 5 YTD			Forecast Outturn			Forecast Outturn	
				Plan	Actual	Variance fav/(adv)	Plan	Actual	Variance fav/(adv)	Recurrent	Non-recurrent
Organisation											
JPUH				7.3	6.4	(1.0)	22.4	22.4	0.0	13.6	8.8
NNUH				14.2	9.7	(4.5)	50.1	50.1	0.0	23.1	27.0
QEH				5.4	2.7	(2.7)	29.5	29.5	0.0	25.1	4.4
NSFT				7.0	5.4	(1.6)	17.4	17.4	0.0	8.1	9.3
NCH&C				2.3	2.5	0.3	8.4	8.4	0.0	3.2	5.1
Provider Subtotal				36.2	26.7	(9.5)	127.8	127.8	0.0	73.1	54.7
ICB*				10.2	18.5	8.3	51.2	46.0	(5.1)	22.7	23.3
N&W System Total				46.4	45.2	(1.2)	178.9	173.8	(5.1)	95.8	78.0
ICB Budget Rephasing*				5.6	0.0	(5.6)	0.0	0.0	(5.1)	0.0	0.0
Reported ICB position				15.8	18.5	2.7	51.2	46.0	(10.3)	22.7	23.3
Revised system position				52.0	45.2	(6.8)	178.9	173.8	(5.1)	95.8	78.0



*ICB Internal reporting differs to the IFR submitted position due to a YTD efficiency plan rephasing of £5.6m. Therefore the ICB are reporting a YTD favourable position of £2.7m against budget whereas the position against the submitted plan is a £8.3m overperformance.

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

Year-to-date:

- The efficiency position M5 YTD against plan is an adverse variance to plan of £1.2m but after the £5.6m ICB budget rephasing is £6.8m adverse.
- Recurrent efficiency delivery is £21.9m against the plan of £29.1m, £7.2m under and NR delivery is £23.4m against the plan of £17.3m, £6m over, generating the net under delivery of efficiencies against plan of £1.2m.
- JPUH, NNUH, QEH and NSFT have various CIP schemes that are not meeting plan due to slippage. All are expected to recover during the year.
- The ICB is £2.7m favourable to budget mainly due to CHC and vacancies delivering sooner than planned. NCHC has also been able to recognise some savings earlier than planned.

Full year forecast:

- Full year efficiency programme forecast is £173.8m, £5.1m adverse to plan. This variance is due to the ICB forecasting £5.1m lower than planned, mainly due to forecast under delivery of some GP prescribing schemes.

6. ICS Financial Summary: Capital

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

- M5 YTD variance to plan is a £4.6m underspend.

- For system CDEL the £3.0m underspend, excluding RAAC, is mainly due to slippage and delays in project roll out.

- IFRS 16 schemes are £0.9m underspent due to timing of expenditure with the impact of IFRS 16 being incorporated into the system capital performance.

- Central Programmes are currently showing a £13.7m underspend.

System CDEL £m	Month 5 Year to Date (YTD)										
Organisation	System CDEL					IFRS 16			Total System Performance		
	Plan	Plan Adj	Total Plan	Actual	Variance	Plan	Actual	Variance	Total Plan	Actual	Variance
	Inc./ (Dec)		(Under)/ Over			(Under)/Over			(Under)/Over		
Excluding RAAC											
JPUH	4.0	0.0	4.0	1.8	(2.2)	0.0	0.0	0.0	4.0	1.8	(2.2)
NNUH	2.4	0.0	2.4	1.7	(0.7)	1.1	0.1	(1.0)	3.6	1.8	(1.7)
QEH	6.8	0.0	6.8	6.4	(0.4)	0.0	0.0	0.0	6.8	6.4	(0.4)
NSFT	4.2	0.0	4.2	3.6	(0.6)	3.3	3.5	0.2	7.5	7.0	(0.5)
NCH&C	1.4	0.0	1.4	2.3	0.9	0.0	0.0	0.0	1.4	2.3	0.9
Subtotal excluding RAAC	18.9	0.0	18.9	15.9	(3.0)	4.5	3.6	(0.9)	23.3	19.5	(3.9)
RAAC											
JPUH	1.7	0.0	1.7	3.5	1.7				1.7	3.5	1.7
QEH	7.6	0.0	7.6	5.2	(2.4)				7.6	5.2	(2.4)
Subtotal Including RAAC	28.3	0.0	28.3	24.6	(3.7)	4.5	3.6	(0.9)	32.7	28.1	(4.6)
Adjustments											
Reduced IFRS 16 Allocation								0.0			0.0
N&W System Total	28.3	0.0	28.3	24.6	(3.7)	4.5	3.6	(0.9)	32.7	28.1	(4.6)

Central Programmes £m	Month 5 Year to Date (YTD)										
	CDEL					IFRS 16			Total System Performance		
	Plan	Plan Adj	Total Plan	Actual	Variance	Plan	Actual	Variance	Tot. Plan	Actual	Variance
	Inc./ (Dec)		(Under)/ Over			(Under)/ Over			(Under)/ Over		
Total Central Programmes			42.4	28.7	(13.7)	0.0	0.0	0.0	42.4	28.7	(13.7)
N&W Total Capital Programme			70.6	53.3		4.5	3.6		75.1	56.9	

Glossary of terms (1)

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

Glossary of terms (2)

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

Agenda item: 17

Subject:	Report from the Finance Committee
Presented by:	Hein van den Wildenberg, Non-executive Member, Finance Committee Chair
Prepared by:	Emma Kriehn-Morris, Director of Commissioning Finance
Submitted to:	Integrated Care Board – Board Meeting
Date:	25 September 2024

Purpose of paper:

To provide the Board with an update on the work of the Finance Committee up to including the 3rd of September 2024.

A further Finance Committee is scheduled for 24th of September, immediately preceding the ICB Board meeting. Any key points will be raised verbally in the Board meeting.

Committee:	Finance Committee
Committee Chair:	Hein van den Wildenberg
Meetings since the previous update	Last update provided: 17.07.2024 Subsequent Meetings: 03.09.2024 Meeting to be held at time of writing: 24.09.2024
Overall objectives of the committee:	The objective of the committee is to contribute to the overall delivery of the ICS objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan and strategy, consistent with the ICS Strategic Plan and its operational deliverables.
Main purpose of meeting:	To gain assurance on the financial position of the NHS entities in the ICS, and ICB respectively.
BAF and any significant risks relevant / aligned to this Committee:	BAF 11 – Achieve the 2024/25 financial plan BAF 11A – Underlying deficit position
Key items for assurance/noting:	The main items discussed at the Finance Committee were as follows: - At Month 4 (July 2024) the NHS entities in the N&W ICS show a deficit of £ 29.3m vs a Planned deficit of £ 19.0m,

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i.e. a shortfall of £ 10.3m. This is a deterioration compared to previous month. The main driver is under-delivery of efficiencies by most providers compared to Plan, resulting in a year-to-date efficiency position that is £4.7m behind plan. The impact of Industrial Action year to date is £2.5m. Whilst the Forecast OutTurn (FOT) for the year is reported as on Plan, the trajectory to get there looks increasingly challenged.

- At Month 4 the ICB shows a delivery on Plan, both year to date and for the financial year. The level of unidentified efficiencies at this time of the financial year demonstrate the significant risk to delivery.
- Based on discussions during the September 3rd committee meeting, there is presently **limited assurance** on either the aggregate of NHS entities in N&W, or the N&W ICB achieving their financial plan for the year.

This would seem to correspond with NHSE assessment, based on Month 4 results, on N&W being moved from category '3' to '3+' in their Investigation & Improvement framework (1 – lowest risk to financial plan delivery <- -> 4 is highest risk to financial plan delivery).

- An updated trajectory to financial plan delivery has been submitted, and delivery in the coming months against this trajectory will be critical to provide more assurance to delivery against plan.
- The CDEL (**Capital** Delegated Expenditure Limit) capital spend is assessed against an envelope, which now includes IFRS16 spend (essentially capitalised leases). Whilst year to date there is an underspend, due to slippage and delay in project roll-out, the Forecast OutTurn presently points to a £ 9.5m overspend vs a Plan of £ 94.4m, largely driven by IFRS16 spend substantially higher than the allocation received. Work is happening through the **Strategic Capital Board** to assess trade-offs and manage within the financial envelope.
- Separately there is a range of capital projects delivered under central programmes, such as Diagnostic Centres, Electronic Patient Record etc. Capital spend for these central projects this year is in line with a Plan of £ 131m.
- The Committee received a report from the **Financial Recovery Board (FRB)**. The FRB, chaired by the NNUH CEO, is being reset, taking effect in September and focussing on a select number of Sprints and work

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programmes to deliver near and medium term results. The 3 Sprint areas are: *) reduce Length of Stay; *) practical workforce actions; and *) clinical standardisation / biosimilars. Other work programmes for the medium term include the potential for a shared/single model for corporate services.

- The Committee received an update on the **Triple Lock** process, where some 60 requests are received on average each week since May this year. The Triple Lock is a set of nationally directed pay and non-pay controls which must be in place and evidenced for all organisations where the system overall is in deficit (NHS entities in N&W submitted a deficit plan). This requires certain expenditure over a defined threshold to have the approval of the organisation, the ICB and NHS England. The aim of the Triple Lock is to demonstrate and provide further grip and control across pay and non-pay expenditure in the system.

Ca 2/3rds of the requests concern Pay requests. So far very few requests have been declined. This is probably a function of rigour applied by individual organisations before submitting requests.

Part 2 of each Finance Committee meeting focusses specifically on the ICB. In addition to regular reporting on Month 4 results, members received a Spotlight report on Pay performance of the ICB, including the tracking of financial implications of the ICB restructuring. Members appreciated the transparency and financial rigour applied.

[see next page]

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Items for escalation to Board:	1. The results up to including Month 4 (July) and Forecast Outturn, summarised in the table below highlight a deteriorating trend vs Plan. There is presently limited assurance that we will achieve the financial plan for the year.		
	2. The Financial Recovery Board reset and focus on a select number of Sprints and work programmes to deliver near and medium term results.		
		NHS entities in N&W ICS, including ICB	N&W ICB
	Month 4 Year to Date	Actual: Deficit of (£ 29.3m) vs Plan of (£ 19.0m)	Actual: Surplus of £ 0.1m vs Plan of £ 0.1m
	Forecast OutTurn (FOT) of year per Month 4	FOT Deficit of (£ 21.0m) vs Plan of (£ 21.0m)	Actual: Surplus of £ 0.4m vs Plan of £ 0.4m
	2024/25 Plan	Deficit (£21m) with significant risk to delivery (risk rating of 16)	£0.4m Surplus Plan, with significant risk to delivery
	Underlying Plan Deficit	£228m	£102m
Planned Efficiency delivery	£179m	£51m	
Items requiring approval:	None		
Confirmation that the meeting was quorate:	Confirmed that both meetings were quorate.		

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

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Subject:	Quality and Safety Committee Report
Presented by:	Aliona Derrett, Quality and Safety Committee Chair
Prepared by:	Evelyn Kelly, Quality Governance & Delivery Manager
Submitted to:	Integrated Care Board Meeting
Date:	25 September 2024

Purpose of Paper

To provide the Board with an update on the work of the Quality and Safety Committee for the period of 17 July 2024 to 25 September 2024.

Committee:	Quality and Safety
Committee Chair:	Aliona Derrett
Meetings since the previous update:	01 August 2024, 14:00 – 17:00 05 September 2024, 14:00 – 17:00
Overall objectives of the committee:	
To seek assurance that the Norfolk and Waveney system has a unified approach to quality governance and internal controls that support it to effectively deliver its strategic objectives and provide sustainable, high-quality care and to have oversight of local implementation of the NHS National Patient Safety Strategy. To be assured that these structures operate effectively, that timely action is taken to address areas of concern, and to respond to lessons learned from all relevant sources including national standards, regulatory changes, and best practice. To oversee and monitor delivery of the ICB key statutory requirements, including scrutiny of the robustness and effectiveness of its arrangements for safeguarding adults and children, infection prevention and control, medicines optimisation and safety, and equality and diversity. To ensure that patient outcomes from care are collected and measured, to inform outcomes-based commissioning for quality. To review and monitor those risks on the BAF and Corporate Risk Register which relate to quality, and the delivery of safe, timely, effective, and equitable care. To consider the effectiveness of proposed mitigations and to escalate concerns to risk owners and operational leads/forums as agreed by Committee Members. To approve ICB arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and secure continuous improvement in quality. To seek assurance that commissioning functions act with a view to supporting quality improvement; developing local services that promote wellbeing and prevent adverse health outcomes, equitably, across all patients and communities in Norfolk and Waveney.	

Main purpose of meeting:	01 August 2024: regular meeting of the Committee covering all standing items plus the following focus areas: • Quality Dashboard and Strategy Oversight • Urgent and Emergency Care (UEC) Update • Right Care NoW (Discharge) • NSFT Learning from Deaths Reviews • David Fuller Inquiry (Mortuary) • Drug and Alcohol Partnership and Mental Health Dual Diagnosis 05 September 2024: regular meeting of the Committee covering all standing items plus the following focus areas: • Quality Dashboard and Strategy Oversight • ICB QIA and EHIA Process Review • Safeguarding, Look After Children, Care Leavers and SEND • EEAST PSIRF Thematic Report • Right Care, Right Person (Police and Mental Health) • Mental Health Transformation Primary Care and Community • Adult Eating Disorder Provision
BAF and any significant risks relevant / aligned to this Committee:	Quality and Safety Committee Risks: BORR02: NHS Continuing Healthcare BORR03: EEAST Response Time and Patient Harms BORR05: NSFT Mortality Action Plan BORR10: CYP Neurodevelopmental Service Provision ORR01: Failure to Meet Cancer Access Standards SR04: Surge Capacity to Support Local Acute Trusts SR10: Care Provider Capacity System-Wide Impact SR14: CYP Mental Health (Allocation of Case Managers) SR16: CYP Mental Health Waiting Lists SR19: CYP Podiatry Provision in Central Norfolk SR20: CYP Speech and Language Therapy Provision SR43: Tuberculosis Service Capacity SR46: 12hr Decision to Admit Breaches: Patient Experience SR47: Familial Hypercholesterolemia Services SR48: Lynch Syndrome Pathway (Cancer) SR49: Equitable Access to End of Life Care SR50: E3 Maternity Information System SR52: Industrial Action Clinical Impact SR53: Community Nursing Unallocated Visits SR54: CYP Responsible and Approved Clinicians in NSFT SR55: CYP Staff Competences in NSFT LC001: Community Epilepsy Commissioning NEW: Access to Tier 3 and 4 Weight Management Services Committee closures and movement: • SR006 Public Trust and Reputational Damage (Ambulance Response) de-escalated to Team management. • BAF01 Health Inequalities and Population Health Management moved to Patients & Communities.

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	• BAF03 CYP Mental Health Transformation moved to Commissioning & Performance Committee. • BAF04 Adult Mental Health Transformation moved to Commissioning & Performance Committee. • BAF06 System and UEC Pressures moved to Commissioning & Performance Committee. • ORR07 Industrial Action moved to Remuneration, People and Culture. • SR005 Workforce Absence and Moral Injury moved to Remuneration, People and Culture. • BORR01 Providers in CQC Special Measures (NSFT) closed as rolled into BAF06. • BORR04 Right Care Now (Discharge) closed as rolled into BAF06. Over the next month we will be moving all Committee risks to the new BORR/ORR register in line with the corporate risk management approach.
Key items for assurance/noting:	<u>Quality Dashboard and Strategy Oversight</u> Committee received update reports on the quality dashboard and the objectives of the ICS Quality Strategy. Focus areas included: • Ambulance Handovers • Dementia Prevalence • Children's Mental Health Service Access • Adult Mental Health Metrics • System Workforce Vacancies • Urgent Community Response Performance • 62-Day Cancer Patient Treatment Lists (Acute Hospitals) <u>01 August 2024</u> <u>Urgent and Emergency Care (UEC)</u> Committee received an update on Emergency Department performance and Ambulance activity. Committee noted the improved in ambulance handover and C1 and C2 ambulance response performance which has translated to a reduction in harms for patients waiting for ambulances in the community. The Chair enquired around the impact of the segmentation of C2 calls which is a nationally led initiative to further improve response times and patient care. The approach aims to triage calls more effectively, directing patients to the most appropriate resources. Committee was asked to note the positive progress in the zero-tolerance approach to ambulance handover delays whilst acknowledging there continues to be some variation in achieving this consistently during times of significant pressure. To support this, system partners continue to work collaboratively, in and out of

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hospital, to create patient flow including alternatives to hospital admission and reducing length of stay. Committee noted that the continuation of funding for the Unscheduled Care Coordination Hub was positive as this is helping to ensure that people receive the right service and support at the right time, closer to home wherever possible. Committee discussed opportunities to implement learning from other systems, at a local level, including the London 'w-45' approach and the Cambridge model for emergency care. It was agreed that full consideration around logistical and demography challenges and the need for appropriate resources would be required.

Committee highlighted a question around whether the national transition to the new Patient Safety Incident Response Framework (PSIRF) was reducing visibility of new trends and emerging themes in incident reports, however, partners reflected their view that the change had not obscured the identification of risk and that PSIRF creates a focus on learning and improvement.

Right Care NoW (Discharge)

Committee received a summary report which updated on the current position of patients with no criteria to reside, >14-day length of stay (LOS) and [discharge pathway](#) activity data. Committee was also briefed on the work of the ICS Right Care Now Transformation Program and ongoing discharge quality improvement initiatives facilitated by the ICB across the system. Committee noted priorities around finalising roll-out of the OPTICA digital solution, stabilising pathway 2 capacity and delivering new build capacity and strengthening the pathway 3 market.

NSFT Learning from Deaths Reviews

Committee received an update from NSFT on work undertaken by the Trust, in partnership with system stakeholders, in response to the Grant Thornton Review, and Forever Gone Report, which identified learning for the Trust around:

- Collection, analysis and reporting on service user deaths;
- Using learning from deaths to improve clinical practice;
- Engaging with patients, carers, and bereaved families.

Committee received an overview of the new Trust processes for managing mortality data and learning from deaths. ICB attendees also spoke to the improved visibility and the breadth of work undertaken in the Trust to make improvements in this area. The importance of recording of ethnicity and other demographic details of service users was also discussed, as an opportunity to ensure that themes around inequalities can be identified.

David Fuller Inquiry (Mortuary)

Committee received a briefing on the ICB's work in response to the findings of the [inquiry](#), which took place following the criminal conviction of David Fuller and his actions at Maidstone and Tunbridge Wells NHS Trust, highlighting the importance of safeguarding the dignity and security of the deceased within hospital settings. The ICB Nursing and Quality Team have undertaken quality assurance visits to

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the local hospital mortuaries, with a focus on the implementation of procedures and practices to prevent similar incidents. Committee heard plans for broader work taking place in partnership with local authorities and the Norfolk Resilience Forum, looking at non-hospital services including hospices and funeral homes.

Drug and Alcohol Partnership and Mental Health Dual Diagnosis

Committee were updated on the development of an integrated dual diagnosis pathway for adults, which aims to bridge the service gaps for individuals with both mental health and substance misuse issues. The pathway is being designed with a focus on ensuring that services are tailored to fit the person, easy to navigate and offer holistic care that meets the needs of dual diagnosis patients more effectively. A clinical model workshop is planned to finalise the approach for the pathway, with input from stakeholders and experts by experience. The pathway is on track for a go-live date of the service in March 2025.

05 September 2024

ICB QIA and EHIA Process Review

Committee approved the recent update of the ICB approach to managing Quality Impact Assessment (QIA) and Equality and Health Inequalities Impact Assessment (EHIA). Robust and action-focused impact assessments are key to ensuring that quality and equity are central to ICB decision making. The ICB Nursing & Quality and Health Inequalities & Inclusion Health Teams completed a 'refresh' and update of existing QIA and EHIA documentation to improve the robustness of the impact assessment process. This included the impact assessment tool, updated QIA and EHIA policies and Terms of Reference for a new QIA and EHIA Panel which will formalise sign-off. This approach will enable quality and health inequalities considerations to be made in parallel, with supportive feedback to project leads completing the assessments. It is proposed that the new QIA and EHIA Panel provide a quarterly report to Committee, with oversight of panel activity and assessment outcome themes and an annual report to Board.

Safeguarding, Look After Children, Care Leavers and SEND

Committee received an update on ICB safeguarding activities, including focused work with Community Safety Partnerships around the national statutory [Serious Violence Duty](#), in particular domestic and sexual violence, as well as roll out of domestic abuse training for ICB staff, and the establishment of a local Joint Health Safeguarding Assurance Group; aiming to relaunch executive-level oversight of safeguarding matters and embed learning from reviews. The ICB continues to participate in NHS England regional safeguarding networks and Committee noted collaborative efforts across various safeguarding domains, including adult and children's safeguarding, SEND, and looked after children, showcasing a comprehensive approach to safeguarding within the ICB. The children's team are currently waiting for confirmation of a Joint Targeted Inspection of the system around the theme of domestic abuse and are undertaking focused work around serious youth violence and transitional

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Davey Heidi 19/09/2024 14:02:47	safeguarding as potentially vulnerable people move between child and adult services. The ICB Executive Director of Nursing requested addition of a deep dive onto the Committee Forward Planner into SEND and NDD pathways for both Norfolk and Suffolk to assess current levels and identify areas for improvement. EEAST PSIRF Thematic Report The East of England Ambulance Service Trust (EEAST) presented a thematic review undertaken as part of the new PSIRF framework, looking at incidents where diagnosis of ST-elevation myocardial infarction (STEMI), which is a type of heart attack, may have been missed. Learning was identified around human factors, variation in staff ECG training and use of technology to support clinical assessment, which is a national challenge. The thematic review has informed quality improvement actions, including the development and standardisation of staff training packages and the introduction of new ECG interpretation software to aid frontline clinicians. ECG recognition has also been a key theme within clinical supervision within the Trust. Committee noted that the review process engaged staff through surveys and case studies, leading to rich data that informed the actions and recommendations to improve STEMI recognition and response. Committee also noted that there was learning for sharing with wider partners around variation in practice across hospital sites delivering percutaneous coronary interventions (PCI). Right Care, Right Person (Police and Mental Health) Norfolk Constabulary attended to provide an update on local delivery of the national Right Care Right Person (RCRP) initiative. The new approach will mean that police focus on attending health incidents where there is a significant safety risk or crime being committed and refer others to the appropriate partner agency. Committee were briefed on the preparatory work, including workshops and partnership meetings with various stakeholders, to identify and address gaps before the initiative's launch and to enable the development of new escalation pathways and shared contact documents to streamline communication across agencies. Committee were briefed on the breadth of the RCRP program which looks at police welfare checks as well as policing responses to vulnerable patients leaving healthcare settings, police transport of patients between healthcare settings and 136 suite handovers. Committee raised a concern around how we maintain oversight of outcomes for people who are signposted and not attended by Police colleagues. Assurance was given that a monthly scrutiny panel is in place to identify and respond collaboratively to any learning coming out of RCRP in relation to pathways, services, and safeguarding. Positive feedback from partners was shared, along with plans for continued partnership working, tracking, and evaluation of the initiative's impact on the system and service delivery. Committee noted the importance of partners sharing data with the police to understand patient journeys across agencies and capture outcomes. Mental Health Transformation Primary Care and Community Committee discussed the feedback from surveys and engagement events with general practice and Primary Care Networks regarding

	mental health transformation in primary care. Key challenges identified include staff recruitment and retention, the need for more consultant psychiatrists, and perceptions about referral rejections from Community Mental Health Teams. The survey also identified the value in PCN-based Mental Health Practitioners and Enhanced Recovery Workers which are working well as integrated roles. There continues to be ongoing dialogue between NSFT and primary care to identify opportunities to strengthen patient pathways and improve outcomes. The development of a data dashboard was mentioned as a key step to evaluate the effectiveness of the mental health transformation model in primary care and to address identified challenges. The Chair emphasised the value of mental health training to support primary care staff at all levels and highlighted the need to continue to promote our Wellbeing Hubs and ensure that professionals are sighted on the skill-mix and referral pathways for these community-based services. Adult Eating Disorder Provision Committee received an update on the Norfolk and Waveney Adult Community Eating Disorder Service, including the move to new premises, reduced waiting times, and the significant reduction in the use of 'out of area' beds, indicating improved service efficiency and patient outcomes. Committee noted the significant reduction in the use of specialist inpatient beds and the impact of community and intensive community offers in supporting patients and avoiding admissions. The ICB Executive Director of Nursing emphasised the need to ensure that services make reasonable adjustments to ensure they are accessible, especially for neurodiverse people. Members and attendees discussed the need for additional training for primary care providers to better understand and refer patients with neurodiversity and autism to appropriate eating disorder services.
Items for escalation to Board:	• Board to note risk closures and movement and the addition of a new risk around access to Tier 3 and 4 Weight Management Services. • Board to note approval of the refreshed and revised ICB Quality Impact Assessment (QIA) and Equality and Health Inequalities Impact Assessment (EHIA) process.
Items requiring approval:	August 2024: Experimental and Unproven Treatments Policy August 2024: Mental Health IFR Policy September 2024: MCA and Deprivation of Liberty Safeguards Policy September 2024: NHSE Controlled Drugs MOU September 2024: ICB QIA and EHIA Process
Confirmation that the meeting was quorate:	Quoracy (as per Governance Handbook): there will be a minimum of one Non-Executive Board Member, plus at least the Director of Nursing or Medical Director. The August and September 2024 meetings were quorate, as defined above.

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Key Risks	
Clinical and Quality:	This report highlights clinical quality and patient safety risks and mitigating actions.
Finance and Performance:	Finance and performance are intrinsically linked to quality, in relation to safe, effective, and sustainable commissioned services.
Impact Assessment (environmental and equalities):	N/A
Reputation:	See above.
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	The report supports the clinical quality and patient safety elements of the NHS Constitution.
Conflicts of Interest:	Committee member's interests are documented and managed according to ICB policy.

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Agenda item: 19

Subject:	Report from the Primary Care Commissioning Committee
Presented by:	Debbie Bartlett, Local Authority Member and Chair of PCCC
Prepared by:	Sadie Parker, Director of Primary Care
Submitted to:	Integrated Care Board – Board Meeting
Date:	25 September 2024

Purpose of paper:

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

Committee:	Primary Care Commissioning Committee
Committee Chair:	Debbie Bartlett, Local Authority Member
Meetings since the previous update on July 2024	10 September 2024.
Overall objectives of the committee:	The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act, and since 1 April 2023 the commissioning of dental, pharmaceutical and optometry services under a Delegation Agreement with NHS England. All committee papers can be found here.
Main purpose of meeting:	To contribute to the overall delivery of the ICB's objectives to create opportunities for the benefit of local residents, to support Health and Wellbeing, to bring care closer to home and to improve and transform services by providing oversight and assurance to the ICB Board on the exercise of the ICB's delegated primary care commissioning functions and any resources received for investment in primary care.
BAF and any significant risks	BAF02 – Primary Care Resilience and Transformation Current mitigated score – 5x4=20

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**relevant / aligned to
this Committee:**

Under the Joint Forward Plan we have committed to integrating primary care services to deliver improved access (including digital tools and remote monitoring offers, etc.) to a wider range of services from multi-professional teams, focused on preventing illness and improving outcomes for our population within their communities.

Our high-level outputs include:

- Developing a vision for providing accessible enhanced primary care services
- Improving patient outcomes and experience
- Stabilise dental services and setting a strategic direction for the next five years

Primary Care Services are the responsibility of the Integrated Care Board, including the recruitment and retention of healthcare professionals.

There are particular risks to the resilience of general practice, access to NHS dentistry treatment and Level 2 dental services which are reflected in the risk scores.

The community pharmacy and optometry landscape is less defined at the time of writing, but workforce and funding challenges are evident across community pharmacy which represent a risk, but could potentially be supported through greater integration and collaborative working with other primary care providers.

Limitations of national contracts, collective action by General Practice, independent contractors 'handing back' NHS contracts, workload pressures, recruitment and retention and interface challenges are, together, impacting on access to high quality, sustainable primary medical, community pharmacy and dentistry services together with Level 2 dental services for our population.

This may lead to delays in accessing care, unavailability of care (particularly dentistry), increased clinical harm because of delays in accessing services, failure to deliver the recovery of services adversely affected, and poor outcomes for patients due to pressured, and fragile services.

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	As the cornerstone of healthcare, primary care resilience risks system ability to deliver against key workstreams, including the overall aim of moving towards a more population-based proactive community model of care which addresses prevention, health inequalities and improves outcomes. Reduced access in primary care may also impact on the resilience of other system providers. BORR08 – secondary care dental services (Oral Surgery and Maxillo Facial Services, Orthodontic Services) Current mitigated score – 4x4=16 Primary Care Services, and secondary care dental services, became the responsibility of the Integrated Care Board from 1st April 2023, the risk is the unknown resilience, stability and quality of secondary care dental services, and critical challenges relating to the recruitment and retention of professionals and waiting lists, and resources within the ICB Primary care team to implement the recommendations from the East of England NHSE report lack of resources to monitor and manage 3 secondary care contracts. BORR09 – resilience of NHS general dental services in Norfolk and Waveney Current mitigated score – 5x4=20 Primary care services became the responsibility of the Integrated Care Board from 1st April 2023; the risk is the resilience, stability and quality of dental services, and critical challenges relating to the recruitment and retention of dentists and dental care professionals and the limitations of the national dental contract, leading to a poor patient experience for our local population with a lack of access to NHS general dental services and Level 2 dental services. BORR11 – the resilience of general practice Current mitigated score – 4x4=16 • There is a risk to the resilience of general practice due to several factors including workforce pressures and increasing workload (including workload associated with secondary care interface issues).

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	• There is also evidence of continuing poor behaviour from patients towards practice staff, leading to retention and recruitment issues. • There is an increasing risk of collective action following the BMA referendum where the GP contract and associated uplift was rejected. Writing referral letters (rather than using standard forms) and applying working limits of 25 face to face appointments per day per clinician appear to be the most common actions adopted in the early weeks of action. • The national GP contract price uplift does not cover the required increase in meeting the minimum wage. The DDRB recommendation has been accepted and will be paid in September payments. • The LMC has written to practices to cease uncommissioned work associated with MGUS monitoring and Advice and Guidance. Further communications are likely. • Individual practices could see their ability to deliver care to patients impacted through lack of capacity and the infrastructure to provide safe and responsive services will be compromised. • This will have a wider impact as neighbouring practices and other health service partners take on additional workload which in turn affects their resilience. • This may lead to delays in accessing care, increased clinical harm because of delays in accessing services, failure to deliver the recovery of services adversely affected, and poor outcomes for patients due to pressured general practice services.
Key items for assurance/noting:	10 September 2024 Members received reports on the following areas: • Pharmaceutical Needs Assessment – the process and accountability of the Health and Wellbeing Boards for Norfolk and Suffolk for developing and agreeing a PNA were noted, to ensure adequate pharmacy services were provided for our population. • General practice collective action – the areas from the BMA toolkit were presented to members, along with the ICB's emergency planning response.

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	It is also included within the overall BAF and ORR risks for primary care and general practice. • Delivery group reports for the Dental Services, Dental Delivery and General Practice and Community Pharmacy Delivery Groups were noted. • A Delivery Report with a particular focus on improving access was noted. Due to the volume of information included, members asked for a separate session to review the data alongside the latest GP Patient Survey data. • Pharmaceutical Services Regulation Committee and Optometry Services Contractual Changes and Other Matters reports were received, noting this work was hosted on the ICB's behalf by NHS Hertfordshire and West Essex. • Strategic reports for Digital, Estates, Finance and Prescribing were noted, along with acknowledgement of the breadth of work being undertaken. The financial challenges and ongoing unidentified efficiencies in the primary care budget were noted.
Items for escalation to Board:	No items for escalation outside of the risks reported to ICB Board.
Items requiring approval:	• A revised Risk Register was approved which included the latest updates to BAF and BORR. A new strategic risk for primary care which linked to delivery of the Joint Forward Plan ambition for primary care was approved. The risk of delivering health checks to people with learning disabilities was moved to the management team for monitoring due to its mitigated score of 9. Performance would be monitored through the delivery report. • Developing our Strategic Framework: Primary Care Vision and Principles – members discussed the proposed vision which had been developed following wide engagement. While it was supported in principle, officers were asked to include further narrative and share a copy offline. • Primary Care Workforce Strategy 2024 - 2027 & Primary Care Workforce Delivery Plan 2024 – 2025 – the documents were approved with a request to consider back-office staff needs as well as clinicians. • Winter Pharmacy Bank Holiday Commissioning – a proposal to commission cover over the winter period was approved with investment of £30k agreed.

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	• GP Patient Survey Results 2024 – a report was received, and the recommendations approved. The difference in patient experience reported by people with learning disabilities and severe mental illness were noted. Along with the delivery report, this item would form part of a separate session for members.
Confirmation that the meeting was quorate:	There are four voting members and three are required to be quorate. The meeting was quorate with the following attendance: 10 September 2024 Debbie Bartlett, ICB Board local authority partner member and chair of the committee Karen Watts, Director of Nursing and Quality (deputising for Patricia D'Orsi, executive director of nursing, ICB) Hein van den Wildenberg, ICB Board non-executive member A finance officer was also in attendance.

Key Risks	
Clinical and Quality:	Care Quality Commission inspection reports are regularly reviewed. Quality responsibilities have been clarified in the revised Terms of Reference.
Finance and Performance:	Finance reports are noted monthly, detailed performance reports are reviewed on prescribing, learning disability and severe mental illness health checks uptake. Access data is reviewed annually through the GP Patient Survey report. The annual contractual e-declaration requirement for practices is reported. A primary care dashboard is being developed and a delivery report is a standing item.
Impact Assessment (environmental and equalities):	All papers considered include consideration of the ICB's duty to reduce health inequalities.
Reputation:	The committee meeting is held in public and includes attendance from the Local Representative Committees, Healthwatch Norfolk and Suffolk and the Health and Wellbeing Boards in Norfolk and Suffolk
Legal:	Terms of reference, primary medical services contracts, premises directions and policy guidance manual, ICB general duties.
Information Governance:	Any confidential or sensitive information is heard in private

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Resource Required:	Primary care commissioning, quality, finance, primary care estates, primary care workforce, primary care digital, prescribing, locality and BI teams
Reference document(s):	Primary care services regulations, statement of financial entitlements, premises directions and policy guidance manual, delegation agreement with NHS England
NHS Constitution:	N/A
Conflicts of Interest:	Arrangements are in place to manage conflicts of interest

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