Meeting of the Board of Norfolk and Waveney Integrated Care Board

Wed 29 January 2025, 13:30 - 16:30

Agenda

13:30 - 13:30
0 min

Meeting agenda

00. Agenda for Part 1 ICB Board 29.01.25.pdf (5 pages)

13:30 - 13:30
0 min

1. Welcome and introductions - Apologies for absence

13:30 - 13:30
0 min

2. Questions

02. protocol-for-submitting-questions-to-the-icb-board.pdf (1 pages)

13:30 - 13:30
0 min

3. Minutes from previous meeting and matters arising

03. DRAFT NW ICB Board Part 1 Minutes 27112024.pdf (9 pages)

13:30 - 13:30
0 min

4. Declarations of interest

04. ICB Board Register.pdf (5 pages)

13:30 - 13:30
0 min

5. Chair's Action Log

13:30 - 13:30
0 min

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

06. ICB Board Action Log Jan 2025.pdf (1 pages)

13:30 - 13:30
0 min

7. Chair and Chief Executive's Report

07. Chair and Chief Executive's Board report.pdf (5 pages)

13:30 - 13:30
0 min

Learning from People, Staff, and Communities

13:30 - 13:30
0 min

8. Dental Lived Experience Item - Our focus today is on dental services in Norfolk and Waveney, utilising the experience of residents to inform the Board.

13:30 - 13:30
0 min

9. Report from Patients and Communities Committee

09. Patients and Communities Committee Report to Board.pdf (4 pages)

13:30 - 13:30
0 min

Strategy and Partnerships

13:30 - 13:30
0 min

10. Joint Children's update (including SEND) (30 mins)

10. ICB - children's system - shared challenge and activities.pdf (32 pages)

13:30 - 13:30
0 min

11. Report from the Quality and Safety Committee

11. Quality and Safety Committee Report to Board.pdf (7 pages)

13:30 - 13:30
0 min

12. Health Inequalities and EDI update and proposed approach for reporting

12. ICB Board_Health Inequalities EDI reporting_Jan25_final.pdf (5 pages)

13:30 - 13:30
0 min

Commissioning, Delivery and Performance

13:30 - 13:30
0 min

13. Financial Report for Month 8

13. ICB Finance Report - Month 08 202425 - Board.pdf (10 pages)

13:30 - 13:30
0 min

14. Report from the Finance Committee

14. Finance Committee Report to Board.pdf (4 pages)

13:30 - 13:30
0 min

15. Integrated Performance Report (IPR)

15. Integrated Performance Report.pdf (15 pages)
15.1 Integrated Performance Report.pdf (54 pages)

13:30 - 13:30
0 min

16. Report from the Commissioning and Performance Committee

16. Commissioning and Performance Report to Board.pdf (7 pages)

13:30 - 13:30
0 min

17. Specialised Commissioning (CEO delegation)

17. Board Paper-Spec comm.pdf (3 pages)

13:30 - 13:30
0 min

18. Primary Care Commissioning Committee

18. Primary Care Committee Report to Board.pdf (6 pages)

13:30 - 13:30
0 min

System Oversight

13:30 - 13:30
0 min

19. NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR)

19. NHS Core Standards for EPRR report to Board.pdf (7 pages)

13:30 - 13:30
0 min

20. Board Assurance Framework

20. Risk Management Report-Board-Pt1-BAF-Jan 25.pdf (3 pages)
20.1 Appendix 1-Board Assurance Framework-Board Pt1 Jan 25.pdf (26 pages)

13:30 - 13:30
0 min

21. Report from the Audit and Risk Committee

21. Audit and Risk Committee Report to Board.pdf (3 pages)

13:30 - 13:30
0 min

Remaining Committees Reports and Questions from the public

13:30 - 13:30
0 min

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

13:30 - 13:30
0 min

23. Questions from the Public.

13:30 - 13:30
0 min

24. Any other business

13:30 - 13:30
0 min

25. ICP update and report

25. ICP Committee Report to Board - for information.pdf (16 pages)

Norfolk and Waveney
Integrated Care Board

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

Wednesday, 29 January 2025 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 24 January 2025, via e-mail to: nwicb.contactus@nhs.net.

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

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

Chair: Hein van den Wildenberg (Vice Chair)

Item	Time	Agenda Item	Lead
Introductory Items			
1.	1.30	**Welcome and introductions - Apologies for absence**	Chair
2.		**Questions** Notification of any questions from members of the public on agenda items for response at the appropriate time on the agenda	Chair
3.		**Minutes from previous meeting and matters arising** To approve the part 1 public minutes of the previous Board meeting.	Chair
4.		**Declarations of interest** To declare any interests that board members may have specific to agenda items that could influence the decisions they make. Declarations made by members of the ICB Board are listed in the ICB's Register of Interests. The Register is available via the ICB's website.	Chair
5.		**Chair's Action Log** To receive an update from the Chair on actions taken since the last meeting. There are no Chairs Action to report at this meeting.	Chair
6.		**Action log – things we have said we will do** To make sure the ICB completes all the actions it agrees are needed.	Chair
7.	1.35	**Chair and Chief Executive's Report** To note an update from the Chair and the Chief Executive of the ICB about the work the ICB has done since the last meeting.	Chair and Tracey Bleakley
		Learning from People, Staff, and Communities	
8.	1.45	Our focus today is on dental services in Norfolk and Waveney, utilising the experience of residents to inform the Board.	Tricia D'Orsi
9.	2.05	**Report from Patients and Communities Committee**	Aliona Derrett
		Strategy and Partnerships	

Item	Time	Agenda Item	Lead
10.	2.10	**Joint Children's update - the Children's Landscape and Opportunities in Norfolk**	Tricia D'Orsi Sara Tough
11.	2.40	**Report from the Quality and Safety Committee**	Aliona Derrett
12.	2.45	**Health Inequalities and EDI update and proposed approach for reporting** To outline reporting requirements for health inequalities and Equality, Diversity and Inclusion.	Mark Burgis
		Comfort Break 10 Minutes	
		Commissioning, Delivery and Performance	
13.	3.05	**Financial Report for Month 8** To receive a summary of the financial position as at month 8.	Steven Course
14.	3.15	**Report from the Finance Committee**	Hein Van Den Wildenberg
15.	3.20	**Integrated Performance Report (IPR)** To provide assurance to the ICB Board and highlight significant elements of the system performance reporting.	Matt Dooley
16.	3.30	**Report from the Commissioning and Performance Committee**	Hein Van Den Wildenberg
17.	3.35	**Specialised Commissioning (CEO delegation)** To ask the Board to agree that the Chief Executive Officer can sign the revised delegation and collaboration agreements on behalf of ICB once finalised.	Andrew Palmer
18.	3.45	**Primary Care Commissioning Committee**	Ian Wake/Hein Van Den Wildenberg
		System Oversight	
19.	3.50	**NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR)** To provide a summary of the core standards annual assurance process for Norfolk Local Health Resilience Partnership (LHRP).	Steven Course
20.	4.00	**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

Item	Time	Agenda Item	Lead
21.	4.10	**Report from the Audit and Risk Committee**	David Holt
		Remaining Committees Reports and Questions from the public	
22.	4.15	**Report from the Remuneration, People and Culture Committee - verbal**	Cathy Armor
23.	4.20	**Questions from the Public.** Where questions in advance relate to items on the agenda.	Chair
24.	4.25	**Any other business**	Chair
25.		**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.	For information
Date, time, and venue of next meeting: 1.30pm – 4.30pm Wednesday 26 March 2025 Meeting to be held virtually via Microsoft teams			
Any queries or items for the next agenda please contact: **nwicb.corporateaffairs@nhs.net**			

Some explanations of terms used in this Agenda.

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

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

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

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

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

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

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

NHS
Norfolk and Waveney
Integrated Care Board

Protocol for submitting questions to the ICB Board

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

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

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

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

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

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

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

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

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

NHS Norfolk and Waveney Integrated Care Board

DRAFT Minutes of the meeting on Wednesday, 27 November 2024

PART 1 – Meeting in public

Board members present:

- Hein Van Den Wildenberg (HvdW), Non-Executive Member and Vice Chair, NHS Norfolk and Waveney ICB
- Tracey Bleakley (TB), Chief Executive, NHS Norfolk and Waveney ICB
- Steven Course (SC), Executive Director of Finance, NHS Norfolk and Waveney ICB
- Dr Frankie Swords (FS), Executive Medical Director, NHS Norfolk and Waveney ICB
- Patricia D'Orsi (PD'O), Executive Director of Nursing, NHS Norfolk and Waveney ICB
- David Holt (DH), Non-Executive Member, NHS Norfolk and Waveney ICB
- Aliona Derrett (AD), Non-Executive Member, NHS Norfolk and Waveney ICB
- Cathy Armor (CA), Non-Executive Member, NHS Norfolk and Waveney ICB
- Cllr Bill Borett (BB), Chair, Norfolk Health and Wellbeing Board, and Chair, Norfolk and Waveney ICP
- Stuart Keeble (SK), Local Authority Partner Member
- Jonathan Barber (JBa), Partner Member – NHS Trusts (Acutes)
- Emma Ratzer (ER), Voluntary, Community and Social Enterprise Sector Board Member

Participants and observers in attendance:

- Andrew Palmer (AP), Executive Director of Performance, Transformation and Strategy, and Deputy Chief Executive, NHS Norfolk and Waveney ICB
- Karen Barker (KB), Executive Director of Corporate Affairs and ICS Development, NHS Norfolk and Waveney ICB
- Matt Dooley (MD), Executive Director of Commissioning and Performance, NHS Norfolk and Waveney ICB

Attending to support the meeting:

- Martin Keegan (MK), Senior Collaborative Lead, Norfolk and Suffolk NHS Foundation Trust (for item 10)
- Dr Wendy Outwin (WO), Chair and Medical Lead, Norfolk and Waveney Local Medical Committee (for item 13)
- Sadie Parker (SP), Director of Primary Care, NHS Norfolk and Waveney ICB (for item 13)
- Marcus Bailey (MB), Director of System Resilience, NHS Norfolk and Waveney ICB (for item 14)
- Janice Shirley (JS), Head of System Clinical Transformation Programmes, NHS Norfolk and Waveney ICB (for item 15)
- James Allen (JA), Clinical Programmes Senior Manager, NHS Norfolk and Waveney ICB (for item 15)
- Paul Benton (PB), Director for Quality in Care NHS Norfolk and Waveney ICB (for item 15)
- Lee Watson (LW), Public Health Consultant, Norfolk County Council (for item 15)
- James Casson, Consultant Geriatrician, Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (for item 15)

• Chris Williams (CW), Head of Communications and Engagement, NHS Norfolk and Waveney ICB (Minutes)		
1.	**Welcome and introductions - apologies for absence**	
	The Chair welcomed everyone to the meeting. Apologies were received from the following Board members: • Rt Hon. Patricia Hewitt (PH), Chair, NHS Norfolk and Waveney ICB • Ian Wake (IW), Local Authority Partner Member • Dr Hilary Byrne (HB), Partner Member – NHS Primary Medical Services • Caroline Donovan (CD), Partner Member – NHS Trusts The Chair noted that it would have been the last Board meeting for CD and thanked her for her contributions. He also welcomed MD to his first Board meeting.	
2.	**Questions**	
	The Chair noted that four questions had been received, two of which did not relate to agenda items. A member of the public noted that they would like to ask a question about winter planning. The Chair noted that the question could be asked at item 14.	
3.	**Minutes from previous meeting and matters arising**	
	Agreed: The draft minutes from the meeting held on 25 September 2024 were approved as an accurate record of the meeting.	
4.	**Declarations of interest**	
	The Chair noted that declarations of interest were kept up-to-date and were available on the ICS's website.	
5.	**Chair's action log**	
	The Chair noted there were no chair's actions to report.	
6.	**Action log**	
	The Chair noted that there was one item on the action log and that it could be closed. The report was noted.	
7.	**Chair and Chief Executive's Report**	
	TB introduced the item by highlighting key points from the report, including the financial position, seasonal resilience, the development of the national ten-year plan for health and an update on Benjamin Court. **Action: TB to arrange for the ICB to involve Mary Russell in discussions about potential space at NHS premises in north Norfolk**	**TB**

	for voluntary, community and social enterprise sector organisations to operate from. The report was noted.	
	Learning from People, Staff, and Communities	
8.	**Learning from People, Staff and Communities**	
	PD'O introduced the item by thanking Healthwatch Norfolk for the video regarding the health and wellbeing of, and support for, veterans and their families. Questions and comments from Board members: • FS highlighted that it was now a requirement for all public sector organisations to recognise the unique obligations and sacrifices of veterans, to remove disadvantages from how we set-up services, and to consider specific additional services. She added that we needed to consider not just veterans, but the wider community, including the family and carers of veterans. She noted the great work being undertaken at the James Paget Hospital with regards to veterans. **Agreed:** The ICB Board noted the report.	
9.	**Report from Patients and Communities Committee**	
	AD introduced the item by highlighting key points from the report, noting that a new approach was being taken to ensure the voice of people with lived experience was being heard by the committee. **Agreed:** The ICB Board noted the report.	
	Strategy and Partnerships	
10.	**Review of intensive and assertive community treatment for people with severe mental health problems**	
	MK introduced the item by highlighting key points from the report. Questions and comments from Board members: • AD asked if there were plans to engage with the carers of people with serious mental illness. • MK confirmed the plan does include engagement. • PD'O reinforced that engaging with carers was important for safety planning. • SK commented that it would be interesting to look at the characteristics of the cohort and asked if analysis showed a need for cultural sensitivities. • MK noted that the data analysis was at an early stage and further work was needed.	

	• SK explained that Suffolk and North East Essex had undertaken some integration of secondary mental health and primary care data. • DH commented that we needed to be clear about the lessons learned from supporting / providing holistic care to this group and veterans, then apply the learning to other groups and across our inequalities agenda. • BB noted that it would be interesting to map the cohort as they were unlikely to be evenly spread across Norfolk and Waveney. • FS commented that the conversation was moving to 'is there a reason not to involve family', rather than 'is there a reason to involve the family'. She questioned if you need a specific outreach service or if you could upskill a wider group of staff. • PD'O explained that her understanding from other areas was that there was an opportunity to have a team involving other partners and that the paper allowed us to start having a conversation about that locally. • ER suggested that a way to make sure we were identifying people would be to engage with the place based rough sleeper initiative and the VCSE organisations that usually run those services. **Agreed:** The ICB Board noted the report.	
11.	**Integrated Performance Report (IPR)**	
	AP introduced the item by explaining that the report picked out the national planning metrics and those most important to represent the performance of our system, adding that the metrics were looked at in detail by the ICB's Commissioning and Performance Committee. Questions and comments from Board members: • DH commented that we need to think about trajectories and what we want to achieve and by when, and questioned what was the ask of the Board. • SK asked how health inequalities were considered and whether there were some indicators that could be broken down by protected characteristics. • AP explained that the system had been analysing the elective wait list by the index of multiple deprivation, but that this was not done for all indicators. **Action: AP to explore which performance indicators could be broken down by protected characteristics.**	**AP**
12.	**Report from the Commissioning and Performance Committee**	
	HvdW introduced the item by highlighting key points from the report **Agreed:**	

	The ICB Board noted the report.	
13.	**Primary Care Access Recovery Plan**	
	HvdW invited WO to address the Board to share the views of the Local Medical Committee. WO thanked the Board for the opportunity to comment on the report. She explained that there were a number of issues the LMC felt had not improved, highlighting uncontracted unfunded work and the impact on general practice of this, the care of patients with serious mental illness, and workforce and funding for general practice. She noted continuity of patient care was proven to be effective and that it was vital for NHS productivity and to reduce pressure on secondary care. SP then introduced the item by highlighting key points from the report. Questions and comments from Board members: • AD asked how effective Pharmacy First was proving to be and whether there was any concern patients were going back and forth between their pharmacy and GP practice. • FS noted there had been a concern that Pharmacy First could lead to an increased workload for general practice, however less than 2% of people using the service were being signposted to see their GP afterwards. She thanked colleagues across community pharmacy for everything they were doing and noted that the feedback from customers was positive. **Action: SP to provide an update to the Board on the timescales for non-medical health professionals being able to request appropriate laboratory tests via the WebICE system.** **Agreed:** The ICB Board noted the report.	**SP**
14.	**Winter plan refresh**	
	MB introduced the item by highlighting key points from the report. David Russell, a member of the public, asked: 'Are the ICB able to forecast what effect the government winter fuel allowance loss will have on hospital admissions this coming winter?' **Action: MB to provide a written answer to David Russell's question regarding the winter fuel allowance.** Questions and comments from Board members: • BB highlighted the importance of people taking up the offer of a vaccination. He commented that it would be the first year that systems would not receive any extra funding for winter and noted that it may increase the pressure on the system.	**MB**

	• CA asked if the Queen Elizabeth Hospital was offering staff the COVID-19 vaccination this year. • ER noted that Norfolk Community Foundation ran a scheme whereby people who did not need their winter fuel allowance could donate the money, and that it might be worth contacting the foundation for their data and insight. • JB commented that the Board and the system needed to focus on reducing the length of stay of patients and that the system could be bold about how it allocated funding to achieve this. **Action: PD'O to confirm if the COVID-19 vaccination was being given to staff at the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust.** **Agreed:** The ICB Board noted the report.	**PD'O**
15.	**Ageing Well Programme**	
	FS and JS introduced the item by highlighting key points from the report. Questions and comments from Board members: • CA asked what work was being done with families of people who are in care homes. • PB explained work was being done to help ensure families have the information they need. • AD asked what attempts were being made to support the left-shift. • JS explained that the focus was on the early identification of potential problems in general practice and putting support in place early. • JC added that work to improve screening and diagnosis was being discussed. • JB explained that he would like to take the outputs of this work to the James Paget's hospital management groups to ensure there was no duplication. He added that it was important we have clear mechanisms for workstreams to share progress with individual partners. • ER asked what work was being done to identify and support people who were frail because of their lifestyles rather than their age. • JS commented that there was some joint work with colleagues working on health inequalities, but that this was a good point. • LW explained that the Joint Strategic Needs Assessment would provide some insight, for example around falls prevention and social isolation. • SK noted that ageing isn't chronological, it's situational. He added that the UK was one of fastest ageing populations and that Norfolk	

	and Suffolk were at the forefront of it, and that this was an opportunity. **Agreed:** The ICB Board noted the report.	
	Commissioning, Delivery and Performance	
16.	**Financial Report for Month 6**	
	SC introduced the item by highlighting key points from the report. **Agreed:** The ICB Board noted the report.	
17.	**Report from the Finance Committee**	
	HvdW highlighted that the committee had looked at the month seven financial report the previous day and that it had showed the gap was widening with four months of the financial year left. Questions and comments from Board members: • SC explained that further work was being done to strengthen the system's financial recovery actions, and that FS and PD'O provided a clinical view on the work being done. • HvdW asked if the system was able to move quickly when it made decisions to implement changes. • SC noted that changes would need to be implemented quickly. • TB added that chairs of the NHS trusts were informed and had committed their boards and organisations to responding appropriately. **Agreed:** The ICB Board noted the report.	
	System oversight	
18.	**ICB Framework for System Quality Deterioration**	
	PD'O introduced the item by highlighting key points from the report. Questions and comments from Board members: • SC welcomed the report, highlighting it would be a helpful tool and that we must consider quality when looking at finances. • AD reinforced that while finance was important, we could not lose focus on quality. She thanked PD'O and her team for their work on the framework, adding that she would like to invite PD'O to talk to non-executives from the system about it. • JB commended the report and noted that it may be helpful to have a discussion with partner organisations about reviewing their risk appetites.	

	• AP noted that there was potential to involve a lot of indicators and offered to work with PD'O on this. He asked what engagement there had been with NHS England. • PD'O explained that Norfolk and Waveney was the first ICB to have created a framework, that it was in line with the national quality board and they were supportive of what we were doing. She added that further work was needed to consider how to use it to inform escalation reports between the ICB and regional quality groups. • DH commented that it was helpful in demonstrating a more quantitative approach to quality and of ensuring we are using evidence, rather than making assumptions. • PD'O noted that it was important to ensure statistical variation and not just a month by month change to a metric. **Action: PD'O and JB to agree amendment to the executive summary of the ICB Framework for System Quality Deterioration.** **Agreed:** The ICB Board: • Approved the Deteriorating Quality Framework for ICB implementation. • Supported the next steps in relation to sharing across the system for provider partner approval and implementation.	**PD'O and JB**
19.	**Report from the Quality and Safety Committee**	
	AD introduced the item by highlighting key points from the report. The report was noted.	
20.	**Board Assurance Framework**	
	KB introduced the item by highlighting key points from the report. Questions and comments from Board members: • HvdW noted that BAF8 was about the ICB's financial plan and not the system's and explained he would like a further discussion of this outside of the meeting to consider if it needed changing. • DH highlighted with BAF 5 the impact of an ageing population. **Action: KB to add changing demographics and ageing population to the forward plan for a future board development meeting.** **Agreed:** The ICB Board noted the contents of the paper and approved the change in responsible committee for BAF03, BAF04 and BAF06.	**KB**
21.	**ICB Constitution Review**	
	KB introduced the item by explaining that the ICB's constitution had only been reviewed a couple of times since the organisation's inception. She noted that the vast majority of the proposed amendments were nationally	

	proposed changes, and that the proposed changes to section 2.3.2. covered changes in job titles of the ICB's directors. She confirmed that NHS England would also have to approve the changes to the ICB's constitution. The ICB Board: • Reviewed and agreed the proposed changes to the Constitution. • Agreed to submit the draft document to NHS England for final approval. • Agreed the Chair's proposal that Hein Van Den Wildenberg would be the Senior Non-Executive Member. • Agreed that the Executive Director of Nursing would take on the executive lead role for care levers, in addition to the other population groups she was already responsible for.	
	Remaining Committees Reports and Questions from the public	
22.	**Report from the Audit and Risk Committee**	
	DH noted that he had given a verbal update to last meeting and had nothing to add. The report was noted.	
23.	**Report from the Primary Care Commissioning Committee**	
	HvdW noted that the committee had not met since last Board meeting.	
24.	**Report from the Remuneration, People and Culture Committee**	
	CA explained that the last meeting of the committee had focused on financial recovery and workforce.	
25.	**Questions from the public**	
	There were no questions from the public.	
26.	**Any other business**	
	No other business was raised.	
Date, time and venue of next meeting: **Wednesday, 29 January 2025, 1.30pm – 4.30pm, via MS Teams.**		
Any queries or items for the next agenda please contact: **nwicb.corporateaffairs@nhs.net**		

Minutes agreed as accurate record of meeting:

Signed: …… Date: ……...
Chair

Davey Heidi
23/01/2025 07:13:21

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

Declared interests of the Board

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Is the interest direct or indirect?		From	To	
Patricia Hewitt	Chair, Norfolk and Waveney ICB	FTI Consulting	X			Direct	Senior advisor, FTI Consulting	2015	Present	Since January 2022 I have not undertaken any work on healthcare or life sciences. Will declare at relevant meetings if a risk arises.
		Newnham College Cambridge			X	Direct	Honorary Associate, Newnham College Cambridge	2018	Present	No conflicts have arisen or foreseen
		Oxford India Centre for Sustainable Development			X	Direct	Chair, Advisory Board, Oxford India Centre for Sustainable Development	2018	Present	No conflicts have arisen or foreseen
		ORA Choral Ensemble			X	Direct	Chair, Board of Trustees, ORA Singers	2020	Present	No conflicts have arisen or foreseen
		Age UK Norfolk			X	Direct	Volunteer, Age UK Norfolk	2020	Present	Declaration of interest made in any relevant conversation
		Future Public Services Taskforce			X	Direct	Member, advisory board, Future Public Services Taskforce, Demos	Sep-23	Present	No conflicts have arisen or foreseen
Cathy Armor	Non-Executive Member, Norfolk and Waveney ICB	Brundall Medical Practice			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
		Educational Association			X		Trustee, Workers Educational Association	Dec-23	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		Council, Norwich University of the Arts			X		Deputy Chair of Council, Norwich University of the Arts	2019		
		Evolution Academy Trust			X		Trustee, Evolution Academy Trust	2022		
		Cambridge University Press Pension Schemes		X			Trustee, Cambridge University Press Pension Schemes	2018		
		East of England Ambulance Service NHS Trust				Indirect	Daughter-in-law is Technician for East of England Ambulance Service NHS Trust			
Jon Barber	Partner Member	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 NHS FT		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

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	
		Great Yarmouth & Waveney		X		Direct	GY&W Place Chair	Ongoing		
		Acle Surgery			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Tracey Bleakley	Chief Executive Officer, Norfolk and Waveney ICB	Drayton Medical Practice			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
		Chair of Primadonna Literary Festival (Suffolk)			X		Chair of the board and attendee of the festival	2021	Current	No link to health and therefore no risk to mitigate
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 Ltd			X	Indirect	Wife is an employee of a physiotherapy business	Sep-15	Present	Ensure not involved in any decision making that may involve the company
Aliona Derrett	Non-Executive Member, Norfolk and Waveney ICB	Norfolk and Norwich University Hospital			X	indirect	My son-in-law, Richard Wharton, is a consultant surgeon at NNUHFT	2004	To date	Will withdraw from any discussions and decision that might directly involve the department or discipline that relates to the declared conflict.
		Norfolk Deaf Association	X			direct	I am the Chief Executive Officer of Hear for Norfolk (Norfolk Deaf Association). The charity holds contracts with the N&W ICB	2010	To date	Not involved in any discussions and decisions that might benefit Hear for Norfolk
		Derrett Consultancy Ltd	X			indirect	I am the Director of Derrett Consultancy Ltd	2018	To date	Low risk. In the unlikely event that a risk arises I will discuss the mitigation actions with the Chair of the ICB Board.

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	
		Norfolk & Waveney MIND	X			indirect	My husband, Robin Derrett, is the HR Director at Norfolk & Waveney MIND. MIND holds contracts	2021	To date	Not involved in any discussions and decisions that might benefit N&W Mind
		Lakers Games Ltd	X			indirect	I am the Director of Lakers Games Ltd	Nov-24	To date	Very low risk. In the unlikely event that a risk arises I will discuss the mitigation actions with the Chair of the ICB Board.
		St Stephens Gate Medical Practice			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Dr Faisil Sethi	Partner Member - Mental Health and Community	Norfolk and Suffolk NHS Foundation Trust					Deputy Chief Executive Officer and Chief Medical Officer - Norfolk and Suffolk NHS Foundation Trust	*28/11/2024	Present	Awaiting Declaration of Interest form
Patricia D'Orsi	Executive Director of Nursing, Norfolk and Waveney ICB	Royal college of Nursing			X	Indirect	Professional Body - RCN Union			
David Holt	Non-Executive Member, Norfolk and Waveney ICB	Ministry of Defence	X			Direct	NED Audit & Risk Assurance Committee	2022	Present	
		Newberry Clinic				Indirect	Wife a Consultant Community Paediatrician	2023	Jul-24	
		Sole Bay Health Centre			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
Stuart Keeble	Director of Public Health and Communities for Suffolk and member elect of Norfolk and Waveney ICB	Nothing to Declare					N/A			N/A
Andrew Palmer	Deputy Chief Executive Officer, Norfolk and Waveney ICB	James Paget University Hospitals				Indirect	My wife works at the JPUH, in a non-decision making role	Ongoing		Any decision relating specifically to the JPUH should ideally be made by the ICB's CEO. However, in their absence the decision will be taken in the best interests of the system with the necessary due-diligence taking place prior to final decision being made
		Beccles Medical Centre			X	Direct	Patient at a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest

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	
Emma Ratzer	Partner Member - VCSE	Norfolk & Wavaney Integrated Care Board	X			Direct	My employing organisation holds contracts with NWICB	2009	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards Community Access Trust
		VCSE Assembly			X	Direct	I am CEO of a voluntary sector organisation operating in NWCCG and Independent Chair of NWVCSE Assembly	2021	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
Dr Frankie Swords	Executive Medical Director, Norfolk and Waveney ICB	Long Stratton medical partnership			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
		Norfolk and Norwich University Hospital			X	Direct	Honorary Consultant Physician and Endocrinologist at Norfolk and Norwich University Hospitals NHS FT (1 day a week)	2008	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Multiple patient charities			X	Direct	Ad hoc Clinical Advisor for multiple patient charities - Addison Self Help Group - Pituitary Patient Support Group - Turner syndrome Society	2008	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		British Medical Association			X	Direct	Member of the British Medical Association	1999	Present	Inform Chair and will not take part in any discussions or decisions relating to BMA
		Better Help, and VCSE provider: St Martin's Housing Trust	X			Inidrect	Husband is a mental health counsellor and undertakes work independently and with the private provider Better Help, and VCSE provider: St Martin's Housing Trust	2022	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of counselling services by St Martin's Housing Trust or Better Help
Ian Wake	Exectutive Director for Adult Social Services	Norfolk County Council						*28/10/2024	Present	

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	
Hein van den Wildenberg	Non-Executive Member, Norfolk and Waveney ICB	Lakenham Surgery			X		Patient at a Norfolk and Waveney GP Practice	Ongoing		To be raised at all relevant meetings where discussions/decisions relate to the conflict declared
		College of West Anglia			X	Direct	Governor at College of West Anglia (Note: the College hosts the School of Nursing, in partnership with QEHKL and borough council)	2021	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		Broadland Housing Association	X			Direct	Non-Executive Director and Board member for Broadland Housing Association	2024	Present	Will excuse myself from any decisions relating to Broadland Housing Association

NORFOLK & WAVENEY ICB Action Log Part 1 - Wednesday 29 January 2025							
No:	**Date of Meeting**	**Description**		**RESP**	**Due Date**	**ACTION / UPDATE**	**Status**
32	27-nov-24	Tracey Bleakley to arrange for the ICB to involve Mary Russell in discussions about potential space at NHS premises in north Norfolk for voluntary, community and social enterprise sector organisations to operate from.	The ICB Place team has contacted Mary Russell to take forward this action.	KB/TB	29-jan-25	Propose closure of action.	
33	27-nov-24	Andrew Palmer to explore which performance indicators could be broken down by protected characteristics.	The ICB is currently refreshing the Integrated Performance Report and the structure of performance oversight. This includes determining where splits by protected characteristics and/or health inequalities groups is achievable and would add value. These breakdowns will be provided within reporting intended for analysis and scrutiny below Board level with key insights brought to the Board through the narrative provided in the performance reporting as well as reports from each Committee - these would also be available to the Board to review at key intervals.	AP	29-jan-25	Propose closure of action.	
34	27-nov-24	Sadie Parker to provide an update to the Board on the timescales for non-medical health professionals being able to request appropriate laboratory tests via the WebICE system.	QEH had already implemented WebICE requesting for non-medical health professionals. Progress for both JPUH and NNUH has stalled due to administrative resources. Liaising with leads we have been advised by the NNUH, that they will be unable to proceed until the new financial year. The JPUH is working through the Expression of Interests from GP Practices. They will also be impacted by the NNUH's delay, but have not yet confirmed a timescale. A further update can be provided in due course.	SP	29-jan-25	Propose closure of action.	
35	27-nov-24	Marcus Bailey to provide a written answer to David Russell's question regarding the winter fuel allowance.	This action was addressed between MB and DR via email correspondence.	MB	29-jan-25	Propose closure of action.	
36	27-nov-24	Patricia D'Orsi to confirm if the COVID-19 vaccination was being given to staff at the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust.	Staff at the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust have been offered COVID vaccinations.	PD'O	29-jan-25	Propose closure of action.	
37	27-nov-24	Patricia D'Orsi and Jon Barber to agree amendment to the executive summary of the ICB Framework for System Quality Deterioration.	Patricia D'Orsi and Jon Barber have met to consider the action. A paper is being drafted on that basis.	PD'O & JB	29-jan-25	Propose closure of action.	
38	27-nov-24	Karen Barker to add changing demographics and ageing population to the forward plan for a future board development meeting.	Item placed on the ICB Board forward plan.	KB	29-jan-25	Propose closure of action.	

Norfolk and Waveney
Integrated Care Board

Agenda item: 07

Subject:	**Chair and Chief Executive's report**
Presented by:	**Hein van den Wildenberg, Non-Executive Member and Vice Chair, NHS Norfolk and Waveney ICB** **Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney ICB**
Prepared by:	**Hein van den Wildenberg, Non-Executive Member and Vice Chair, NHS Norfolk and Waveney ICB** **Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney ICB**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**29 January 2025**

Purpose of paper:

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

Executive Summary:

The report covers the following:

A. Looking ahead to 2025
B. Operational performance
C. Reducing waits for planned care
D. Closer working between our three acute hospitals
E. Government reaffirms commitment to rebuilding the Queen Elizabeth and James Paget Hospitals
F. Recognition for Rt Hon. Patricia Hewitt's lifetime of service to improving people's health
G. Meetings and visits

Report

A. Looking ahead to 2025

2025 is going to start with a series of positive developments for local health and care services. In the first weeks of 2025 we will see the opening of:

- The Willows therapy unit, which will help patients who don't need to be in hospital, but do need some support before they can go home.
- The new Rivers Centre wards at Hellesdon Hospital, which will increase the number of in-patient mental health beds in Norfolk and Waveney.
- The Community Diagnostic Centre at the Norfolk and Norwich University Hospital, which will increase the number of scans and tests we can do, speeding-up the diagnosis and treatment of cancer and other conditions.

Investments like these in our buildings are great, but of course alongside these we will also be making improvements to services and how we work as a system. We are looking forward to seeing the innovations and developments that we will make happen in 2025.

At the same time, the financial position continues to be very challenging, not just for us in Norfolk and Waveney, but for systems across the country too. So, as well as the investments and innovations we will make in 2025, we know that there will also be some very hard choices we will have to make.

We do not have our financial allocation for 2025/26, or the planning guidance that sets out what we will be required to deliver over the next financial year, but we do know finances will be very difficult. This is true of the wider public sector and for our partners too, both statutory organisations, like local councils, and the voluntary, community and social enterprise sector.

Board members will have heard in previous years that NHS finances were challenging, and they have been. However, the scale of the challenge for next year means it will be incredibly difficult. As an ICB alone, we expect to have to make over £160m of savings in 2025/26.

There are a range of factors that are affecting our finances. For example:

- The recent period of higher inflation has played a role in making the equipment and supplies we buy more expensive.
- The impact of the COVID-19 pandemic is still being felt. For example, there are a lot of people on waiting lists for planned care who weren't seen during the pandemic because the NHS focused on caring for people with the virus and those needing urgent care. It is vital we now treat those who have been waiting, but of course treating everyone waiting will cost money.
- It is great that people are living longer and we all welcome that, however, as we age, people are more likely to have more than one health condition and so will naturally need more treatment from the NHS. As Norfolk and Waveney

has an older population compared to the national average, this is an important trend for us.

These aren't the only factors and of course the NHS can be more productive, but the fundamental problem is that we have a significant underlying deficit, and we spend more each year than we receive to pay for services. In fact, the gap between the money we receive to pay for services and the cost of those services is growing. This is why we need a reset to create a more sustainable system.

There are changes we can and will make that will not impact on the services people receive. We will do everything we can to make efficiencies in order to protect services, but given the scale of the challenge, we are going to have to make savings, and this will mean making changes to services.

We now expect to receive our financial allocation for 2025/26 and the planning guidance in the next couple of weeks. Once we receive these, we will then need some time to assess what it means for us. We will continue to keep the Board informed.

B. Operational performance

Operationally it has been a very busy Christmas period and start to the new year, and we would like to thank health and care staff for their hard work and dedication. The early start to the flu season and high numbers of people with the virus, coupled with cases of COVID-19, RSV and norovirus, put the system under significant pressure. This has been felt across primary, community and secondary care, including social care.

We will of course be exploring what has worked well this year and what we need to do differently next year. In terms of the wider context, it is worth remembering that over the past five years we have made some really good progress in terms of managing demand for urgent and emergency care. For example, compared to 2019/20, we are now dispatching 0.6% fewer ambulances, there are 9.1% fewer ambulances arriving at our hospitals and 4.5% fewer emergency admissions.

Our Unscheduled Care Coordination Hub is a really good example of how we have done this and how we have changed the way we work to improve people's care. The hub helps to ensure people get the right care in the right place and we avoid conveying people to hospital unnecessarily, by re-directing people to community services.

C. Reducing waits for planned care

Locally we have undertaken a significant amount of work to reduce waits for planned care and nationally the NHS is now delivering more elective care than ever before, but there is much more to do to reduce waiting times and improve people's care while they wait. On 6 January the government and NHS England published their plan 'Reforming elective care for patients'. We are working through the plan to understand what it means for us in Norfolk and Waveney. There is a lot in the plan, and we will provide an update to the Board at a future meeting.

D. Closer working between our three acute hospitals

Board members will be aware that on 12 December 2024, Norfolk's three acute hospitals announced they would be exploring moving to a group model and being led by a single chair and chief executive. We are very supportive of this proposed change; it feels like the natural next step in the way the hospitals work together.

We can see the benefits it would have for patients, staff and the health and care system. By streamlining decision-making and strengthening collaboration, this change would help us to reduce variation in care, improve health outcomes, and make better use of resources. Most importantly, it would enable us to deliver more consistent, high-quality care for patients across Norfolk and Waveney.

E. Government reaffirms commitment to rebuilding the Queen Elizabeth and James Paget Hospitals

The Secretary of State for Health and Social Care announced the outcome of the Review of the New Hospital Programme in Parliament on 20 January 2025. The announcement confirmed that the rebuilding of the Queen Elizabeth and James Paget Hospitals remains a priority and will progress, although it may take slightly longer than previously envisaged. Together with the trusts and NHS England, we are assessing the impact of the announcement.

We have already done a lot of work locally to plan for the two new hospitals and we will do everything we can to get them built as quickly as we can. In the meantime, our absolute priority will be to ensure that services continue to run safely and effectively at the existing hospitals until the new buildings are ready.

F. Recognition for Rt Hon. Patricia Hewitt's lifetime of service to improving people's health

We want to congratulate Patricia for being awarded a damehood in the New Year Honours List, recognising her significant contribution to health and care services. Throughout her career, Dame Patricia has demonstrated an absolute commitment to improving people's health, wellbeing and care.

As Secretary of State, alongside many other achievements, Dame Patricia introduced the smoking ban, which has had a significant impact on the health of our nation and continues to do so. It was her personal drive, commitment to the issue and focus on making practical changes that meant the ban she introduced went beyond what was first committed to. Ten years after the ban was introduced, analysis by Public Health England showed there had been a 21 per cent drop in the number of smokers aged 35 and over dying from heart attacks and other cardiac conditions, as well as many, many other health benefits.

In her current role, Dame Patricia has continued to make a difference locally and nationally. Her collaborative approach and leadership style has enabled local health and care services to tackle some long-standing challenges.

G. Meetings and visits

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

- There continues to be a strong focus on our finances and efficiencies, both for the ICB and the system, so I have been involved in a number of regional and local meetings about this, along with other executive colleagues.
- I have taken a lead on a piece of regional work around palliative and end of life care, and so I have been in contact with colleagues from across the east of England to discuss this. Locally, I also met with the chief executive of St Elizabeth Hospice to hear about their plans for Gorleston, and the chief executive of St Nicholas Hospice Care to discuss care for people in Thetford.
- I had a catch-up with Neill Moloney in his new role as chief executive of the ambulance service.
- I attended the ICB CEOs and NHS England Executive Group meeting to discuss national priorities and plans.
- I have attended a few meetings with our MPs about social care, preparations for winter, the move to a group model for our acute hospital trusts and an update on progress being made by the mental health trust.
- I really enjoyed attending the opening of The James Paget Orthopaedic Centre and Community Diagnostic Centre – these new facilities will make a positive difference to the local community and to staff as well. While at the hospital, I also took the opportunity to meet with and thank staff working in the emergency department, as well as to ask them for their views on what we could change as a system to make things better.
- I have also been attending some ICB team meetings – most recently the Insights and Analytics Team, and the Cancer Team – which are a great way for me to learn more about some of the fantastic work colleagues are doing every day, as well as the challenges they are facing and plans for the future.

Norfolk and Waveney
Integrated Care Board

Agenda item: 09

Subject:	**Patients and Communities Committee Report**
Presented by:	**Aliona Derrett, Chair of the Patients and Communities Committee**
Prepared by:	**Mark Burgis, Executive Director of Patients and Communities**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**29 January 2025**

Purpose of paper:

To provide the Board with an update on the work of the Patients and Communities Committee.

Committee:	Patients and Communities
Committee Chair:	Aliona Derrett
Meetings since the previous update on 27/11/24)	This paper provides an update from the meeting held on 25 November 2024.
Overall objectives of the committee:	The Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that meets the needs of patients and communities, that is based on engagement and feedback from local people and groups, and that takes account of and reduces the health inequalities experienced by individuals and communities. The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care.
Main purpose of meeting:	• Spotlight on: Mental Health including: - Patient Experience - Healthwatch Perspective - Patient Feedback - Strategic MH Team - A View from Place

	• Community Voices in Practice • Communications and Engagement Update • Urgent and Emergency Care: Resilience and Winter Planning • Population Health and Inequalities Board Update • VCSE Assembly Update • Healthwatch Suffolk Update • Healthwatch Norfolk Update
BAF and any Board Operational risks relevant / aligned to this Committee:	BAF01 – Health Inequalities and Population Health Management and the ICB meeting its statutory duty. The score had not changed since the last committee in September. BAF05 – around the increasing number and complexity of the ageing population in Norfolk and Waveney. A important risk for the ICB to consider, but the scoring had not changed since the last committee. No operational risks had been raised specifically for the Patients and Communities Committee however this was expected to change following conversations with some place-based colleagues who had expressed a wish to highlight to the committee some concerns at an operational level. It was noted there were some operational risks proposed that are already being picked up by other committees e.g. the Primary Care Commissioning Committee.
Key items for Board to take note of:	**Spotlight on: Mental Health** • The challenges relating to referrals to specialist mental health services was noted particularly at times of crisis. **The ICB took an action to seek clarification regarding NSFT referral process and what happens when referrals don't get through or are not dealt with.** • The committee heard how carers of people with serious mental illness (SMI) often feel undervalued and unsupported and they face challenges in getting adequate support, which negatively impacts their own physical and mental health. Healthwatch Norfolk have made several recommendations to NSFT which include increased communication and information for carers and the possibility of care groups or forums with care champions in each part of the Trust. NSFT acknowledged the recommendations however it was noted that the ICB did not respond to the report. **The ICB took an action at the meeting for the ICB**

	Mental Transformation team to link with HWN regarding learning from SMI carers project. • The significant delays in ADHD and ASD diagnostic assessments were highlighted along with the potential for patients to fall through cracks between primary and secondary care services, and complex patients having a distrust of services due to negative experiences over time thus making it more challenging to resolve their issues and provide effective support. • Two videos were presented that highlighted patients experience with community-based interventions and multidisciplinary working which had significantly improved patients' wellbeing and confidence. • The committee discussed the Mental Health Coproduction Strategy which had been developed with Rethink and emphasises the importance of involving patients, services users and families in service development. The committee heard how coproduction had influenced the design of a mental health joint response car with EEAST. • The committee received an overview of mental health initiatives in Norwich including collaboration with local providers, and various community projects aimed at improving mental health and well-being. • **The following items were added to the committee forward planner for reviewing at a future meeting:** - **Co-production Strategy** - **NSFT response to a request from Healthwatch Norfolk around intensive services** - **Urgent and Emergency Care** • UEC is focussed on nine specific areas this year based on where we've had the greatest impact historically in past years. • Areas of concern included capacity demands and the strain on health, social care and the wider ICS. However, there are some good preventative initiatives within the system that are supporting people and helping to avoid an acute presentation. • Category two (C2) ambulance response times in Norfolk and Waveney, last year N&W had the second worst ambulance response times across the east of England but at the end of October 2024 they were the second best. • It is important to remember that urgent and emergency care is much more than just ambulances and hospitals, and from a capacity perspective we must ensure we support all areas of our system including the voluntary sector, social care and community teams, and primary care. **Population Health and Inequalities**

	• The ICB Equality Health and Impact Assessment process is now live and receiving positive feedback. • Health Inequalities Training is being rolled out across primary care and a new cohort of Core20PLUS ambassadors will shortly be announced by NHS England. It was noted that the Norfolk and Waveney had the most ambassadors in the region, and they cut across many sectors. • Population insights and use of the Explorer dashboard have been promoted through the Place Boards to help PCNs and practices utilise the information available. • It was noted that the voluntary sector also had access to the Explorer dashboard and the population health team could support with specific population health management projects. **The VCSE Assembly chair took an action to inform the voluntary sector on how to access population insights and data from the Explorer dashboard.** There are no items for escalation to ICB Board on this occasion.
Items requiring formal approval of Board:	There are no items requiring approval from Board.
Confirmation that the meeting was quorate:	The meeting on 27 November 2024 was quorate, as defined in the Governance Handbook

The Childrens Landscape and Opportunities in Norfolk

Integrated Care Board

29/01/2025

Norfolk Context

Norfolk County Council | flourish | Vital Signs for Children | SEND Norfolk

5th largest county in the Country 5,371km²
With Urban, rural and coastal communities

Population
916k
Predicted to exceed 1m by 2036

238,000
people aged under 25 in Norfolk

167,000
people aged under 18 in Norfolk

1 County Council

7 District/borough councils, one city council

463 Schools

722 Early Years Providers

1 Police Force

1 Probation delivery unit

1 Integrated Care Board
with 1 Mental Health Trust, 3 Acute Hospitals, 1 Ambulance Service, 2 Children's Community Nursing providers and 1 Healthy Child Programme

27,740
Children eligible for Free School Meals (2023/2024)

135,000
or 15% residents live in areas classified as among the 20% most deprived in England

94.7%
of population from white ethnic group (England 81.0%

Main languages

- English 95%
- Polish 0.8%
- Lithuanian 0.8%
- Portuguese 0.6%

29,000
children with identified SEND in Norfolk

5.6% of children in Norfolk have an Education Health and Care Plan (4.8% nationally)

14.3% receive SEND support (13.6% nationally)

Social Care

990
children in care
(non-UASC at 31 March 24)

1339
children in need
(section 17 at 31 March 24)

484
Child Protection Plans open at 31 March 2024.

What is FLOURISH?

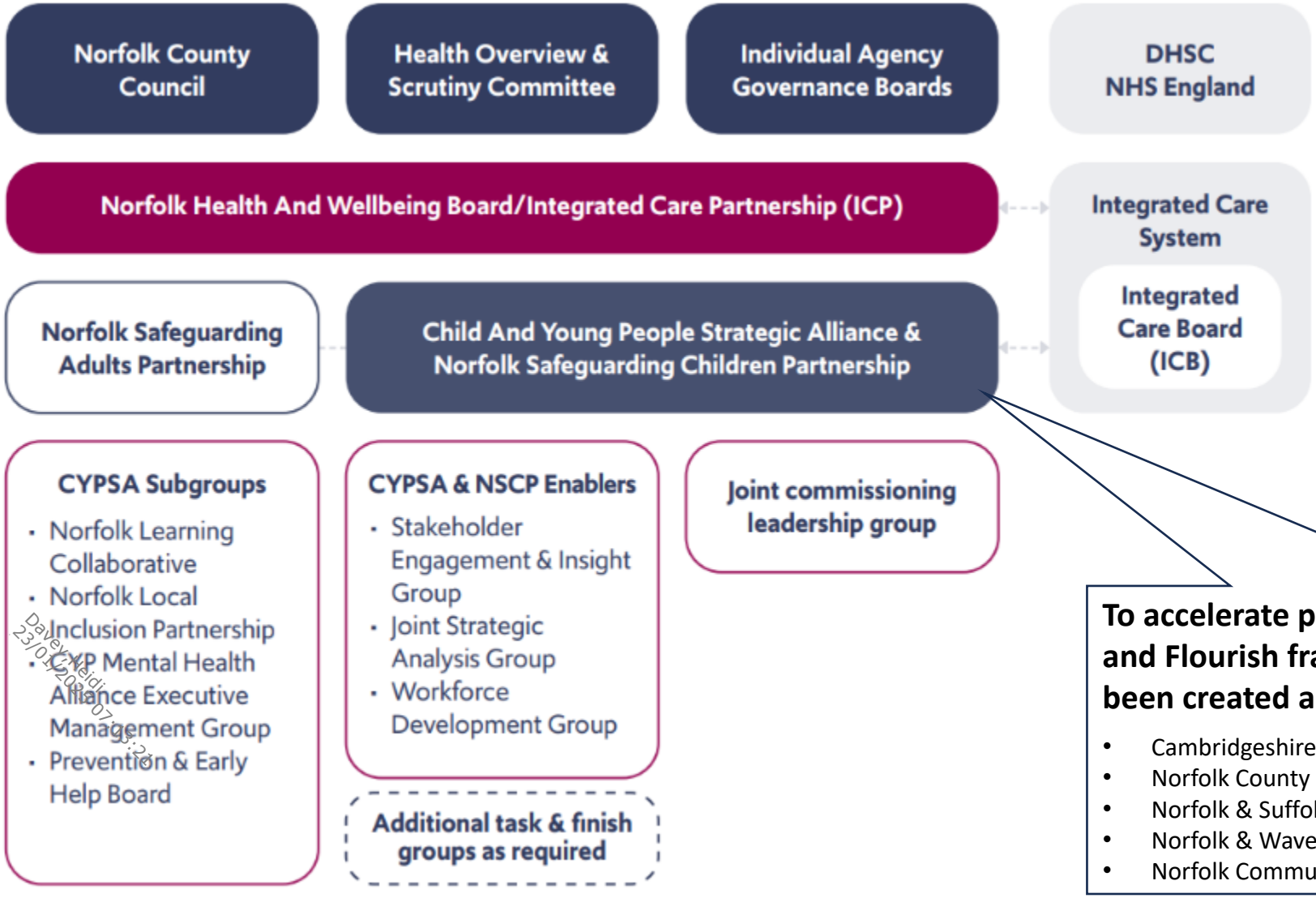
FLOURISH is the overarching system ambition for all children and young people in Norfolk.

The FLOURISH ambition has been developed and endorsed by Children and Young People Strategic Alliance members (including young people) and will form the basis of the Children and Young People Strategy as well as underpinning the work of partner organisations – ultimately making a difference for children and young people.

Creating a Flourish 'movement' through:

- A plethora of **partnership activity** against shared strategic priorities.
- **Embedding Flourish** across the children and young people's system as a shared ambition and common language about outcomes.
- **The Flourish Pledge initiative** – a commitment to do one thing over the year to help children and young people to Flourish, with over 200 teams or organisations making a pledge to date.
- **The Flourish Awards** – 'for outstanding contributions to helping children and young people to flourish' with over 400 nomination for over 220 people/projects/teams this year
- **The Flourish Outcomes Tool** – early stages of development. An evidence-based distance travelled tool for use with children, young people and families.

Children and Young People Strategic Alliance



To accelerate progress against ambitions of the Alliance and Flourish framework, the System Collaborative has been created and endorsed by:

- Cambridgeshire Community Services NHS Trust
- Norfolk County Council
- Norfolk & Suffolk NHS Foundation Trust
- Norfolk & Waveney Integrated Care Board
- Norfolk Community Health and Care NHS Trust

ICB statutory duties relating to CYP

Child safeguarding

- ICBs have a statutory duty to safeguard children as set out in Working Together to Safeguard Children (2018) statutory guidance.
- The NHS England Safeguarding Assurance and Accountability Framework clearly sets out safeguarding roles and responsibilities and will apply to all ICBs.
- ICBs will be required to set out how they have discharged duties in relation to child safeguarding in their annual report.
- To ensure that statutory duties in relation to child safeguarding receive sufficient focus in ICBs, responsibility for functions will be delegated to an ICB executive lead.
- Together to Safeguard Children (2018) statutory guidance.
- The NHS England Safeguarding Assurance and Accountability Framework clearly sets out safeguarding roles and responsibilities and will apply to all ICBs.
- ICBs will be required to set out how they have discharged duties in relation to child safeguarding in their annual report.
- To ensure that statutory duties in relation to child safeguarding receive sufficient focus in ICBs, responsibility for functions will be delegated to an ICB executive

Looked after children

- ICBs have a statutory duty to meet the health needs of looked after children, as set out in the Promoting the health and well-being of looked-after children (2015) statutory guidance.

Children and young people with special educational needs and disabilities (SEND)

- ICBs must continue to deliver the commissioner duties set out in Part 3 of the Children and Families Act 2014 and the SEND Code of Practice (2015) statutory guidance. This includes jointly commission services for children and young people with SEND, with local authorities.
- To ensure that statutory duties in relation to SEND receive sufficient focus in ICBs, responsibility for functions will be delegated to an ICB executive lead

Children in the justice system

- ICBs have a statutory duty to co-operate with LAs, police and probation services on the provision and delivery of local youth justice services, as set out in Modern Youth Offending Partnership Guidance (2013) statutory guidance.

Mental health

The statutory duties which apply to ICBs for mental health, including children and young people's mental health, are imposed by the NHS Act 2006 (which requires CCGs to commission healthcare services to meet people's needs) and the Mental Health Act 1983. They are explained in the Code of Practice (2015).

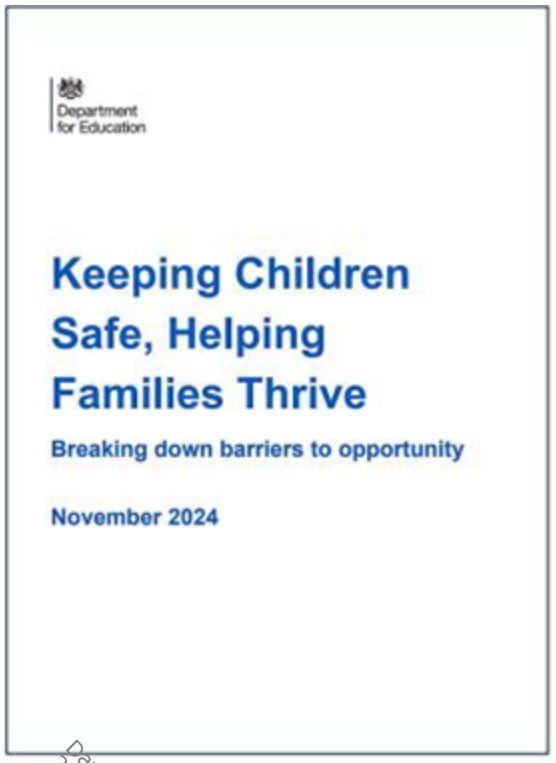
Common national and local guidance and reform

- Keeping Children Safe Helping Families Thrive 2024
- Working together to Safeguard Children 2023
- Children's Social Care National Framework 2023/4
- Norfolk and Waveney Five-Year Joint Forward Plan
- NHS 10-year plan 2018 (update awaited)
- NHS England priorities and operational planning guidance – awaiting 2025/26 guidance
- SEND and AP Improvement Plan
- Public Health Strategy - Ready to Change, Ready to Act
- Norfolk and Waveney Integrated Care Strategy and Norfolk Joint Health and Wellbeing Strategy

Common national and local guidance and reform

- Health Inequalities Strategic Framework for Action 2024 – 2034
- Children's Commissioner – Independent Family Review
- The Competition and Markets Authority study into Children's Social Care Placements
- National Review into the murders of Arthur Labinjo-Hughes and Star Hobson
- Safeguarding Children with Complex Health Needs in residential Settings.
- The Report of the Independent Inquiry into Child Sexual Abuse

Policy statement –
Keeping Children Safe, Helping Families Thrive



The vision set out in the policy paper is built around creating a system which:

- **works with the whole family** so more children and young people can thrive in their family
- **prioritises kinship care** for children who cannot live safely with their parents
- **supports children in care and care leavers** to live healthy and happy lives
- **provides a high quality of care,** which all children deserve
- **takes action to end excessive profit-making** by care providers
- **works effectively across agencies** and **empowers professionals** working within it

The policy statement also builds on the National Framework for Children's Social Care, published in December 2023, which sets a clear vision for the outcomes we want the whole system to achieve.

Case for reform is familiar

The Competition and Markets Authority study into Children's Social Care Placements

March 2022

National Review into the murders of Arthur Labinjo-Hughes and Star Hobson

May 2022

Safeguarding Children with Complex Health Needs in residential Settings.

April 2023

The Independent Review of Children's Social Care

May 2022

The Report of the Independent Inquiry into Child Sexual Abuse

October 2022

Prevent. 1

Children should remain with their families and supported to thrive and be safely prevented from entering the care system wherever possible.

Support. 2

Where children cannot remain at home, we should support children to live with kinship carers or in fostering families. We will also improve support for care leavers.

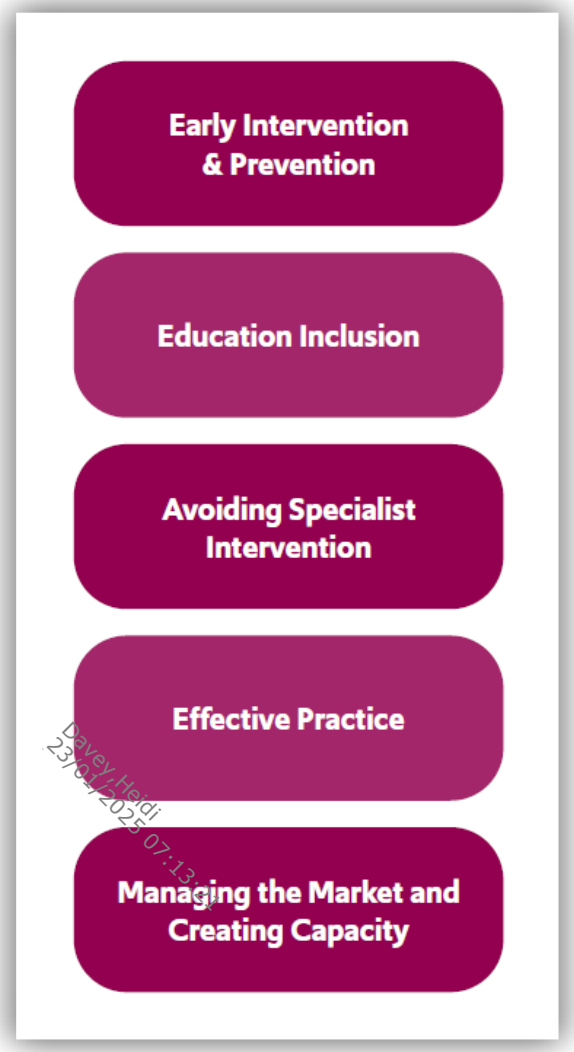
Fix the market. 3

Placements for children in care should be first and foremost, homes for young people to live in and we must bring a swift end to excessive profit making.

Key enablers. 4

Investing in key enablers which underpin the system – workforce, better data & information sharing, evidence-based programmes and the National Framework.

Keeping Children Safe, Help Families Thrive
Themes and principles that resonate in Norfolk



Our Practice

- **Relationships Matter**
  We build trusted relationships with children and families.
- **Whole Family**
  We work with whole families and their networks.
- **Strengths oriented**
  We build on families' strengths.
- **Whole system**
  We are one children's system, working together so that children flourish.
- **Outcomes focused**
  We always focus on achieving the best outcomes for children and young people.

Pillar 1: Prevent – providing the right support at the right time to support children and families to thrive and stay together.
Pillar 2: Support – supporting most children to live with kinship carers or in fostering families, rather than in residential care.
Pillar 3: Fix the market – fixing the broken care market and tackling profiteering in the placement market.
Pillar 4: Critical enablers – investing in the key enablers which underpin the children's social care system – including the workforce, better data and information sharing and to scale and spread evidence-based, proven approaches

Key components of national Family Help model

The key components of Family Help

Merging targeted early help and section 17 into a single offer of support – bringing together family support workers (or equivalent) and social work teams co-working to provide seamless support for children and families

Part of an end-to-end system of support, from universal services through to care. This could include building support out of Family Hubs, where they exist.

Establishing multi-disciplinary family help teams, based in the heart of communities

Teams should be determined by a local needs assessment – in pathfinders, we are seeing the following agencies/professionals within the team: SEND link workers, domestic abuse specialists, mental health practitioners, youth workers, alcohol and substance misuse specialists, and employment advisers etc.

Targeted whole-family support delivered at the earliest opportunity

Family Help

The Family Help Lead practitioner will have the **skills, knowledge** and **experience** to work with the family to produce a 'Family Help plan'. They will build a flexible and responsive **'team around the family'**, (TAF) brought in from the multi-disciplinary team and beyond. Oversight and supervision arrangements in line with Working Together 23 reviewed to account for the broader range of professionals who can be lead practitioners and have updated local protocols to reflect the changes.

Establishing the Family Help Lead Practitioner Role - can be held by a broad range of practitioners able to build a strong and trusted relationship with the family and remain their main point of contact for as long as they need support.

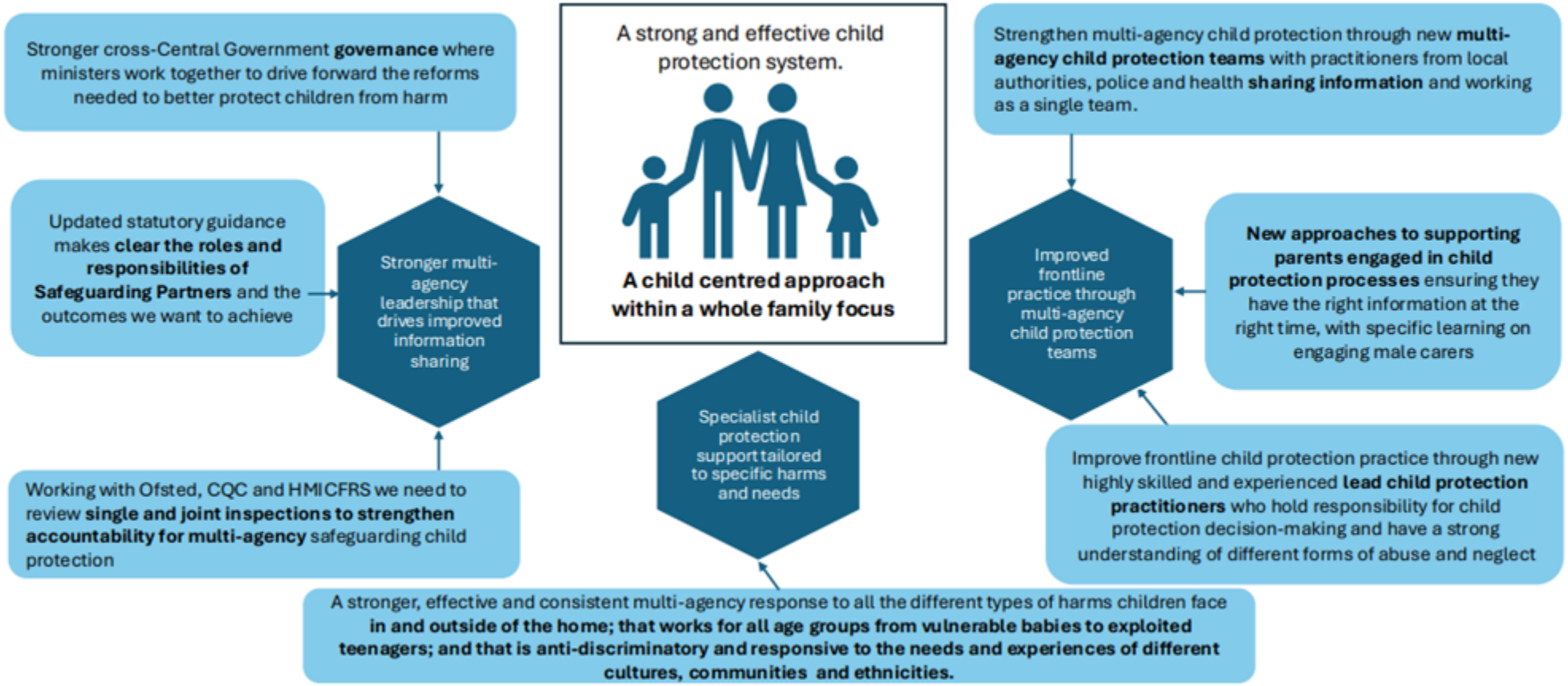
Bring together a range of professionals and services (e.g. SEND specialists) into **an integrated front door model** – where children and families can be triaged to the right level of service based on their needs

Reforming practice at the front door - with an emphasis on **having a supportive conversation**, to promote engagement and the reduce stigma associated with asking for help

Implementing single Family Help assessments and plans - remove duplication between targeted early help and CIN assessments, to ensure that families only have to tell their story once, even as needs change

Practitioners will develop a single plan in collaboration with the family, which clearly sets out goals, milestones and the services that will be provided for the family. The plan should be accessed and jointly managed by all agencies working with the family

Ambitions for a multi-agency safeguarding and child protection system



As part of our implementation of Family Help model, we have:

- Expanded our model around safeguarding and child protection to create expert CP and Court Work roles
- Currently expanding our offer / capacity to bring together all Children's Services roles within child protection together e.g . courtwork facilitators and the Family Time service to adopt MDT approach
- Looking forward multi-agency working and teams is a next step e.g. case holding model, sharing of data etc, shared funding model?
- Established Norfolk Family Connect, opportunity to grow this further

Our direction of travel …

- Simplified access to the right help at the right time
- Resources move fluidly around the family and education setting, with specialist teams working alongside earlier help professionals
- Holistic multi-disciplinary and multi-agency zone-based delivery is the norm
- Streamlined processes, reduced bureaucracy and increased use of technology
- Proactive identification of need through intelligent use of data

Implementing safeguarding partnership infrastructure and a strengthened role for education in line with Working Together 2023

flourish

Key features of reformed safeguarding partnerships:

Identify Lead Safeguarding Partners (LSP)
Jointly responsible for ensuring the proper involvement of and oversight of all relevant agencies. They should act as a team, as opposed to a voice for their agency alone.

+

Identify Delegated Safeguarding Partners (DSP)
Sufficiently senior to carry out these functions. Ultimate accountability remains with the LSP as the individual responsible for the delivery of the statutory duties of the safeguarding partners.

Should have oversight of the quality and compliance of delivery of agreed shared priorities; and have processes in place that assure multi-agency practice is reviewed and operating well.

+

Identify Partnership Chair
LSPs should jointly agree and appoint one of the DSPs as the partnership chair for the multi-agency safeguarding arrangements.

The partnership chair should facilitate partner discussions, working in conjunction with independent scrutiny. The functions of the partnership chair are separate and distinct from the functions of independent scrutiny.

Independent scrutiny

- Should provide independent, rigorous and effective support and challenge, assurance to the whole multi-agency system, and drive continuous improvement.
- Ensure statutory duties are fulfilled and that local child safeguarding practice reviews and national reviews are analysed. Learning should be identified and implemented.
- Ensure that the voice of children and families is considered as part of scrutiny and that this is at the heart of arrangements through direct feedback, informing policy and practice.

Implement a Strengthened Role for Education

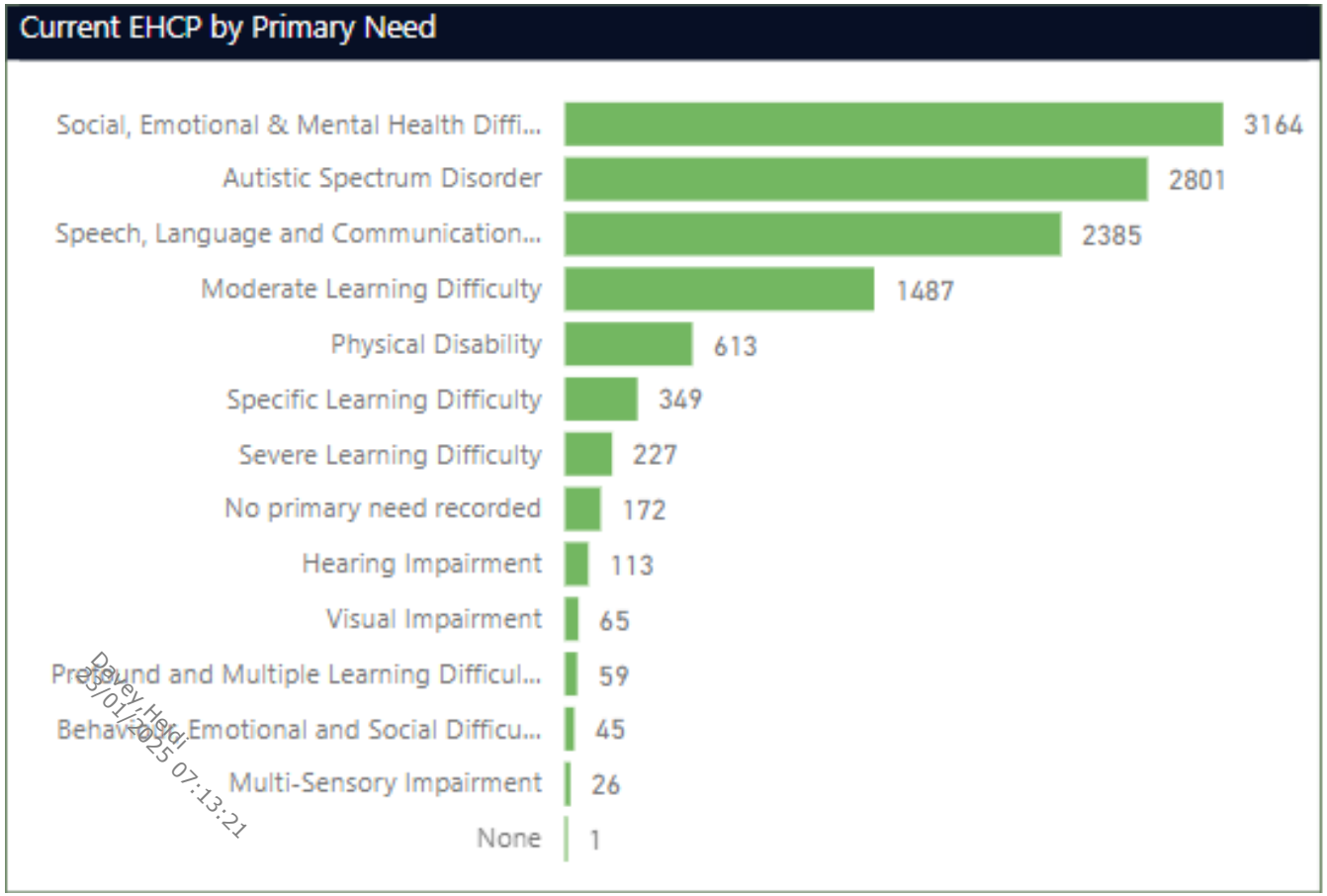
- An education forum with representatives from across the education sector (including early years and childcare, academies, independent schools, further education and alternative provision).
- Identify representatives who can provide a voice for education settings locally to enable effective inclusion and representation for education at operational and strategic decision-making Identify what impact this has on services.

Opportunities to further enhance how we work together

flourish

Common challenges

3. We see the same types of needs across our organisations



Rising Mental Health Support Needs

- Over 60% of children and young people referred for mental health support have neurodiversity needs
- Speech and language support requests for school-age children continue to rise

The problems we aim to address

1. Families tell us that it is difficult to get help in a timely way and they often have to wait a long time to get help and those waits are increasing.

2. Families tell us that the help offered doesn't match what they feel their need is and the whole family's needs are not considered together.

3. A number of services are only accessed by having an assessment and the wait is too long, and the status of private assessment is unclear.

4. The people who can contribute to understanding needs or providing early help are not joined up with each other. Referrals are made too soon without speaking with all the people who can help with understanding needs.

5. Different assessments for similar needs are not co-ordinated so a child might have wait on different waiting lists and undergo different assessments with different professionals who aren't joined up with each other.

6. Schools, educational settings, parents/carers and other supporting people don't always feel they have the understanding and tools to help with the needs being raised by children and young people.

7. Children's and adult services are not joined up enough and therefore children and families don't experience a smooth transition as they get older.

Solutions

To achieve the System Collaborative's approach, we have delivered:

- A new mental health clinical model adopting the THRIVE framework
- The Integrated Front Door (Just One) for access to self-care resources
- The Occupational Therapy transformation programme
- Implementation of School and Community zones to support inclusion in mainstream schools and prevent escalation

And work is underway to deliver:

- **ND digital toolkit**: a toolkit that provides accessible advice, guidance and validated resources.
- **Early needs assessment tool**: shifting from diagnosis-driven to needs-led support through an assessment tool that identifies the needs of an individual and matches them with support.
- **Community support pathway**: a new Norfolk model for supporting neurodiversity embedded within School and Community Zones.
- **Universal Training Offer**: developing a training programme for the wider children's workforce to build confidence and competencies in supporting neurodivergent needs.

These projects will be supported by co-production activities and joint CYP data analysis, ensuring that the initiatives are collaboratively developed with input from all stakeholders and informed by comprehensive data insights.

Our Family Help Approach

1. **Retain relationships** for longer – families will remain in one team unless a child becomes long term looked after
2. Wrap **multi-disciplinary and multi-agency support** around families to respond to need more holistically
3. More timely interventions for families leading to faster more sustainable resolutions
4. **More children living safely with their families**

Full roll-out of approach from September 2024, following 9-month test and learn

Larger multi-disciplinary teams led by pairs of Team Managers -

Currently teams of Social Workers, Family Practitioners, Domestic Abuse, Intensive Support Workers and Network Co-ordinator.

Family remains open to one team throughout their journey through help and protection, allowing practitioners to build long standing relationships with families and design interventions as a multi-disciplinary team.

New Child Protection Experts, Court Work Experts and Intervention Managers in each locality to provide additional wrap around support for practitioners

Further enhance ways of working and practice expectations to ensure they support **family-led plans** and focus on right things.

Norfolk Healthy Child Programme – Public Health Services

The prevention and early intervention **public health** framework includes mandated health and development reviews, health improvement, wellbeing and parenting. Local prevention and early intervention activities span preconception to 19 years of age, or 25 where there is a statutory entitlement. It includes

- preconception care
- promoting child development
- improving babies, children and young people's health outcomes
- ensuring that families at risk are identified at the earliest opportunity

Just One Norfolk – digital platform, Pregnancy & Early days, Emotional health, Child Development & Additional needs Childhood illnesses, Staying safe, Healthy Lifestyles, Speech and Language, School life, Health Services in Norfolk

Just One Number on 0300 300 0123 or **Parentline** on text 07520 631590 Clinical Team provide support, advice and information on child's health, wellbeing or development. Via telephone, video call or text.

Healthy Child Programme Services 5-19, school nursing services, healthy lifestyles, emotional well being, FYI Website for 11-24s, ChatHealth text messaging service for 11- 19 year olds

National Child Measurement Programme (NCMP) measures the height and weight of children in Reception and Year 6 in schools. Where information is used to address obesity and overweight which is more prevalent in deprived communities.

Healthy Child Programme Services 0-5 Mandated Health Visitor Development Reviews at pregnancy, birth 6-8 weeks, 1 year and 2 ½ years. Pathway to Parenting (P2P) Infant Feeding Support, School Readiness & Starting School

Ensuring our children in care have the right placements

Placement sufficiency in Norfolk remains a challenge:

- the external care market is driving unsustainable increases in costs, whilst not always achieving good outcomes
- needs of children and young people have changed substantially – most clearly for adolescents who make up a greater proportion of children coming into care and have experienced significant trauma, requiring complex high-cost forms of care

As such, we have recognised that we need a bold approach, and we have developed a sufficiency strategy which will:

Invest in further innovative **interventions at the edge of care** to reduce the number of children and young people needing to be looked after

Achieve a step-change in **in-house fostering capacity** through a whole-Council and whole County focus on carer recruitment and retention

Significantly expand and **re-shape in-house provision** to achieve greater value from this capacity and secure leverage in the external market through a strong in-house offer.

Creating **more specialist provision** for children with learning disability, autism, physical disabilities and mental health needs

Work differently with and **challenge the external market** – shifting to a focus on the outcomes for children rather than unit cost

Our Local First Inclusion ambition

- Children get the right help, as early as possible, as close to home as possible.
- We have a more inclusive system, where more children flourish in mainstream education.
- Parents, carers, teachers and school leaders feel supported to help their children and pupils.
- We spend money on the right support for children and are able to “live within our means.”

flourish

The challenge

The numbers of children with SEND, both in Norfolk and nationally, has been growing at an unprecedented rate. This is attributed to a range of environmental, social and economic factors.

Norfolk has a higher proportion of children with EHCPs than the national average (4.7%, compared with 4.3%). Also, when comparing ourselves with other LA's, including our statistical neighbours we do not score well on indicators for inclusion, for example Cornwall have only 0.9% of their population in special school, Cumbria 1.4%, Shropshire 1.7%, and Norfolk .2.2%

We are a large, rural county, which means children often have to travel long distances to specialist provision – this is not good for them and is expensive and means less to spend on supporting outcomes.

The demand on specialist places is pushing more children into high-cost independent places meaning the High Needs Block element of the schools' budget has a significant deficit which must be brought back to balance.

The combined cumulative year-on-year overspend on Norfolk's Dedicated Schools Grant, as a result of overspending on the High Needs Block, is more than £81m (the annual budget for HNB is c.£142million – in addition to c.£39million in SB for Notional SEND)

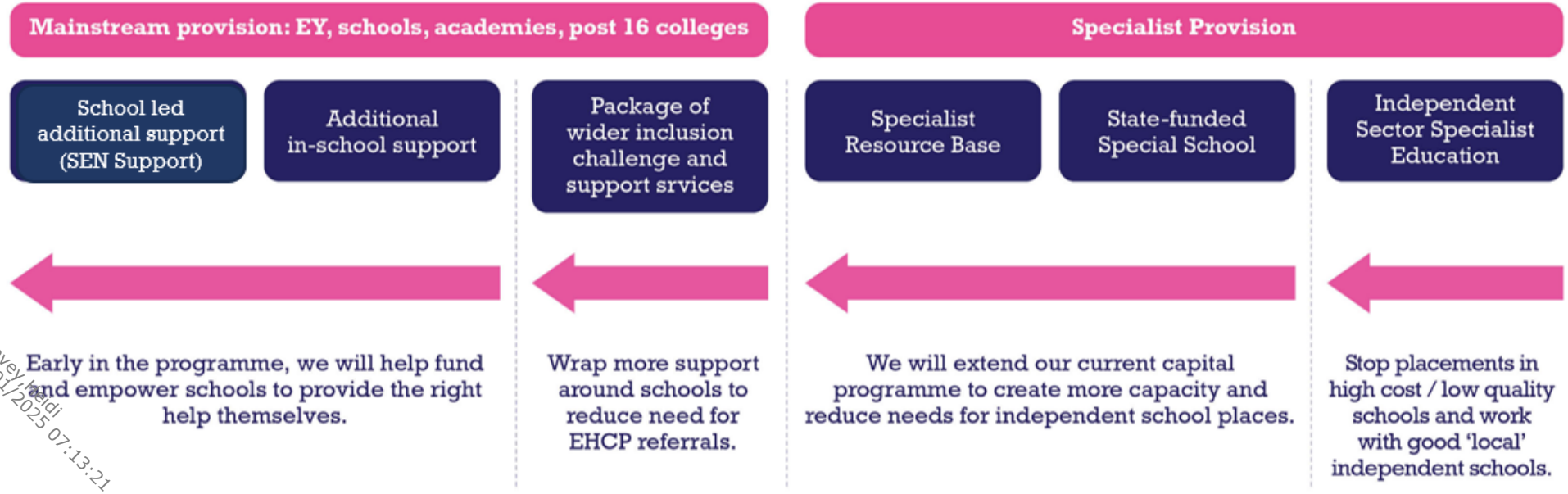
This risks the long-term sustainability of the education system in Norfolk.

We are currently reviewing our programme with the DfE, in light of growing budget pressures.

The strategy

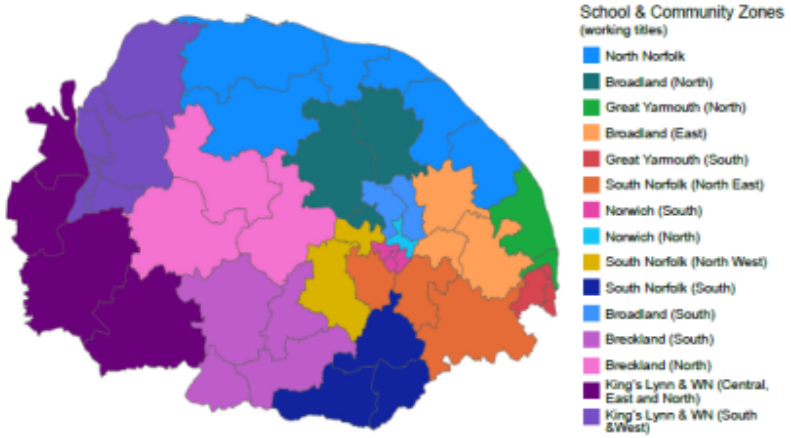
We want to ensure that children and young people get the support that they need, as early as possible. For most children this will be in their local school or early years setting.

If we are able to identify needs earlier and wrap support around children and families, we believe that we can improve outcomes for our children and reduce the need for EHCPs and high cost specialist placements



flourish

Embedding School and Community zones



There are **15** School & Community Zones...

...with an average of **26** schools...

...around **40** Early Years settings and childminders...

...and around **11500** children & young people per zone.

Davey Heidi 23/01/2025

- Access to a pool of multidisciplinary professionals supporting each zone
- Strategic use of data to predict and support locality based decision making ensure time and resourcing supports the localities needs
- Develop a self improving and supporting system through regular dialogue, sharing knowledge and best practice
- Increased awareness of each other's phases and sectors in order to best support parents and their young person on their door step around ways forwards
- Cultural collective shift to ensure the right children have access to the right provision with the right support at the right point in their learning experience

ICB CYP Ambitions

Four National purposes of an ICS

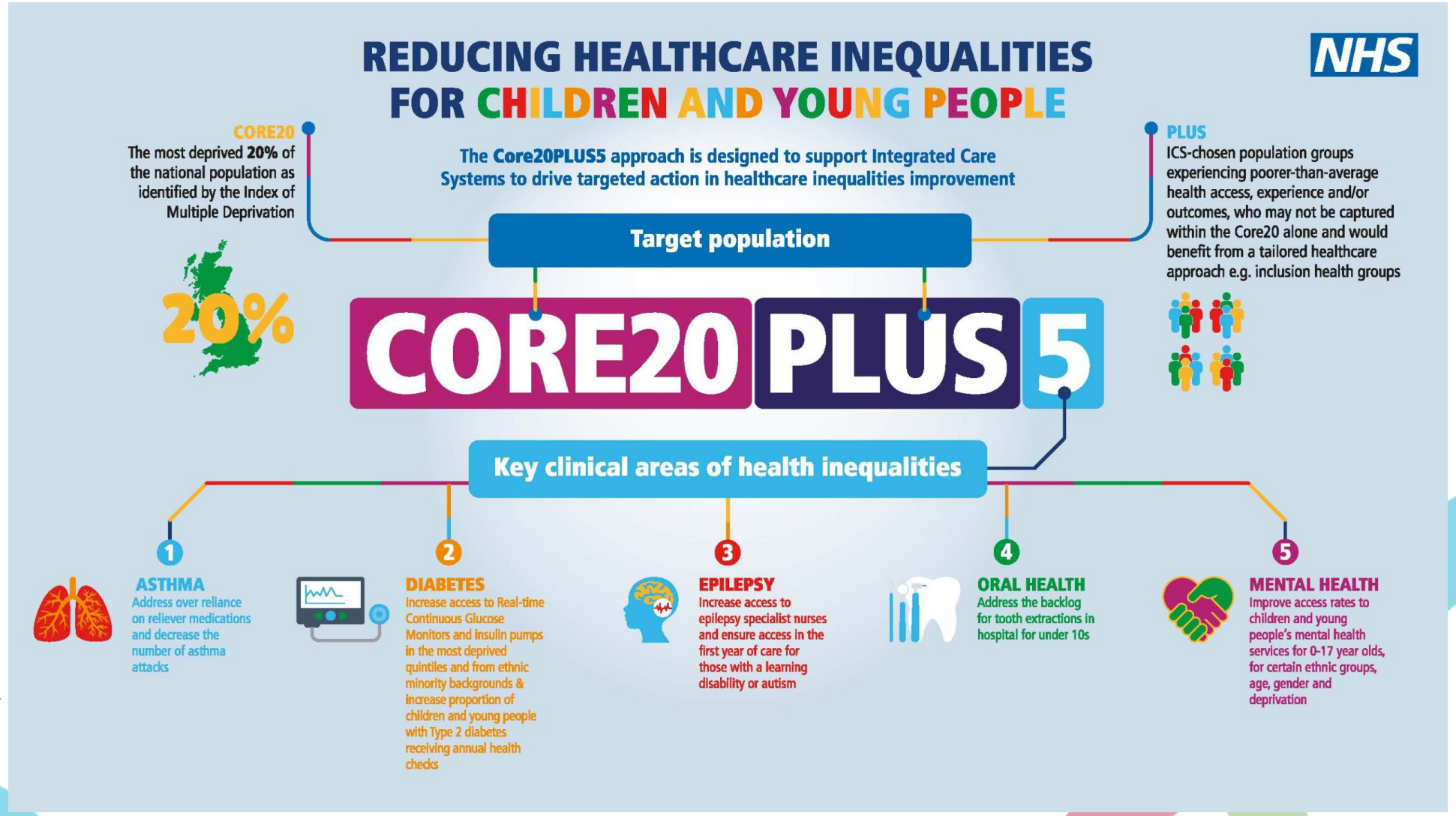
- Improving outcomes in population health and care
- Tackling inequalities in outcomes, experience and access
- Enhancing productivity and value for money
- Helping the NHS to support broader social and economic development

Norfolk and Waveney Integrated Care System (ICS)

- To improve the health, wellbeing and care of people living and working in Norfolk and Waveney, and to reduce inequalities and unjustified differences in care.
- To provide the best possible health and care services, integrated around the needs of individuals and families.
- To get the best value for the Norfolk and Waveney pound.

Joint Forward Plan Ambitions for BCYP and Maternity

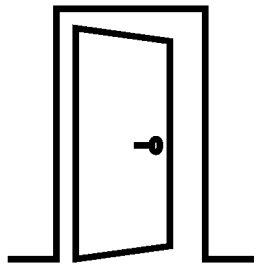
1. Smoking during pregnancy - develop and provide a **maternity led stop smoking service for pregnant people**
2. Successful implementation of **Norfolk's Start for Life and Family Hubs approach**
3. Continued development of our **Local Maternity and Neonatal System (LMNS)**, including the 3-year Maternity Delivery Plan
4. Implementation of **asthma and epilepsy recommendations**, for Children and Young People
5. Develop an improved and appropriate offer for **Children's Occupational Therapy**
6. Work together to **increase awareness of mental health**; enable our population to develop skills and knowledge to support wellbeing and improve mental health; and deliver a refreshed suicide prevention strategy. This will prompt early intervention and prevention for people of all ages, including those who experience inequalities or challenges to their mental health and wellbeing.
7. **Mobilise a children and young people's collaborative** so that partners work as one to deliver better health outcomes for our people and communities.
8. Establish a Children and Young People's (0-25 years) **Emotional Wellbeing and Mental Health 'integrated front door'** so all requests for advice, guidance and help are accepted, and the appropriate level of support is given to ensure that needs are met.



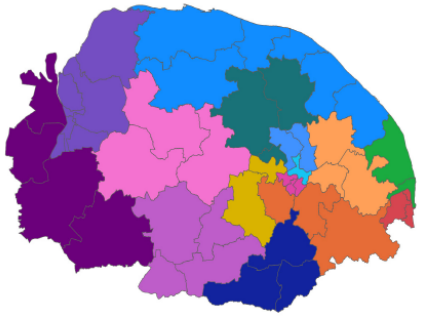
CYP System Collaborative

- We are co-designing and planning the implementation of next steps for an integrated ‘whole system’ approach to meeting the needs of CYP 0-25 in Norfolk in particular relation to:
  - Emotional wellbeing and mental health needs
  - Special educational needs and disabilities
  - Needs associated with neurodiversity
- It’s looking creatively and holistically at all the resources across the key partners and to re-design the support model to achieve the best outcomes.
- The ambition includes making structural, operational, and cultural changes required to deliver community based multi-disciplinary team working across organisations
- **This is a clear step beyond ‘partnership collaboration’ to a fully integrated approach.**

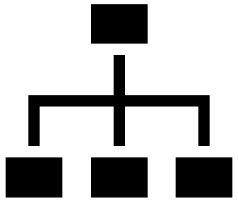
What will the system collaborative look like?



Simplified front doors to make it easier for families to request help

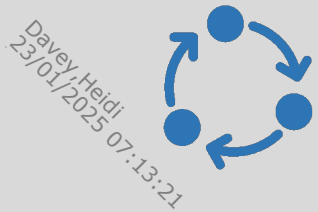


Zone based early prevention and help to support children and families earlier



Integrated intervention teams to provide joined up interventions when families require help

Enabled by the key building blocks



Outcome based system and commissioning approach supported by joint commissioning teams

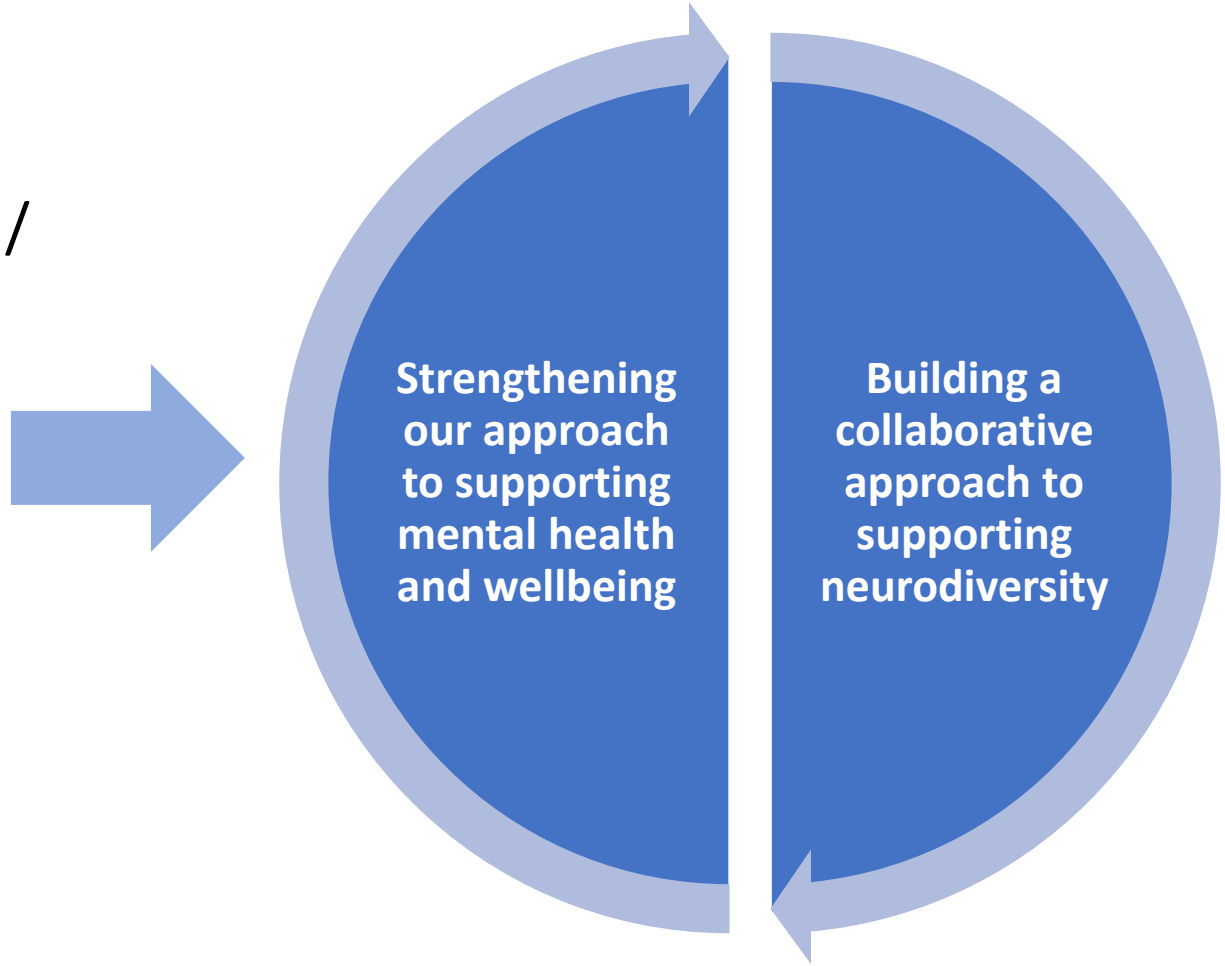
Proactive use of joined up data to help identify where help is needed earlier, including use of a single identifier

Joint approach to measurement of impact and quality assurance

Greater join up of assessment and plans e.g. Single Session approach

System collaborative recent developments and next steps

- Just One Number as an integrated front door for mental health access (0-25) – ICB / CCS
- Practice Model (CAIST, Integrated Care Planning)
- Mental Health Support Teams in Schools
- School & Community Zones
- Healthy Child Programme Services Development and Improvement
- Alternatives to acute or inpatient care



Norfolk and Waveney
Integrated Care Board

Agenda item: 11

Subject:	**Quality and Safety Committee Report**
Presented by:	**Aliona Derrett, Quality and Safety Committee Chair**
Prepared by:	**Evelyn Kelly, Quality Governance & Delivery Manager**
Submitted to:	**Integrated Care Board - Board Meeting**
Date:	**29 January 2025**

Purpose of paper:

To provide the Board with an update on the work of the Quality and Safety Committee for the period of 27 November 2024 to 29 January 2025.

Committee:	**Quality and Safety**
Committee Chair:	Aliona Derrett
Meetings since the previous update on 25/09/24:	05 December 2024,14:00 – 17:00 *January Meeting Cancelled*
Overall objectives of the committee:	
To seek assurance that the Norfolk and Waveney system has a unified approach to quality governance and internal controls that support it to effectively deliver its strategic objectives and provide sustainable, high-quality care and to have oversight of implementation of the ICS Quality Strategy and NHS National Patient Safety Strategy. To be assured that these structures operate effectively, that timely action is taken to address areas of concern, and to respond to lessons learned from all relevant sources including national standards, regulatory changes, and best practice. To oversee and monitor delivery of the ICB key statutory requirements, including scrutiny of the robustness and effectiveness of its arrangements for safeguarding adults and children, infection prevention and control, medicines optimisation and safety, and equality and diversity. To ensure that patient outcomes from care are collected and measured, to inform outcomes-based commissioning for quality. To review and monitor those risks on the BAF and Corporate Risk Register which relate to quality, and the delivery of safe, timely, effective, and equitable care. To consider the effectiveness of proposed mitigations and to escalate concerns to risk owners and operational leads/forums as agreed by Committee Members.	

To approve ICB arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and secure continuous improvement in quality. To seek assurance that commissioning functions act with a view to supporting quality improvement; developing local services that promote wellbeing and prevent adverse health outcomes, equitably, across all patients and communities in Norfolk and Waveney.	
Main purpose of meeting:	**05 December 2024** • ICS Quality Dashboard and Strategy Oversight • Mental Health Waiting Lists and Referral Management • Local Maternity and Neonatal System (LMNS) • Safeguarding Health Assurance Network Update • Risk Deep Dive on Equitable Access to End of Life Care **Committee Approvals for this period:** • Child Death Overview Panel (CDOP) Annual Report • ICS Advanced Practice and Competency Framework • Coordination of Cross System PSIRF Responses • CHC Commissioning and 1:1 Care Policies • Revised Regional Ambulance Delay Learning Process
BAF and any Board Operational risks relevant / aligned to this Committee:	**BORR02: Continuing Healthcare** Risk remains at 20, reflecting the challenges in sourcing appropriate care due to care market capacity, particularly in relation to specialised care for people with complex needs. This creates risk in relation to quality and experience of care, as well as increased financial cost of sourcing care. **BORR13: Community Nursing Unallocated Visits** Risk remains at 16, reflecting the current challenges in demand and capacity, which creates risk in relation to the quality and experience of care as well as moral injury to staff and resilience across the wider community services. **BORR14: CYP Mental Health Case Managers** Risk remains at 16, reflecting the challenges in meeting demand for case management allocation, which in turn creates risk in relation to quality and experience of care and the potential for poorer long-term outcomes. **BORR15: CYP Mental Health Waiting Lists** Risk remains at 16, reflecting the challenges in demand and capacity, which creates risk in relation to delayed treatment which impacts on the long-term outcomes for children and young people as they move into adulthood. This is also a potential area of moral injury to staff and resilience across the wider mental health pathways.

SRR54: CYP MH Approved/Responsible Clinicians
Risk was proposed to reduce from 16 to 12 in Month 07. NSFT is currently reviewing its crisis pathways, which will include consideration of an all-age psychiatric liaison that will cover these roles. In the interim, the Trust is using community resources to mitigate the gaps. Committee requested that the risk remain at a score of 16 with Committee oversight, to ensure that the mitigation is effective and sustainable, with a review next month.

BORR16: CYP Speech and Language Therapy
Risk remains at 16, reflecting the fact that NCC, as lead commissioner, are not currently assured of service delivery against some of the provider's key performance measures. This creates risk in relation to accessibility, quality and experience of care and outcomes for children and families.

BORR17: Euroking E3 Maternity Information
Risk remains at 16, reflecting the National Patient Safety Alert issued in relation to this information system. Concerns relate to the potential for unintended errors in pregnancy records, both within current pregnancy and those previous, which raises a patient safety risk.

BORR18: Children's Mental Health Team Skill Mix
Risk remains at 16, reflecting the Trust's challenge in accessing available trained staff to deliver its services for babies, children, young people, and families, which creates risk in relation to delayed treatment and long-term outcomes for children and young people.

BORR19: Lynch Syndrome Pathway
Risk remains at 16, reflecting the absence of a local pathway, which is opposed to NICE guidance. This creates a risk that potentially affected people will not be screened, identified, and offered risk reducing measures to protect against potentially preventable cancers.

BORR20: Care Provider Capacity System-Wide Impact
Risk remains at 15, reflecting local social care market capacity, and the risk of providers terminating care provision or closing due to failure to comply with statutory regulations. This has the potential to impact on hospital discharge activity as well as LD&A hospital admissions. Feedback was shared from last week's social care event, noting that NORCA were present, to provide a collective voice for local care providers. An emerging risk around the national NI increase was flagged with the potential for a 30% decrease in care capacity due to financial constraints, particularly

	within small businesses. ICB and local authority market engagement will continue to support and monitor impact. **BORR21: CYP Podiatry Provision** Risk remains at 15, reflecting the inequity of paediatric podiatry services across Norfolk and Waveney. Children in Central Norfolk are unable to easily access podiatry services which creates a risk of poorer outcomes, across the short term and into adulthood. **BORR22: Adult Speech & Language Therapy Provision** Risk remains at 16, reflecting gaps in service provision emerging across the system, due to historical commissioning gaps, amendments to provider service criteria and staff skill mix. This creates a risk of some patients receiving a limited service, with poorer experiences of care and outcomes. It was noted this month that the local HOSCs have identified an interest in this area of service provision and the inequity of the offer across the county. Commissioners are preparing a position statement / options paper for ICB Executive Management Team as an urgent priority. It was also noted that the local Disfluency Service contract is ending in March 2025. **BORR23: Tuberculosis Service Provision** Risk remains at 16, reflecting the challenge for existing specialist TB Nurse capacity to meet increasing demand. This is particularly an issue in Central Norfolk and there is inequity across the community pathway across the system. This creates risk around impact on patient safety, quality of care and public health protection. **BORR24: 12hr DTA Mental Health Breaches** Risk remains at 16, reflecting the impact of 'decision to admit' breaches where a specialist mental health bed cannot be found in a timely way. This causes extended waits for service users in busy A&E departments, that raises the risk of poor experience of care and exacerbation of symptoms in a clinically unsuitable environment. **BORR25: Surge Capacity to Support Acute Trusts** Risk was proposed to increase from 12 to 16 in Month 07 and added to the BORR. This reflects the seasonal pressures currently being experienced within the system and reflects the increased use of surge beds, which creates risk in relation to quality and experience of care. This is also a potential area of moral injury to staff. Committee supported this increase in risk rating.

Key items for Board to take note of:	**Mental Health Waiting Lists and Referral Management** As a national outlier with high referral volumes, NSFT presented a paper outlining their current waiting list position across their core services and the Trust's approach to safety-netting and harm review. Committee noted the Trust's work with people waiting for services including safety planning, communication and signposting. Discussion was had around the use of national guidance on harm review processes and the triangulation of waiting list, complaint and clinical incident data. The ICB Executive Medical Director identified an opportunity to share learning from elective pathway recovery with NSFT to help inform their approach. Questions were raised around the Trust's interface with primary care, where patients waiting for specialist services are supported; particularly around how 'rejected' GP referrals are managed. A recommendation was made to the Trust to review their triage process for GP referrals and consider learning and best practice from other Mental Health Trusts. Committee discussed the waiting list challenges in relation to Children, Families and Young People (CFYP) specifically, highlighting the potential for delays to impact on children's access to education and social opportunities as well as the risk of family breakdown. It was also highlighted that around 40% of children waiting for mental health services in Norfolk and Waveney are potentially neurodiverse in some way. Committee requested clarification on how locality oversight of CFYP will be brought together to achieve oversight of these pathways and link in with the wider system of care and support for Children and families. The Chair highlighted that the mental health waiting list position requires escalation to Board and a system response to support NSFT. **Palliative and End of Life Care Risk Deep Dive** The need for palliative and end of life care (PEOLC) in Norfolk and Waveney is rising as the population ages with a projected increase of around 114,000 residents by 2041 and there is a risk that some people will not be able to access palliative care as quickly or easily as those in other parts of the county due to lack of hospice provision and specialist palliative care beds and a lack of standard specification can also lead to variation in offer and access. Committee supported the priorities set to identify people in their last year of life and commence personalised support and care planning early, and to address poorer access to

	specialist palliative care or hospice care for people with a non-Cancer diagnosis and poorer outcomes in our most socially deprived populations. Committee were updated on the programme of work taking place across the system to improve access to PEOLC, including work around standard service specifications, demand and capacity planning and supporting and developing hospice, VCSE and social care resilience. Quality improvement initiatives are also taking place around Advanced Care Planning (ACP) and RESPECT emergency documentation as well as essential 'anticipatory' medicines provision. This included the No Barriers Here project, upskilling nurses and AHPs working with people with learning disabilities to have meaningful conversations about care at the end of life. EEAST provided reflection from an Ambulance Service perspective, highlighting that Crews are experiencing challenges where ACP/RESPECT and anticipatory medicines are not in place. Clinical support lines have been effective in enabling shared decision making to help crews avoid unnecessary hospital admissions, but the offer is inconsistent across the county. EEAST spoke to a project that has taken place elsewhere in the region, which hosted a paramedic rotation into specialist hospice care to develop skills and competencies. Committee noted that primary care and community teams deliver a significant amount of care at end of life, alongside hospital and hospice care, to support people to die at home. Members agreed that there needs to be a way to link projects together across the system to share good practice and identify gaps. Discussion also highlighted the need for children's palliative care to be considered equitably within the overarching programme. **Committee Approvals** **Child Death Overview Panel (CDOP) Annual Report** Committee discussed learning around 'modifiable factors,' including safer sleep, recognising the unwell child, and maternal health risk factors. Communication between professionals working with young people in mental health crisis was discussed and the importance of engaging outside of health and working more closely with education and community support was noted. Committee approved the annual report. **ICS Advanced Practice and Competency Framework** Committee commended the amount of clinical engagement that has taken place across the system and welcomed the

	framework as a way to champion and recognise advanced practice. It was agreed that the framework supports and develops new roles that are having a positive benefit across the system. Committee approved the framework. **Coordination of Cross System PSIRF Responses** Committee noted the new regionally developed policy which supports cross-organisational working to take forward learning collectively across partners, as part of delivering the national Patient Safety Incident Review Framework (PSIRF) principles. Committee approved the policy. **CHC Commissioning and 1:1 Care Policies** These ICB policies relate to adult NHS Continuing Healthcare (CHC), supporting the provision of safe and effective care packages within an equitable legal framework. Committee acknowledged the background of financial pressures across the NHS and social care and noted the need for communication and clear expectations with the wider care market. Committee approved these policies in principle, with some minor amendments and the addition of virtual ward as a provision that supports care packages and helps keep care closer to home. **Revised Regional Ambulance Delay Learning Process** Committee fed back on the new process, prior to it progressing through provider partner governance routes ready for an April 2025 launch. The revision builds on the existing arrangement but aligns more closely to PSIRF principles, with a focus on joining up learning across Ambulance and Hospitals and sharing at a system and regional level. Committee approved the approach.
Items requiring formal approval of Board:	*None this month.*
Confirmation that the meeting was quorate:	The December 2024 meeting was quorate, as defined in the Governance Handbook.

Norfolk and Waveney
Integrated Care Board

Agenda item: 12

Subject:	**Health Inequalities and EDI reporting**
Presented by:	**Mark Burgis, Executive Director Patient & Communities**
Prepared by:	**Shelley Ames, Head of Health Inequalities & VCSE** **Amanda Brown, Associate Director of Corporate Governance** **Dawn Turner, HR & OD Business Partner**
Submitted to:	**Norfolk & Waveney Integrated Care Board**
Date:	**29 January 2025**

Purpose of paper:

To outline reporting requirements for health inequalities and Equality, Diversity and Inclusion (EDI), confirm arrangements for ensuring compliance for 2024/25 and agree proposed approach for future reporting arrangements.

Executive Summary:

The Integrated Care Board has several legal duties and reporting obligations relating to health inequalities.

This paper provides a summary of requirements and a proposed approach for compliance in 2024/25, as well as a recommended future approach to enable a more joined up and comprehensive future response that details all of the work underway to tackle health inequalities and ensure equality, diversity and inclusion is at the heart of the organisation.

The report recommends a Chair's action be undertaken for finalising 2024/25 submission of EDS2, with the NHSE Statement on Information report to be brought to Board in March 2025.

Report

Introduction

The NHS Act 2006 (as amended by the Health and Care Act 2022) places a range of health inequalities duties on the NHS. Changes arising from the Health and Care Act 2022 provide extended legal duties on reducing and tackling health inequalities.

NHS England published their Statement on 27 November 2023. It sets out their views on how ICBs, trusts and foundation trusts (relevant NHS bodies) should collect, analyse,

publish and use information on health inequalities. Relevant NHS bodies have a legal duty to include in their annual reports a review of the extend to which they have exercised their functions consistently with this Statement.

In addition, ICBs have responsibility for demonstrating their compliance to the Public Sector Equality Duty (PSED) as well as ensure publication of the Equality Delivery System 2 (EDS2) report Workplace Race Equality Standard (WRES) report, Workplace Disability Equality Standard (WDES) report and Gender Pay Gap Report on an annual basis.

These collective requirements consider both the impacts of inequalities and required actions to address them for our ICB/NHS workforce (EDI), as well as our impacts on our patients, residents and communities (health inequalities).

Approach to demonstrate compliance in 2024/25

There are several reporting requirements with approaching deadlines that ICB Board will be asked to endorse prior to publication.

EDS2

We are required to publish EDS2 by 28th February 2025 and the content is currently being shaped by teams from across the ICB. It is proposed that the EDS2 report is circulated to ICB Board members on Monday 10th February with a proposed deadline of Friday 21st February for comment before finalising for 2024/25 submission via Chair's action.

WRES and WDES

We are required to commit to the principles of the WRES/WDES and apply as much as possible to our workforce. There is a requirement to produce action plans to close any race and disability equality gaps in workplace experience. The WRES / WDES is an annual report alongside the EDS2 report and it is therefore proposed that we aim for publication by 31 March and will bring this report alongside the finalized EDS2 report and Health Inequalities and Equality, Diversity and Improvement Plan to the ICB Board March 2025 meeting.

Gender Pay Gap Report

In accordance with the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017, we are required to publish Gender Pay Gap calculations no later than 30 March each year. It is therefore proposed that we bring this report alongside the finalized EDS2 report and Health Inequalities and Equality, Diversity and Improvement Plan to the ICB Board March 2025 meeting.

NHSE Statement on Information

The NHSE Statement on Information on Health Inequalities is due to be published alongside the annual report in summer 2025, however earlier publication of this report would support compliance associated with the Public Sector Equality Duty. It is therefore proposed that we aim for publication by 31st March and will bring this report alongside the finalized EDS2 report and Health Inequalities Improvement Plan to the ICB Board March 2025 meeting.

Proposed approach 2025/26 onwards

Given the inclusion of a Health Inequalities and VCSE Partnering team into the ICBs organisational structure, it is proposed that this team lead the future coordination and oversight of the health inequalities (including EDI) requirements that relate to the NHSE Statement, PSED and EDS2.

Oversight and governance will be provided by the Population Health & Inequalities Board and Patient & Communities Committee.

An ICB Health Inequalities Improvement Plan is in development, due to be completed by March 2025 and brought to ICB Board for agreement. To implement and monitor the progress of this plan and small working party will be established within the ICB with representatives from across the relevant departments. This group will collect evidence of compliance throughout the year in support of future reporting requirements.

From 2026 one single integrated annual ICB Health Inequalities Impact Report will be published, which will meet the requirements of the Annual Report, PSED, EDS2 and the NHSE Statement.

This will accompany the publication of an annual plan for the subsequent year, developed by the working group which will include clear objectives and meet the requirements of the Joint Forward Plan and Operational Planning Guidance.

Through the NHS Anchors Leadership Group established by the HI & VCSE team, which brings together the health inequalities leads from trusts and foundation trusts, as well as primary care representation, we will seek to align our approach with the wider system and coordinate a single report and improvement plan for our ICS in future years.

Recommendation to the Board:

Agree the proposed approach to publication of the 2024/25 EDS2 and NHSE Statement on Information reports. Agree the proposed approach to the 2025/26 reporting which will be outlined further in the ICB Health Inequalities Improvement plan which will be brought to Board in March 2026.

Key Risks	
Clinical and Quality:	Unfair and avoidable differences in access to care, quality and experience of care within our Core20plus communities and those with protected characteristics. This will impact on outcomes for individuals and contribute to system pressures.
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	The ICB is providing systems leadership for Health Inequalities within the ICS, and us such needs to remain exemplar in all practices to ensure ongoing reputation.

Legal:	The NHS has legal duties that relate to health inequalities as outlined in the NHSE Statement on Information on Health Inequalities. These include to: - Arrange services to meet reasonable needs - Have regard to reducing inequalities in access and outcomes. - To improvement in quality of services. - To promote integration. - To consider effects of wider decisions on inequalities. - Include consideration for inequalities in annual plans, joint forward plans, performance assessments and annual reports.
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	https://www.england.nhs.uk/publication/equality-delivery-system-2022-guidance-and-resources/ https://www.gov.uk/government/publications/public-sector-equality-duty-guidance-for-public-authorities/public-sector-equality-duty-guidance-for-public-authorities https://www.england.nhs.uk/publication/nhs-workforce-race-equality-standard-technical-guidance/ https://www.gov.uk/government/publications/gender-pay-gap-reporting-guidance-for-employers https://www.england.nhs.uk/publication/nhs-workforce-disability-equality-standard-technical-guidance/ https://www.england.nhs.uk/publication/nhs-englands-statement-on-information-on-health-inequalities/
NHS Constitution:	1. The NHS provides a comprehensive service, available to all 3. The NHS aspires to the highest standards of excellence and professionalism 4. The patient will be at the heart of everything the NHS does 5. The NHS works across organisational boundaries 6. The NHS is committed to providing best value for taxpayers' money 7. The NHS is accountable to the public, communities, and patients that it serves
Conflicts of Interest:	N/A

Reference to relevant risk on the Board Assurance Framework	BAF06

Governance

Process/Committee approval with date(s) (as appropriate)	Patient and Communities Committee approval received 20.5.24 Integrated Care Partnership approval being sought June 2024

Improving lives **together**

Norfolk and Waveney Integrated Care System

Integrated Care Board Finance Report

November 2024

(Month 8 2024/25)

ICB Board – Part One: 29th January 2025

Contents

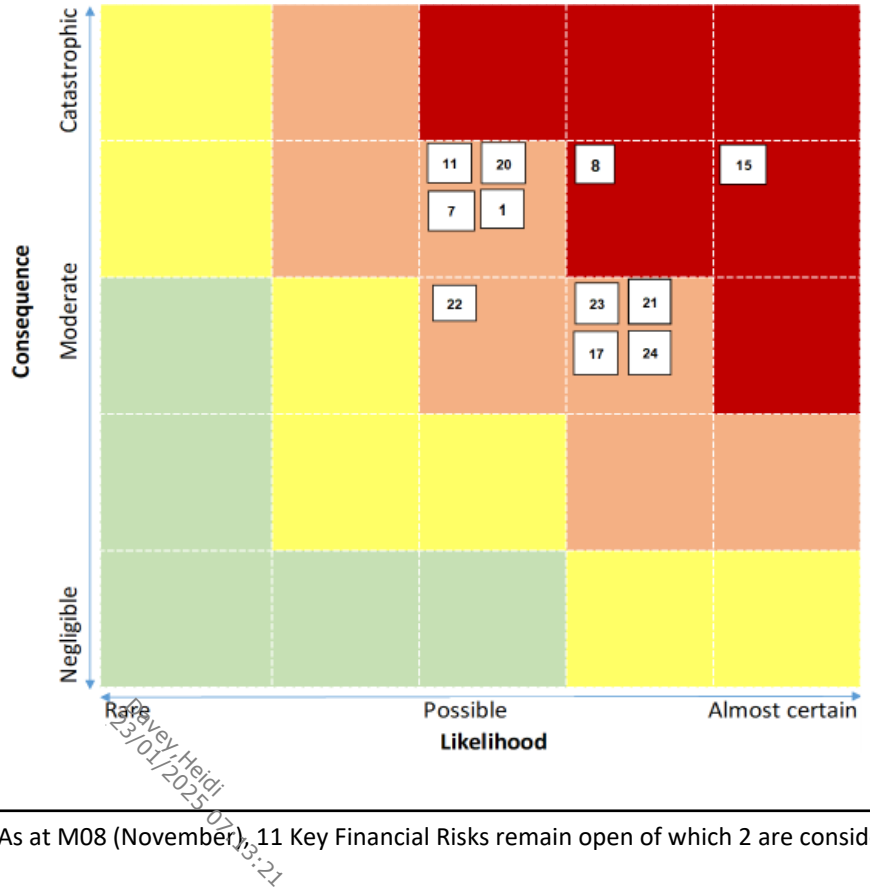
1. ICB Executive Highlights

- The following report is based on the financial plan submitted to NHSE on 12 June 2024, which included a planned £387k surplus position.
- This report represents the **M08 November 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 £0.258m Surplus**,
- The ICB has reported an **on plan Forecast out-turn position of £0.39m Surplus**, but includes offsetting variances and other forecast assumptions, the major items being:
    - The assumed delivery of the Non-Recurrent Unidentified Efficiencies of £8.1m. As part of the I&I process, the ICB has produced a mitigation plan to breakeven should these efficiencies not be identified. This plan is centred around the over achievement of the Elective Recovery Fund (ERF). Whilst this will provide financial support in-year, it will not improve the underlying deficit or the financial plan for 2025/26.
    - £(3.1)m of slippage on identified efficiency delivery within the Prescribing and Better Care Fund portfolios, and
    - £5.4m 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 M08 £51.3m net planning risks were reassessed to £14m, which are excluded from the forecast. **Total net risks, including new risks in addition to planning risks, total £12m**. This is a reduction of £4.3m from last month, which is primarily due to positive Elective Recovery Funding figures being published by NHS England and reduced risks in prescribing due to the latest information received.
- The M08 **underlying deficit is £120.3m**, a deterioration against the planned deficit of £101.8m. This arises from the full year effect of Recurrent CHC packages and the removal of the Non-Recurrent in-year savings being used to deliver the 2024/25 Financial Position. This figure is a £1m deterioration on M07 (£119.3m), which is due to increased activity in Neurodevelopmental Disorder (NDD) assessments and associated prescribing costs.

2. ICB Strategic Financial Risk Register

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

Key: = Worsening Risk = Stable risk = Improving risk



Financial Strategic Risks	Ref.	Details	Tolerated Risk appetite	Sep-24	Oct-24	Nov-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	16	12	12
	22	Re-Organisation: Running Costs Reduction, Increased Pay Costs and Cost of Delivery	9	9	9	9
	23	Debt and Working Capital Management (NCC)	6	12	12	12
Demand and Capacity	7	Continuing Health Care demand growth	9	12	12	12
	11	ERF: RTT backlog and Acute demand management	9	12	12	12
	24	Patient Choice (Learning Disabilities & Autism)	9	9	12	12
Efficiency	8	Efficiency, transformation development/delivery	8	16	16	16

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

As at M08 (November), 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 M07 (October), there have been no changes to either the impact and likelihood as well as the risk classifications.

3. ICB Statement of Financial Position (SOFP)

The Statement of Financial Position presents the aggregate closing position of the ICB as at 30th November 2024.

Non-Current assets
The property, plant & equipment balance relates to the future connectivity gigabit pathway upgrade. The right of use assets balance is for the lease of premises at King's Lynn and Norfolk County Council, following implementation of IFRS16 in April 2022. Corresponding entries are also included in both current and non-current Lease Liabilities.

Current assets
Total current assets have decreased since March 2024. The £11m balance is made up of aged debtors of £0.8m (including NHS England £0.4m & Norfolk County Council £0.1m), net of a provision against this balance of £0.4m, prepayments & accrued income of £7.6m and dental under delivery of £3m. 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 £22m since March 2024, driven principally by ICB and system invoice accrual timing. The £164m balance is made up of trade creditors of £5m, Prescription Pricing Authority & dental accruals of £22m, payroll costs including GP pensions of £3m, deferred income of £3m, prior year accruals of £22m and ICB and system invoice accruals of £109m. Provisions include redundancy, legal claims, estates, standard staffing costs and elective recovery funding conditions. There has been an in-year part release against these provisions as costs are being incurred.

As part of the improvement in working capital with Norfolk County Council, outstanding non-PO transactions stand at £8.3m. 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 31/10/24	Position as at 30/11/24
ASSETS EMPLOYED			
Non-Current assets			
Property, Plant & Equipment	0	335	335
Right-of-use Assets	673	561	545
Total non-current assets	673	896	880
Current assets			
Trade and Other Receivables	23,673	14,386	10,998
Cash and Cash Equivalents	376	1,593	402
Total current assets	24,049	15,979	11,400
Current liabilities			
Trade and Other Payables	(174,924)	(156,224)	(163,661)
Lease Liabilities	(218)	(193)	(193)
Provisions for liabilities and charges (including non-current)	(12,786)	(1,984)	(1,839)
Total current liabilities	(187,928)	(158,401)	(165,693)
Long Term liabilities			
Non-Current Payables	(820)	(422)	(422)
Non-Current Lease Liabilities	(472)	(366)	(327)
Total non-current liabilities	(1,292)	(788)	(749)
Net assets employed	(164,498)	(142,314)	(154,162)
FINANCED BY TAXPAYERS EQUITY			
General fund	(164,498)	(142,314)	(154,162)
Total taxpayers equity	(164,498)	(142,314)	(154,162)

4. ICS Financial Summary: Revenue

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

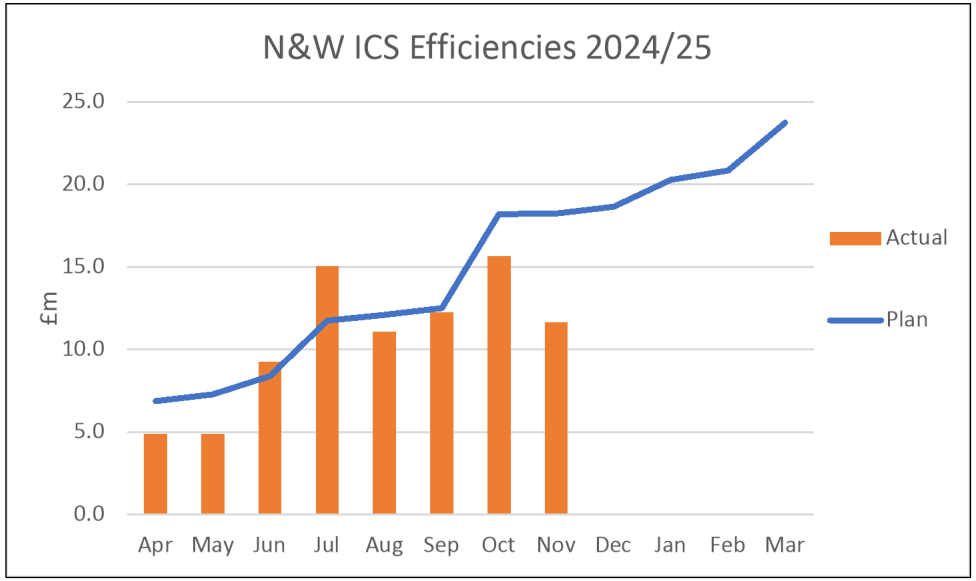
Revenue surplus/(deficit) £m	Month 8 YTD			Forecast Outturn		
Organisation	Plan	Actual	Variance	Plan	Actual	Variance
JPUH	(0.8)	(4.6)	(3.8)	(1.1)	(1.1)	0.0
NNUH	(2.8)	(16.5)	(13.7)	0.0	0.0	0.0
QEH	(5.4)	(24.1)	(18.8)	(0.8)	(0.8)	0.0
NSFT	0.5	(0.9)	(1.5)	0.0	0.0	0.0
NCH&C	0.3	0.4	0.1	1.5	1.5	0.0
Provider Subtotal	**(8.2)**	**(45.7)**	(37.6)	**(0.4)**	**(0.4)**	0.0
ICB	0.3	0.3	0.0	0.4	0.4	0.0
N&W System Total	**(7.9)**	**(45.5)**	(37.6)	**0.0**	**0.0**	0.0

- The position M8 YTD is a £45.5m deficit, which is £37.6m adverse against plan. This is a deterioration of £6.6m from M7 when the position was £31.0m off plan.
- The forecast outturn for the system is per plan, including the non-recurrent deficit funding of £21.0m allocated in M6, though there is a significant net risk of £70.5m against this reported position.
- The following slides provide detail by organisation.

5. ICS Financial Summary: Efficiency and Transformation

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

System Efficiencies £m	Month 8 YTD			Forecast Outturn			Forecast Outturn	
Organisation	Plan	Actual	Variance fav/(adv)	Plan	Actual	Variance fav/(adv)	Recurrent	Non-recurrent
JPUH	13.3	12.2	(1.1)	22.4	22.4	0.0	12.9	9.5
NNUH	27.3	18.4	(8.9)	50.1	50.1	0.0	23.2	26.9
QEH	13.7	5.3	(8.4)	29.5	29.5	0.0	24.5	5.0
NSFT	11.4	9.9	(1.5)	17.4	17.4	0.0	9.2	8.2
NCH&C	4.3	4.5	0.2	8.4	8.4	0.0	3.1	5.3
Provider Subtotal	**70.0**	**50.3**	(19.6)	**127.8**	**127.8**	0.0	**72.7**	**55.0**
ICB*	25.4	34.5	9.1	51.2	48.0	(3.1)	23.0	24.5
N&W System Total	**95.4**	**84.8**	(10.6)	**178.9**	**175.8**	(3.1)	**95.8**	**79.5**
ICB Budget Rephasing*	4.0	0.0	(4.0)	0.0	0.0	0.0	0.0	0.0
Reported ICB position	**29.4**	**34.5**	**5.1**	**51.2**	**48.0**	**(3.1)**	**23.0**	**24.5**
Revised system position	**99.4**	**84.8**	**(14.6)**	**178.9**	**175.8**	**(3.1)**	**95.8**	**79.5**



**ICB Internal reporting differs to the IFR submitted position due to a YTD efficiency plan rephasing of £4.0m. Therefore, the ICB are reporting a YTD favourable position of £5.1m against plan whereas the position against the submitted plan is a £9.1m overperformance.*

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

Year-to-date:

- The efficiency position M8 YTD against plan is an adverse variance to plan of £10.6m. When including the ICB internal plan rephasing it is £14.6m adverse.
- Recurrent efficiency delivery is £42.8m against the plan of £60.5m, £17.6m under and NR delivery is £42.0m against the plan of £34.9m, £7.1m over, generating the net under delivery of efficiencies against plan of £10.6m.
- 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 £9.1m favourable to plan mainly due to the 'closing the gap' exercise. NCHC has also been able to recognise some savings earlier than planned.

Full year forecast:

- Full year efficiency programme forecast is £175.8m, £3.1m adverse to plan. This variance is due to the ICB forecasting £3.1m lower than planned, mainly due to under delivery of Non-NHS procurement..

6. ICS Financial Summary: Capital

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

System CDEL £m	Forecast Outturn @ Mth 8											
	System CDEL					IFRS 16			Total System Performance			
Organisation	Plan	Plan Adj	Total Plan	Actual	Variance	Plan	Actual	Variance	Tot. Plan	Actual	Variance	
		Inc./(Dec)			(Under)/Over			(Under)/Over			(Under)/Over	
Excluding RAAC												
JPUH	9.1	0.0	9.1	9.1	(0.0)	0.2	0.1	(0.1)	9.3	9.2	(0.1)	
NNUH	15.8	0.0	15.8	15.8	0.0	15.5	6.6	(9.0)	31.3	22.3	(9.0)	
QEH	10.7	0.0	10.7	10.7	0.0	0.0	0.0	0.0	10.7	10.7	0.0	
NSFT	9.7	0.0	9.7	13.8	4.2	3.6	(0.1)	(3.7)	13.2	13.7	0.5	
NCH&C	4.6	0.0	4.6	4.6	(0.0)	2.0	0.0	(2.0)	6.7	4.6	(2.1)	
Subtotal excluding RAAC	**49.9**	**0.0**	**49.9**	**54.1**	**4.1**	**21.3**	**6.6**	**(14.8)**	**71.3**	**60.6**	**(10.6)**	
RAAC												
JPUH	7.2	1.7	8.9	8.9	(0.0)				8.9	8.9	(0.0)	
QEH	25.0	0.0	25.0	25.0	0.0				25.0	25.0	0.0	
Subtotal Including RAAC	**82.1**	**1.7**	**83.9**	**88.0**	**4.1**	**21.3**	**6.6**	**(14.8)**	**105.2**	**94.6**	**(10.6)**	
Adjustments												
Reduced IFRS 16 Allocation						(10.8)	0.0	10.8	(10.8)	0.0	10.8	
N&W System Total	**82.1**	**1.7**	**83.9**	**88.0**	**4.1**	**10.6**	**6.6**	**(4.0)**	**94.4**	**94.6**	**0.1**	

Central Programmes £m	Forecast Outturn @ Mth 8											
	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			131.2	109.6	(21.6)	0.0	0.0	0.0	131.2	109.6	(21.6)	
N&W Total Capital Programme			**215.1**	**197.6**		**10.6**	**6.6**		**225.6**	**204.1**		

- M8 combined system CDEL performance FOT is £0.1m below plan.
- IFRS16 schemes are £14.8m lower than plan, this underspend is fully offset by the £10.8m reduced IFRS16 allocation.
- In addition to system CDEL, RAAC & IFRS 16 funds, there is £131.2m of central programme funding, making the total capital resource for N&W ICS £225.6m.

Glossary of terms (1)

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

Glossary of terms (2)

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

Norfolk and Waveney
Integrated Care Board

Agenda item: 14

Subject:	**Finance Committee Report to Board**
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:	**29 January 2025**

Purpose of paper:

To provide the Board with an update on the work of the Finance Committee up to including the 7th of January 2025.

Committee:	Finance Committee
Committee Chair:	Hein van den Wildenberg
Meetings since the previous update	Last update provided: 27.11.2024 Subsequent Meetings: 07.01.2025
Overall objectives of the committee:	The objective of the committee is to contribute to the overall delivery of the ICS objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan and strategy, consistent with the ICS Strategic Plan and its operational deliverables.
Main purpose of meeting:	To gain assurance on the financial position of the NHS entities in the ICS, and ICB respectively.
BAF and any significant risks relevant / aligned to this Committee:	BAF 8 – Achieve the 2024/25 (ICB) financial plan BORR08 – Underlying deficit position
Key items for assurance/noting:	*The information below is based on **Month 8** results, i.e. per November 2024.* The main items discussed at the January 7th Finance Committee were as follows: - At **Month 8 (November 2024)** the NHS entities in the N&W ICS show a Year to Date deficit of £(45.5)m vs a Planned deficit of £(7.9)m, i.e. a shortfall of £(37.6)m.

	This is a further deterioration compared to month 6, when the shortfall was £(26.2)m. The main drivers are under-delivery of efficiencies by most providers compared to Plan and pay cost expenditure. At month 08 the full year forecast remains on plan which for the ICS is a break-even position. Any formal change of the Forecast Outturn (FOT) for the year needs to first go through a national NHSEI Protocol for approval, and may be considered for month 10 reporting where supported. Given the trajectory year to date, achieving the break-even plan as a system for the financial year, looks unlikely. A change in Forecast Outturn in month 10 is a realistic prospect. As reported before, there continues to be **limited assurance** on the aggregate of NHS entities in N&W ICS achieving their financial plan for the year. This assessment is based on the continued trend in shortfall, alongside current operational pressures in the system. - The forecast outturn for Provider staff costs are £13m (nearly 1%) over Plan, driven by expected bank and agency staff overspend of c.£40m, offset by underspend in substantive staff of c.£27m. - At Month 8 the ICB continues to show a delivery on Plan, both year-to-date and for the full financial year forecast. There remains **reasonable assurance** for the ICB to achieve their financial plan, in view of the efficiency schemes identified. - In view of the deteriorating trend, NHSE moved N&W ICS into category 4 in their Investigation & Improvement framework. Deloitte have been appointed to conduct the first of a two-phase exercise. At the time of the meeting, the first phase 1 report had not been finalised yet. System leaders are considering best ways to work Stage 2 for maximum recurrent savings at pace for this year in view of a likely increasingly difficult context for next year's plan. - The CDEL (**Capital** Delegated Expenditure Limit) capital spend is assessed against an envelope, which now includes IFRS16 spend (essentially capitalised right-of-use leases). Whilst year-to-date there is an underspend, due to slippage and delays in project roll-out, the Forecast Outturn presently points to the Plan being achieved. Oversight of the capital investment programme

	happens through the Strategic Capital Board, that provides monthly assurance to the finance committee. - Separately there are 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 are in line with Plan for most projects, with the exception of an extension of the orthopaedic centre at NNUH, which is delayed. - The Committee received an update from the **Financial Recovery Board (FRB)**. Previous works on system wide spotlights continue with varying success but increasingly focus is on the outcome and recommendations of the Deloitte's Phase 1 Investigation and Rapid Intervention (I&I4) work and proposals against which the FRB may re-review its priorities to ensure the best financial outcomes. - At the time of the meeting no formal Planning guidance was available. The expectation was repeated that a very tight financial envelope for 2025/26 is foreseen which is likely to result in negative real-terms growth both for the ICB and the aggregate of NHS entities in the system. The impact is expected to go beyond efficiencies currently delivered.
Items for escalation to Board:	1. The results up to including Month 8 (November) and Forecast Outturn, summarised in the table below highlight a deteriorating trend vs Plan. There continues to be limited assurance that the NHS entities in the N&W ICS will achieve the financial plan for the year, and a change in Forecast Outturn in month 10 is a realistic prospect but requires prior approval from NHSEI before being reported. 2. The Medium-Term Financial Plan highlights a very tight financial envelope for 2025/26, not least for the ICB.

	<table><tr><th></th><th>NHS entities in N&W ICS, including ICB</th><th>N&W ICB</th></tr><tr><td>Month 8 Year to Date</td><td>Actual: Deficit of £(45.5)m vs Plan of £(7.9)m</td><td>Actual: Surplus of £ 0.3m vs Plan of £ 0.3m</td></tr><tr><td>Forecast OutTurn (FOT) of year per Month 8</td><td>FOT £0.0m vs Plan of £ 0.0m Realistic prospect of a formal change in FOT with month 10 reporting subject to NHSEI prior-approval.</td><td>Actual: Surplus of £ 0.4m vs Plan of £ 0.4m</td></tr><tr><td>2024/25 Plan</td><td>Financially balanced plan with significant risk to delivery (risk rating of 16)</td><td>Balanced Plan, with risk to delivery</td></tr><tr><td>Underlying Deficit (* September MTFP)</td><td>£(279)m *</td><td>£(102)m Plan £(120)m Forecast</td></tr><tr><td>Efficiency delivery</td><td>£179m Plan £176m Forecast</td><td>£51m Plan £48m Forecast</td></tr></table>
Items requiring approval:	None
Confirmation that the meeting was quorate:	Confirmed that meeting was quorate.

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

NHS
Norfolk and Waveney
Integrated Care Board

Agenda item: 15

Subject:	**Integrated ICB Performance Report**
Presented by:	**Matt Dooley Executive Director of Commissioning and Performance**
Prepared by:	**Diane Smith ICB Commissioning and Performance team with contributions from teams working in subject areas.**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**29 January 2025**

Purpose of Paper:

To provide assurance to the ICB Board and highlight significant elements of the system performance reporting. Appendix 1 provides a view of performance data for areas of performance concern.

Executive Summary:

Committee are asked to note – areas of concern:

- Active provider and system management of diagnostic and elective care has resulted in continued improvement against diagnostic and 65-week treatment standards. The position remains very challenged and some areas are not expected to reach the in-year or end of year targets.
- Cancer performance continues to see gradual improvements overall, but with variation across specialties and provider, and remains under plan.
- Inappropriate Out of Area Placements in mental health have reduced but remain double the target in the reporting period.
- Admissions for people with LD and autistic people remains above target but has improved to December 2024.
- Community long waits remain high, though there has been a 45% reduction in long waits.
- Dental activity is improving but is forecast to not meet the end of year plan.
- A&E waiting times and Ambulance response times remain very challenged and below targets.
- The system financial position is in deficit, with significant work underway from Q4 24/25 to mitigate and move towards a balanced end-of-year position.

Areas of achievement:

- The Women's health hub has been operationalised to plan and current reporting against operationalising this is proposed to cease.
- The dementia diagnosis rate continues to steadily improve, aligning with national trends but remaining 0.8% below plan.
- LD health check performance is on track to achieve the full-year ambition.
- Norfolk and Waveney continue to benchmark well in prevention areas, while continuing to work to improvement trajectories.
- Access to general practice improved but remains below the regional average.

Report

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

1. Cancer

Is there a recovery trajectory?	Y	Is there an up-to-date action plan?	Y	Is there a contractual escalation in place?	N

Is there a risk logged against performance?	BAF07, ORR13/14/15	Which Committee has risk oversight?	Commissioning and Performance

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

Queen Elizabeth Hospital: 28-day performance was 75% just 1% below the trajectory and 62-day was 60% which is below their 66% trajectory for October 2024. All funding received used to support diagnostic and histopathology waiting times using outsourcing. Current challenges with capacity in urology but working with the service to ringfence where needed. Breast pain pathway in place and work continues to fully implement as referrals still coming through incorrect route. QEH has formally written to the Cancer Alliance regarding a request for increased funding to support insourcing.

Norfolk & Norwich University Hospital: 28-day performance was 60% which is below the 75% trajectory and 62-day was 54%, below their 63% trajectory for October 2024. Skin performance has significantly improved since October's low of 17% and is provisionally at 70% for December 2024. January 2025 FDS performance is expected to follow trajectory, with further improvement expected. December 2024 saw higher than average number of referrals, many with incomplete pre-referral tests to enable straight to test. Additional support from float PPC to ensure CWT guidance for clock stops enacted (interval scanning). Pathway analysis being undertaken to identify any further mitigating actions required. Additional Chemotherapy agency staff commenced in September and additional substantive staff to deliver treatment from October onwards, to support increased capacity and improvements in time to SACT delivery. Urology hosting additional 2ww sessions throughout January. Additional weekend robotic lists are being planned through February. Gynae performance impacted by capacity issues – lack of GA Hysteroscopy/OPH /theatres and a high number of patients deferring investigations and treatment to the new year. Plans to utilise outsourcing to release some capacity for cancer. Lower GI recent funding used for 7-day colon capacity achieving <10 days to investigation. Head and Neck additional four all-day lists per month to new Head and Neck surgeon fully implemented. Challenge remains with Transoral Robotic Surgery list and Division working towards increased capacity plan.

James Paget University Hospital: 28-day performance was 76% exceeding the 72% trajectory and 62-day 71% against a 65% trajectory for October 2024. November's validated FDS performance is 79.2%, 2.2% above the 2024/25 trajectory and has shown a 3% improvement on October's position. Six tumour sites have achieved the national 75% target, with gynaecology, colorectal and lung continuing to see an increase in performance. The Cancer Services team was impacted heavily by sickness combined alongside annual leave in December. Cancer Alliance funding was awarded to enable continuation of a dermatology locum. The Cotman Centre is working to address challenges with skin histopathologist to reduce reporting delays. Head and neck turnaround times have been impacted by sickness during December. Skin plastics have seen an increase in the backlog due to histology delays. A further plastic locum has been identified. Colorectal remains a challenge however waiting times for oncology OPAs have improved significantly following recent recruitment.

Delays with administration process requires review to progress patient's pathways. Additional secretarial resources have been funded to support prioritisation of letter typing and reduction in the backlog. Urology diagnostic and surgical capacity for complex procedures, alongside planned and long wait elective patients remains a challenge.

2. Elective care and Diagnostics

Is there a recovery trajectory?	Y	Is there an up-to-date action plan?	Y	Is there a contractual escalation in place?	N

Is there a risk logged against performance?	BAF07	Which Committee has risk oversight?	Commissioning and Performance

There is ongoing elective recovery challenge to deliver 65 week waits across the system. This is challenged by complexities of cases that remain on the longest waits.Each trust has individual plans to mitigate the remaining long waiters which are frequently monitored and have plans to help overcome this challenge. Teams are in place at all trusts to actively ensure optimal management and prioritisation of patient pathways.

State-of-the-art Community and Diagnostic Centres (CDCs) are now open and operational in Great Yarmouth area (2 CDC's), and at the QEH in Kings Lynn. The CDC at NNUH is scheduled to be completed in February 2025. Ensuring staff are available to maximise the use of these facilities will be crucial in realizing the potential they offer.

Further work to drive activity and performance ~~up~~ to reach the 95% target of offering a diagnostic test within six weeks includes: sharing best practices; standardising procedures, processes and pathways; the use of digital innovations. These will enable an increase in productivity, efficiencies and clinical quality, and align with the *'Reforming Elective Care for Patients'* guidance released in January 2025.

Norfolk and Waveney continue to treat more patients compared to 19/20 (pre-pandemic). However, meeting nationally set ambitions is and will continue to be a very significant challenge, considering the backlog of work and present demand combined with capacity challenges.

3. Maternity, Neonatal and Women's Health

Is there a recovery trajectory?	N	Is there an up-to-date action plan?	Y	Is there a contractual escalation in place?	N

Is there a risk logged against performance?	BAF03 BORR17	Which Committee has risk oversight?	Quality and Safety Committee

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

The Women's Health Hub has delivered the request to implement the 8 core services by December 2024.

4. Mental Health

Is there a recovery trajectory?	N	Is there an up-to-date action plan?	N	Is there a contractual escalation in place?	N

Is there a risk logged against performance?	BAF03/04, BORR14/15/18/24	Which Committee has risk oversight?	Commissioning and Performance

Out of Area Placement: Inappropriate out of area placement position is challenged. Work continues at Norfolk and Suffolk Foundation Trust including monitoring by the Discharge and Flow Incident Management Group. Additionally, from December 2024 a daily out of area meeting is in place which seeks to unblock barriers to discharge and to identify alternatives to out of area placements.

Dementia diagnosis: Work continues at Norfolk and Suffolk Foundation Trust to improve Dementia Assessment and Treatment Service. Focuses include - Assessment session optimization to remove diagnosis inefficiencies and improve assessment-driven diagnosis; addressing demand and capacity issues, especially in North Norfolk and Norwich, where longer wait times persist, and Mild Cognitive Impairment (MCI) Workstream improvements

5. People with a Learning Disability and Autistic People

Is there a recovery trajectory?	Y	Is there an up-to-date action plan?	Y	Is there a contractual escalation in place?	N

Is there a risk logged against performance?	No	Which Committee has risk oversight?	Primary Care Commissioning Committee and Quality and Safety

Health checks: As of the end of November 2024, year-on-year delivery is 260 more than November 2023, at 42% of the total Learning Disabilities register. Notably, N&W ICB has delivered the highest number of LD HCs with a Health Action Plan completed in its history. Current projections indicate a 76% delivery rate by March 2025.
The ICB is collaborating with PCNs and practices to boost activity in underperforming areas, particularly Norwich, where targeted initiatives have started. Some practices and PCNs have requested additional clinical capacity to assist with LD HCs, as in past years.

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

6. Prevention and Health Inequalities

Is there a recovery trajectory?	Y (varied)	Is there an up-to-date action plan?	Y	Is there a contractual escalation in place?	N

Is there a risk logged against performance?	BAF01	Which Committee has risk oversight?	Patients and Communities

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

Cardiovascular Disease: Hypertension diagnosis' have increased in the last 6 months. This means more patients are receiving appropriate, lifesaving treatment but results in a slight drop in attainment of national Hypertensive treatment targets - more newly diagnosed patients whose blood pressure readings are yet to be controlled means less of the overall ratio of patients with Hypertension are optimised.

Norfolk and Waveney ICS remain amongst the very best performing systems nationally for Hypertension management, with the 6th highest ratio of patients treated to target out of the 42 systems in England.

Childhood Immunisations: Performance varies between practices, with the Regional NHSE team responsible supporting uptake and reducing variation. Performance varies across each immunization, however for all immunisations Norfolk and Waveney performance is: higher than England performance; higher than regional performance for all except 12month Rotavirus.

7. Primary and Community Services

Is there a recovery trajectory?	N	Is there an up-to-date action plan?	Y	Is there a contractual escalation in place?	Y

Is there a risk logged against performance?	BAF02, BORR09/11/27	Which Committee has risk oversight?	Primary Care Commissioning Committee & Commissioning and Performance Committee (Community services)

GP appointments: Norfolk & Waveney has seen an increase in the percentage of appointments within 2 weeks, with 81% seen within 2 weeks during November. Benchmarking is available for September and shows performance locally behind the regional average. Our data shows that there are more face-to-face appointments being offered than the national average and patient satisfaction is high.

Dental: The national performance target for dental access is to restore activity to pre-covid levels. Activity achievement for 2024/2026 is forecast to be higher than 2023/2024 based on delivery at end Dec 2024 and historical trend for Q4 activity. With a shift towards flexible commissioning and use of sessional payments for new pathways including access improvement, the national target will be a challenge to meet. Using “number of new patients” as a measure of success is preferred outcome measure by the ICB. The ICB released £1.5m investment to 11 NHS providers to improve access for individuals not seen for more than two years in areas of geographical need; services started to open to new patients in November 2024. A new pathway for high street dentists working in collaboration with Community Dental Services to treat vulnerable children and young people is planned to start February 2025. This will help to reduce waiting times for treatment and enable more children to be seen and treated. Urgent treatment appointments available per month has increased from 1900 to 2000 with a further planned increase from January 2025 to nearly 2500 per month.

Community Services: In November 2024 there were 479 patients waiting over 52 weeks in community services. The trend is reducing, and work continues on this. Overall, the services are meeting waiting time requirements, but there are a few areas such as wheelchairs or Children and Young People neurodevelopmental which have long waiting times. For these services, joint commissioner and provider working groups are taking place to plan recovery. As part of the launch of the Getting It Right First Time Musculoskeletal (MSK) Community Delivery Programme, Norfolk & Waveney were identified as a recipient for funding. This will be used to reduce the waiting list for MSK services, through a combination of additional activity at clinical assessment days and data cleansing.

8. Urgent and Emergency Care

Is there a recovery trajectory?	Y (national)	Is there an up-to-date action plan?	Y	Is there a contractual escalation in place?	N

Is there a risk logged against performance?	BAF06, BORR25, ORR11	Which Committee has risk oversight?	Commissioning and Performance

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

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

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

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

There is now a regional expectation that Handover 45 (release to respond) is adopted across acute hospital sites to support a timelier category 2 response to patients within our community. All site visits have been completed and an approach agreed to achieve this standard. All three acute sites have identified achieving by the end of February 2025.

9. Workforce, use of resources and Quality & Safety

Is there a recovery trajectory?	Y	Is there an up-to-date action plan?	Y	Is there a contractual escalation in place?	N

Is there a risk logged against performance?	BAF08 BORR09/11 ORR05/06/17/18	Which Committee has risk oversight?	Finance. Quality and Safety. People and Culture.

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

Staff retention and attendance levels have been stable over the 3-months to October 2024. Retention figures in year have been driven by organisational restructurings. Attendance has followed national trends and seasonal expectations and tracked on average 0.1 percentage point above the national figure.

Recommendation to the Board:

The anticipated impact of the '*Reforming elective care for patients'* guidance (Jan 2024) and the upcoming NHS England Planning Guidance is likely to set new, more challenging

performance objectives. These will require whole-system engagement and commitment to new ways of working and delivering care.

To the end of 2024/25 (financial year) the Norfolk and Waveney system continues to work to achieve current ambitions for:

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

Governance

Committee Approval	Norfolk and Waveney Integrated Care Board, January 2025.

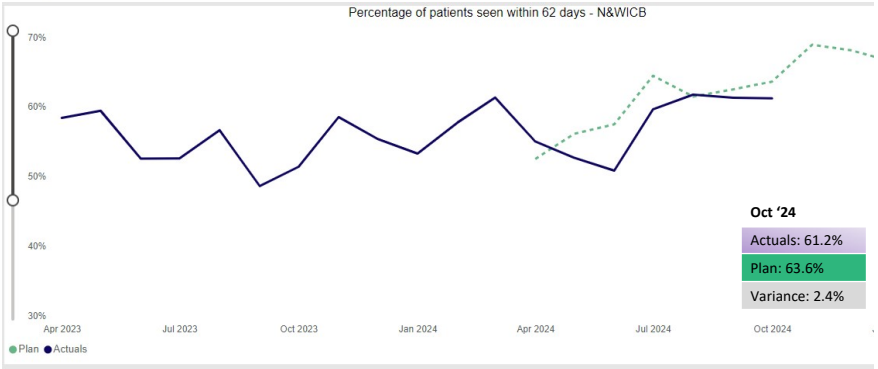
Appendix 1 – areas of performance concern

Delivery area	Metric – national planning objective metrics (24/25) that show cause for some concern	Target (local trajectory target as appropriate)	Actual (to latest reporting period, as per linked slide)
Cancer	62-day standard to 70% by March 2025	63.6%	61.2 % (Oct '24)
	28-day Faster Diagnosis Standard to 77% by March 2025	74.5%	66.1 % (Oct '24)
	Increase the percentage of cancers diagnosed at stage 1 and 2 to 75% by 2028	75%	56.6 % (12m to June '24)
Diagnostics and Elective	Diagnostic tests within 6 weeks at 95% by March 2025	95%	70.9% (Oct '24)
	Eliminate waits of over 65 weeks for elective care by September 2024	1,050	1,086 (Oct '24)
Mental Health	Eliminating Out of Area placements	5	10 (Sept'24)
	Achieve the Dementia Diagnosis Rate by March 2025	63.4%	62.6 % (Nov '24)
People with learning disability and autistic people	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12-15 under 18s for every 1 million population	23	30
Prevention and Health Inequalities	Continue to address health inequalities and deliver on the Core20PLUS5 approach	Mastering	Foundation
	Increase vaccination uptake for children and young people year on year	95 %	87-96% (Q2 '24-25)
Primary and Community Services	Increase dental activity improving units of dental activity (UDAs) towards pre-pandemic levels	Increase	Decrease
UEC	Improve A&E Waiting Times, compared to 2023/24, with a minimum of 78% of Patients seen within 4 hours in March 2025	80%	72.8% (Nov '24)
	Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25	18 min (30 min interim)	47.2 min (Nov '24)
Use of Resources	Reduce agency spend to a maximum of 3.2% of the total pay bill across 24/25	£41.2m	£48.4m (Forecast year)
	Deliver a balanced financial position for 24/25	£0	£37.6m (Nov '24)

PMO
Project Management across Norfolk and Waveney

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

Improving lives **together**
Norfolk and Waveney Integrated Care System



Trust	Actuals Trend	Latest Month	Actuals	Plan	Latest Gap To Plan	YTD Value	YTD Plan	YTD Gap To Plan	End FY Plan	Variance Trend
N&WICB		Oct-24	61.2%	63.6%	13	57.5%	59.7%	79	70.8%	

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

Description of the metric

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

Description of performance

62-day performance at 61.2% against the trajectory of 63.6% for October 2024. All but the breast, sarcoma and haem pathways are challenged.

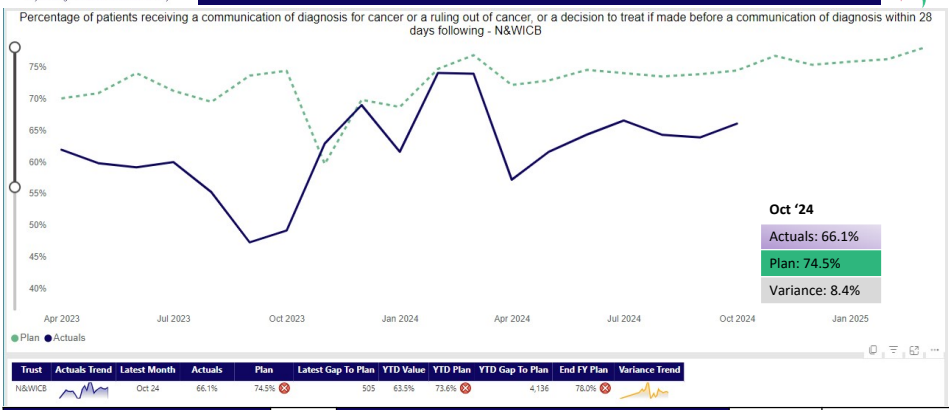
Is performance meeting national KPI?	No	If no above, is performance meeting recovery trajectory?	No	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
Backlogs, variation in demand. Capacity of the oncology medical workforce.	Regional and national tiering support meetings, allocation of additional NHS E funding to support backlog clearance, re-allocation of cancer SDF underspend in year. Workforce redesign steering group progressing medium to long term solutions. Oncology speciality network creating 5-year action plan which includes a hub and spoke model. Proposal to review capacity and demand within the system acutes.	Cancer Transformation Oversight Group and Cancer Alliance.	Acutes to work towards meeting their planned trajectories ending March 2025 when the standard is required to be met.	The continued surges in Urgent Suspected Cancer referral demand continue to provide a challenge for trusts to manage while clearing backlogs.

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide



Trust	Actuals Trend	Latest Month	Actuals	Plan	Latest Gap To Plan	YTD Value	YTD Plan	YTD Gap To Plan	End FY Plan	Variance Trend
N&WICB		Oct 24	66.1%	74.5%	505	63.5%	73.6%	4,136	78.0%	

Description of the metric

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

Description of performance

FDS is 66.1% against the trajectory of 74.5% for October 2024. With all but testicular, breast, upper GI, children's and head and neck being the most challenged pathways.

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

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
Diagnostic and treatment backlogs, variation in demand, particular issues with histopathology and imaging. Incomplete imple mentation of best practice timed pathways (BPTPs).	Regional and national tiering support meetings, allocation of additional NHS E funding to support backlog clearance, re allocation of cancer SDF underspend in year. Focus on FDS project with the Cancer Alliance. Monthly FDS workstream meetings in place and baselining of all BPTPs. Completion of pathway analysers and introduction of a more robust QI approach to BPTPs/capacity and demand analysis at the acutes. Histopathology contract for QEH moving from Addenbrookes to NNUH from April 2025.	Cancer Transformation Oversight Group and Cancer Alliance.	Acutes to work towards meeting their planned trajectories ending March 2025 when the standard is required to be met.	The continued surges in demand. Access to action / improvement plans for all providers where required. Fixed term funding for lower GI redirect (FIT negative) service ends March 2025. Resource to support Non-site-specific (NSS) pathway pending commissioning outputs from ICB.

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide

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

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

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

Regional view of stage 1 and 2 diagnosis by Cancer pathway

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

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

Description of the metric

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

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

Description of performance

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

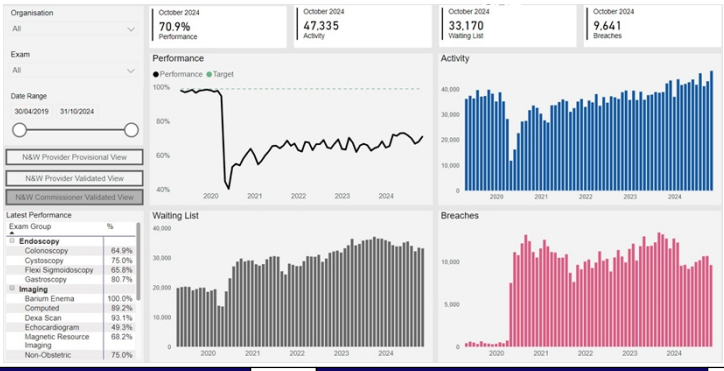
Is performance meeting national KPI?	No	If no above, is performance meeting recovery trajectory?	No	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
There is variation in urgent suspected cancer (USC) referrals and a variable awareness of benefits of screening, signs and symptoms of cancer and NG12 guidance re early detection of cancer.	Local campaigns to raise awareness of signs and symptoms of benefits of screening in partnership with CRUK. Engagement with Core20+5 groups to gain insight into challenges. Review of USC referral forms and implementation of C the Signs decision support tool. Piloting Community Pharmacy Access for USC referrals. NSS cancer pathway in place. Early Diagnosis Primary Care education event in March 25. ED and Screening engagement event Jan 25.	Cancer Transformation Oversight Group.	Trajectories in place for March 2025.	Variable uptake of awareness raising, risk reducing and engagement activities. Fixed term funding for C the Signs, Community Pharmacy and NSS pathway.

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide



Description of the metric

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

Description of performance

Activity has continued to underachieve plan at Month (October).

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

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

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide

Description of the metric

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

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

Description of performance

Activity has continued to underachieve plan at Month 7 (October).

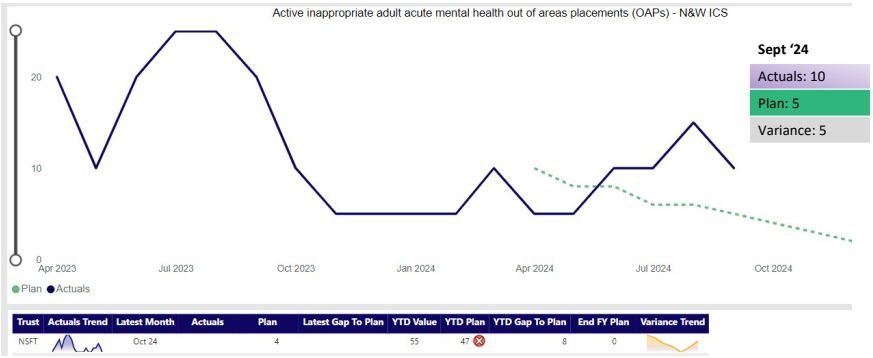
Is performance meeting national KPI?	no	If no above, is performance meeting recovery trajectory?	no	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
• Wait list validation. • Grip & control. • Theatre utilisation. • UEC impact. • Workforce power is unsustainable. • Mutual Aid offering is limited due to patient complexities and financial flow. • Complexities of patients now breaching 65w.	• Patient Tracker List (PTL) non-clinical validation / data quality across system. • PTL oversight weekly / monthly including with Independent Sector Providers. Increasing oversight of ISP. • Super clinics (T&O and ENT) / additional outpatients all lists. Mutual Aid and Outsourcing/Insourcing. 7 day working implemented at JPUH and NNUH considering. Getting It Right First Time team support and system-wide best practice. • Provider Performance and Planning Oversight Group establishing working groups to cover productivity and demand management.	• Provider Performance and Planning Oversight Group. • Scheduled Care Board.	December '24: Overdue	• Collaborating with neighbouring Systems and across the Region for additional support. • Surgical Hubs being built to provide additional capacity.

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide



Trust	Actuals Trend	Latest Month	Actuals	Plan	Latest Gap To Plan	YTD Value	YTD Plan	YTD Gap To Plan	End FY Plan	Variance Trend
NSFT		Oct 24		4		55	47	8	0	

Description of the metric

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

Description of performance

Target of 5 was exceeded but the trajectory is going in the right direction. Actual numbers of people in out of area placement: 10

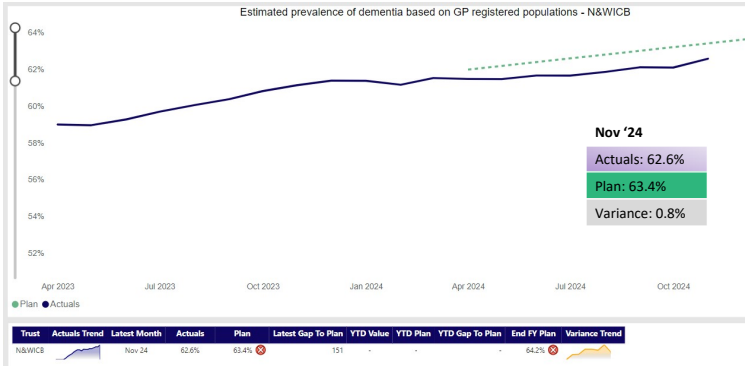
Is performance meeting national KPI?	No	If no above, is performance meeting recovery trajectory?	no	(if no to either/both, complete below)

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

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide



Trust	Actuals Trend	Latest Month	Actuals	Plan	Latest Gap To Plan	YTD Value	YTD Plan	YTD Gap To Plan	End FY Plan	Variance Trend
N&WICB		Nov 24	62.6%	63.4%	151	-	-	-	64.2%	

Description of the metric

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

Description of performance

N&W ICS committed to achieving 64.2% by the end of the financial year (24/25) and 66.7% by end of 25/26. November plan to deliver 63.4% with 62.6% achieved and an upward trajectory continues to be achieved.

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

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
Significant Place variation, which is also replicated across Dementia Assessment Treatment Services (DATS).	Assessment session optimization to remove diagnosis inefficiencies and improve assessment-driven diagnosis; addressing demand and capacity issues, and Mild Cognitive Impairment (MCI) Workstream improvements	Mental Health Integrated Delivery Group		Delays to demand and capacity work and programme to address diagnosis inefficiencies impacts on delivery of plan to boost performance in line with agreed trajectory, in year.

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

Improving lives together
Norfolk and Waveney Integrated Care System

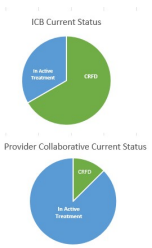
Link back to overview of underachieving metrics slide

NWICB Adult Inpatients	2024								
	Q1			Q2			Q3		
Source Data	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Plan	12	12	12	12	12	12	12	12	12
Actual	12	13	14	14	14	14	20	17	15
Performance	0	1	2	2	2	2	8	5	3
Admissions	1	2	1	1	1	0	6	0	2
Discharges	4	1	0	1	1	0	0	3	4
Cumulative Admissions	1	3	4	5	6	6	12	12	14
Cumulative Discharges	4	5	5	6	7	7	7	10	14

NWICB Adult Inpatients	2024								
	Q1			Q2			Q3		
Source Data	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Plan	12	12	12	12	12	12	12	12	12
Actual	12	13	14	14	14	14	20	17	15
Performance	0	1	2	2	2	2	8	5	3
Admissions	1	2	1	1	1	0	6	0	2
Discharges	4	1	0	1	1	0	0	3	4
Cumulative Admissions	1	3	4	5	6	6	12	12	14
Cumulative Discharges	4	5	5	6	7	7	7	10	14

Tom Cahill, National Director of Learning Disability and Autism for NHS England has asked all regions for a push to ensure inpatient numbers are 10% less at end of year to 2023-24 totals.

This maximum figure is 29 for our ICB.



Description of the metric

Reducing the reliance on inpatient settings and enabling people with a learning disability and autistic people to live as independently as possible within their local community.
The target is 23 or below, split to:
- ICB inpatient trajectory: 12
- Provider Collaborative inpatient trajectory: 11

Description of performance

Current position is 30, split to:
- ICB inpatient total: 15.
- Provider Collaborative inpatient total: 15

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

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

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

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide

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

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

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

Description of the metric

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

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

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

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

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide

		23/24 Q2	23/24 Q3	23/24 Q4	24/25 Q1	24/25 Q2	Difference
12 months	DTaP / IPV / Hib	95.2%	94.7%	93.4%	94.4%	92.7%	↓
	Meningitis B	95.2%	94.5%	93.2%	94.1%	92.9%	↓
	Rotavirus	93.3%	91.4%	91.7%	91.2%	90.3%	↓
	Pneumococcal	96.9%	95.8%	95.3%	96.1%	94.2%	↓
24 months	DTaP / IPV / Hib	95.2%	95.6%	96.0%	95.3%	96.0%	↑
	Hib / Men C booster	93.6%	93.4%	94.4%	93.4%	93.7%	↓
	Men B booster	92.8%	91.6%	92.0%	90.8%	92.2%	↑
	MMR dose 1	93.8%	93.1%	94.1%	93.0%	93.5%	↑
	Pneumococcal booster	93.2%	92.5%	93.3%	92.1%	90.3%	↓
5 years	DTaP/IPV/Hib	96.2%	96.2%	95.8%	96.2%	95.8%	↓
	MMR dose 1	95.3%	95.8%	95.6%	96.0%	94.3%	↓
	MMR dose 2	89.7%	91.2%	90.4%	90.2%	88.8%	↓
	DTaP/IPV booster	88.1%	89.8%	89.1%	88.6%	87.3%	↓
	Hib / Men C booster	92.3%	93.6%	92.3%	92.9%	91.6%	↓

Description of the metric

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

Delivery of these are with NHSE Regional team.

Q1 24/25 data is not yet available.

Description of performance

Performance varies between vaccination.
For all immunisations Norfolk and Waveney performance is higher than England performance and is higher than regional performance for all except 12m Rotavirus.

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

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
Practice level variation	Child Health Information Centre sending practice level dashboards with league tables. Regional team contact practices to offer support. Regional call-recall pilot evaluation to be reported on in Jan '25. Regional team mapping impact of local and national campaigns. Focus on Did Not Attend and time between immunisations.	Child Health Information Centre / NHSE Norfolk and Waveney Health Protection Assurance Board	March 2025	Primary Care capacity

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide

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

- Overall activity delivered as of 31Dec 2024 is 52.6%. Forecast is that the ambition to restore activity to 2019 activity levels will not be met by year end however the trend indicates an improvement in activity achieved at year end.
- Access Improvement scheme started November 2024 aimed at improving access in areas of geographical need (South Norfolk and Norwich) and to reduce health inequalities. 11 Providers across ICB area with a recurrent investment of £1.5m
- Action plans for providers forecast to underachieve this year have been released to the ICB to assess and to agree contract renegotiations releasing funds for reinvestment in 2025/2026. Principles for renegotiation agreed by Dental Services Delivery Group (14 January 2025).

Description of the metric

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

Description of performance

New patient data is unavailable pending validation of data with NHSBSA

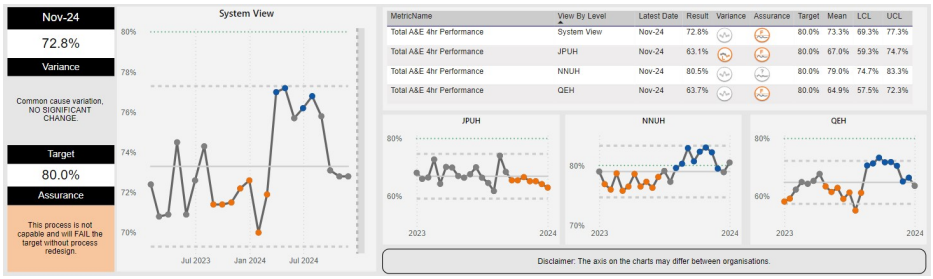
Is performance meeting national KPI?	no	If no above, is performance meeting recovery trajectory?	no	(if no to either/both, complete below)

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

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide



Description of the metric

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

Description of performance

System performance: 72.8%

JPUH performance: 63.1%
NNUH performance: 80.5%
QEH performance: 63.7%

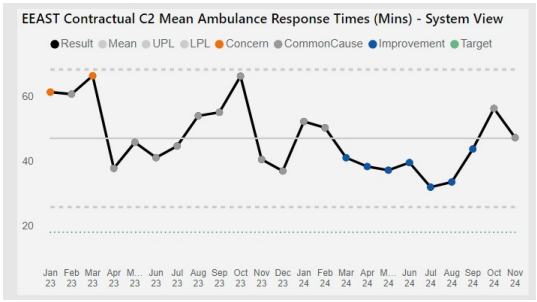
Is performance meeting national KPI?	no	If no above, is performance meeting recovery trajectory?	no	(if no to either/both, complete below)

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

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide



Description of the metric

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

Description of performance

Ambulance C2 response times for N&W system 47.2 minutes.

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

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

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide

£m	Agency 2024/25					
	M8 YTD			Forecast Outturn		
Organisation	Plan	Actual	Variance	Plan	Actual	Variance
JPUH	3.9	6.4	(2.4)	5.7	8.7	(2.9)
NNUH	9.8	8.4	1.4	14.1	14.2	(0.1)
QEH	8.4	7.3	1.1	11.3	15.1	(3.8)
NSFT	6.3	6.5	(0.2)	8.4	8.7	(0.3)
NCH&C	1.2	1.2	0.0	1.8	1.7	0.1
N&W System Total	**29.5**	**29.6**	**(0.1)**	**41.4**	**48.4**	**(7.1)**

The system agency expenditure M8 Year To Date (YTD) excluding Capitalised Staff Costs (CSC) was £29.6m, £0.1m above plan.

£7.1m forecast overspend within agency (exc. CSC) is mainly due to the forecast total agency overspend at QEH of £3.8m (trainee grades £2.0m, other scientific, therapeutic and technical staff £1.0m, infrastructure support £0.8m) and JPUH of £2.9m (consultants £1.6m, registered nursing, midwifery & health visiting staff £0.7m).

The forecast agency spend of £48.4m is £4.3m above the agency cap.

Description of the metric

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

Description of performance

Plan is set to: £41.2m
Current FOT is: £48.4m

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

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

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

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide

The position M6 Year To Date (YTD) is a £45.5m deficit, which is £37.6m adverse against plan. This is a deterioration of £6.6m from M7 when the position was £31.0m off plan.

The forecast outturn (FOT) for the system is break even per the plan, although there is a reported £71m net risk to this position which needs careful mitigation if the plan is to be achieved.

The YTD QEH variance of £18.8m is mainly due to slippage within Cost Improvement Programme (CIP) delivery, bank spend and below plan activity levels. JPUH variance of £3.8m is mainly due to under delivery of CIP and the impact of industrial action. NNUH variance of £13.7m is mainly due to overspends on pay and under delivery of CIP.

Revenue surplus/(deficit) £m	Month 8 YTD			Forecast Outturn		
Organisation	Plan	Actual	Variance	Plan	Actual	Variance
JPUH	(0.8)	(4.6)	(3.8)	(1.1)	(1.1)	0.0
NNUH	(2.8)	(16.5)	(13.7)	0.0	0.0	0.0
QEH	(5.4)	(24.1)	(18.8)	(0.8)	(0.8)	0.0
NSFT	0.5	(0.9)	(1.5)	0.0	0.0	0.0
NCH&C	0.3	0.4	0.1	1.5	1.5	0.0
Provider Subtotal	**(8.2)**	**(45.7)**	(37.6)	**(0.4)**	**(0.4)**	0.0
ICB	0.3	0.3	0.0	0.4	0.4	0.0
N&W System Total	**(7.9)**	**(45.5)**	(37.6)	**0.0**	**0.0**	0.0

Description of the metric

Deliver a balanced financial position.

Description of performance

The position M8 YTD is a £45.5m deficit, which is £37.6m adverse against plan. The forecast outturn is per plan, although there is a reported £71m net risk to this.

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

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
Increased staff costs, resulting from sickness / vacancies. Cost Improvement Programme (CIP) slippage. Industrial action.	Workforce plan. Triple Lock process. CIP overview.	Finance Committee		At month 68 the system is forecasting to meet plan at year end. Finance Committee will oversee progress.

PMO-008 Project on a Page Document TEMPLATE v2.1 August 2022 nwicb.nwtransformation@nhs.net

PMO
Project Management across Norfolk and Waveney

Improving lives **together**
Norfolk and Waveney Integrated Care System

IPR: National Planning Metrics

Commissioning and Performance Committee, 23rd January 2025

PMO
Project Management across Norfolk and Waveney

Contents

Improving lives **together**
Norfolk and Waveney Integrated Care System

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

Section 1 (slides 3-6) – Overview

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

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

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

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

Section 3 (slides 54-57) – appendices

Additional contextual metrics and guide.

National Planning Objectives (24/25) requiring development

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

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

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

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

Davey Heidi 23/01/2025 07:13:21

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

PMO
Project Management across Norfolk and Waveney

Metrics that are underachieving against plan / local trajectory

Improving lives together
Norfolk and Waveney Integrated Care System

Delivery area	Metric – national planning objective metrics (24/25) that show cause for some concern	Target (local trajectory target as appropriate)	Actual (to latest reporting period, as per linked slide)	Linked slide
Cancer	62-day standard to 70% by March 2025	63.6%	61.2 % (Oct '24)	Slide 8
	28-day Faster Diagnosis Standard to 77% by March 2025	74.5%	66.1 % (Oct '24)	Slide 9
	Increase the percentage of cancers diagnosed at stage 1 and 2 to 75% by 2028	75%	56.6 % (12m to June '24)	Slide 10
Diagnostics and Elective	Diagnostic tests within 6 weeks at 95% by March 2025	95%	70.9% (Oct '24)	Slide 12
	Eliminate waits of over 65 weeks for elective care by September 2024	1,050	1,086 (Oct '24)	Slide 13
Mental Health	Eliminating Out of Area placements	5	10 (Sept'24)	Slide 23
	Achieve the Dementia Diagnosis Rate by March 2025	63.4%	62.6 % (Nov '24)	Slide 26
People with learning disability and autistic people	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12-15 under 18s for every 1 million population	23	30	Slide 34
Prevention and Health Inequalities	Continue to address health inequalities and deliver on the Core20PLUS5 approach	Mastering	Foundation	Slide 36
	Increase vaccination uptake for children and young people year on year	95 %	87-96% (Q2 '24-25)	Slide 39
Primary and Community Services	Increase dental activity improving units of dental activity (UDAs) towards pre-pandemic levels	Increase	Decrease	Slide 43
UEC	Improve A&E Waiting Times, compared to 2023/24, with a minimum of 78% of Patients seen within 4 hours in March 2025	80%	72.8% (Nov '24)	Slide 45
	Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25	18 min (30 min interim)	47.2 min (Nov '24)	Slide 46
Use of Resources	Reduce agency spend to a maximum of 3.2% of the total pay bill across 24/25	£41.2m	£48.4m (Forecast year)	Slide 51
	Deliver a balanced financial position for 24/25	£0	£37.6m (Nov '24)	Slide 52

PMO
Project Management across Norfolk and Waveney

National Planning Metrics – overview (1/2)

Improving lives together
Norfolk and Waveney Integrated Care System

Area	Objective	Date	ICB/ICS	Has Plan	Reporting Value	On Plan	On Target	Capability	Variation
Quality and Patient Safety	Implement the Patient Safety Incident Response Framework (PSIRF)		ICB						
Urgent and Emergency Care	Improve A&E Waiting Times, compared to 2023/24, with a minimum of 78% of Patients seen within 4 hours in March 2025	November 2024	ICB	✓	72.8%	✗	✗	F	
Urgent and Emergency Care	Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25	November 2024	ICB	✗	47.2		✗	F	
Primary and Community Services	Improve community services waiting times, with a focus on reducing long waits	October 2024	ICB	✓	409	✗			H
Primary and Community Services	Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are accessed the same or next day according to clinical need	November 2024	ICB	✓	81.4%	✓			
Primary and Community Services	Increase dental activity by implementing the plan to recover and reform NHS dentistry, improving units of dental activity (UDAs) towards pre-pandemic levels		ICB						
Elective Care	Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)	October 2024	ICB	✓	1,086	✗	✗	F	L
Elective Care	Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%	August 2024	ICB	✓	117.5%	✓	✓		
Elective Care	Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25	November 2024	ICB	✗	45.9%		✗	?	
Elective Care	Improve patients' experience of choice at point of referral		ICB						
Cancer	Improve performance against the headline 62-day standard to 70% by March 2025	October 2024	ICB	✓	61.2%	✗	✗	F	
Cancer	Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026	October 2024	ICB	✓	66.1%	✗	✗	?	
Cancer	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028?	January 2024	ICB	✗	62.0%		✗		
Diagnostics	increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	October 2024	ICB	✓	70.9%	✗	✗	F	
Maternity neonatal and women's health	Continue to implement the Three-year delivery plan for maternity and neonatal services, including making progress towards the national safety ambition and increasing fill rates against funded establishment		ICB						
Maternity neonatal and women's health	Establish and develop at least one women's health hub in every ICB by December 2024, working in partnership with local authorities		ICB						

PMO
Project Management across Norfolk and Waveney

National Planning Metrics – overview (2/2)

Improving lives together
Norfolk and Waveney Integrated Care System

Area	Objective	Date	ICB/ICS	Has Plan	Reporting Value	On Plan	On Target	Capability	Variation
Mental Health	Improve patient flow and work towards eliminating inappropriate out of area placements	September 2024	ICB	✓	10	✗	✗	F	
Mental Health	Increase the number of people accessing transformed models of adult community mental health (to 400,000)	March 2024	ICB	✓	8,235	✓	✓		
Mental Health	Increase the number of people accessing perinatal mental health (to 66,000)	October 2024	ICB	✓	1,065	✓	✓	?	H
Mental Health	Increase the number of people accessing children and young people services (345,000 additional CYP aged 0-25 compared to 2019)	October 2024	ICB	✓	14,690	✓	✓	P	H
Mental Health	Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement	October 2024	ICB	✓	67.3%	✓	✓	?	
Mental Health	Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 48% achieving reliable recovery	October 2024	ICB	✓	50.2%	✓	✓	?	
Mental Health	Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025	September 2024	ICB	✓	62.3%	✓	✓		
Mental Health	Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2026	November 2024	ICB	✓	62.6%	✗	✗	F	H
People with a learning disability and autistic people	Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025	November 2024	ICB	✗	41.4%		✗		
People with a learning disability and autistic people	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12-15 under 18s for every 1 million population		ICB						
Prevention and health inequalities	Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people		ICB						
Prevention and health inequalities	Increase the % of patients with hypertension treated according to NICE guidance to 80% by March 2025		ICB						
Prevention and health inequalities	Increase the percentage of patients aged 25-84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 2025		ICB						
Prevention and health inequalities	Increase vaccination uptake for children and young people year on year towards WHO recommended levels		ICB						
Workforce	Improve the working lives of all staff and increase staff retention and attendance through systematic implementation of all elements of People Promise retention		ICB						
Workforce	Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the NHS Long Term Workforce Plan		ICB						
Use of Resources	Deliver a balanced net system financial position for 2024/25	October 2024	ICS	✓	£0	✓	✓		
Use of Resources	Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25	October 2024	ICS	✓	3.4%	✗	✗		

PMO
Project Management across Norfolk and Waveney

Cancer – summary

Improving lives together
Norfolk and Waveney Integrated Care System

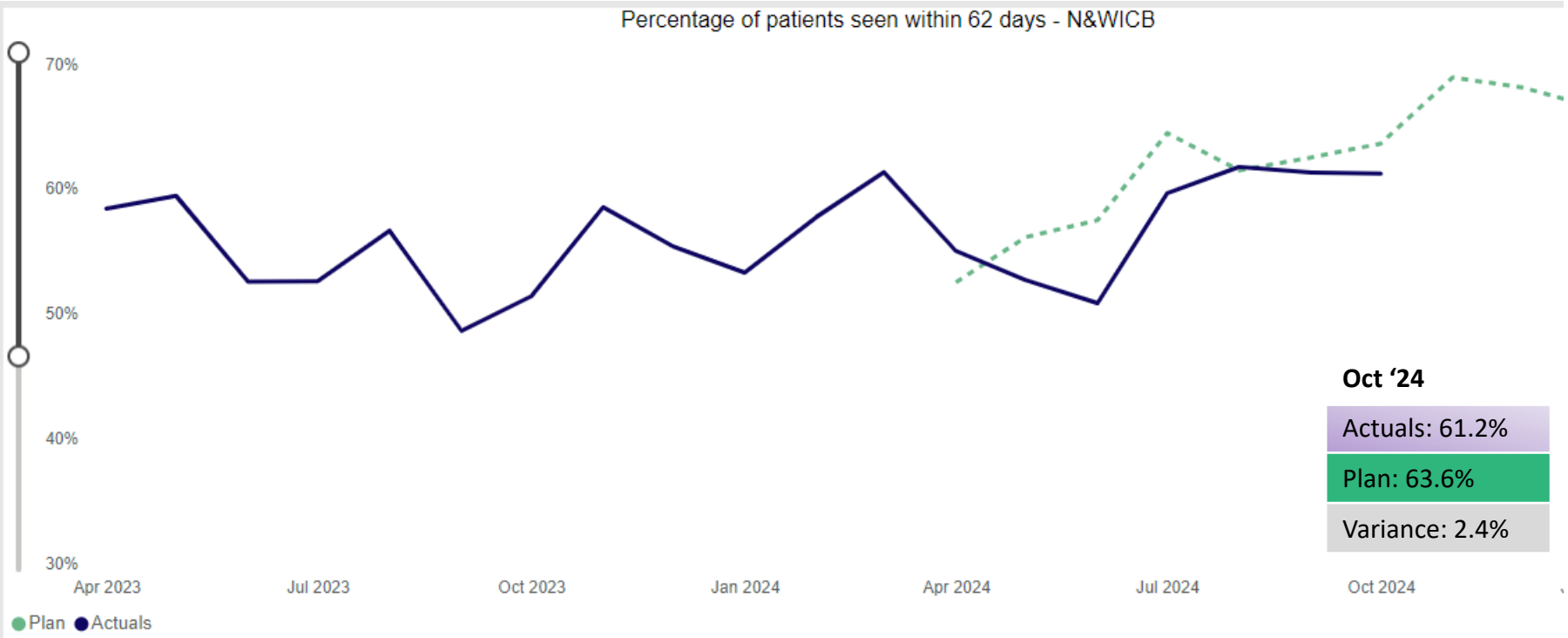
Metric Description	Target	Actual	Regularity of reporting	Reporting period	Date report updated	Board with assurance oversight	Risk to escalate to Commissioning and Performance Committee?	Related Board Assurance Framework risk? (provide reference)
Improve performance against the headline 62-day standard to 70% by March 2025	63.7%	61.2%	Monthly	Oct '24	15/01/25	Cancer Oversight Group	No	BAF07 – Elective Recovery
Improve performance against the 28-day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026	74.1%	66.1%	Monthly	Oct '24	15/01/25		No	BAF07 – Elective Recovery
Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	75%	56.6%	Rolling 12 monthly	June '24	15/01/25		No	N/A
Local Metrics as indicated by exception								
Timely cancer diagnosis and treatment (including medical staffing in oncology)			Bi-monthly	To Nov 24	15/01/25	Cancer Oversight Group		BAF07 – Elective Recovery

Davey,Heidi
23/01/2025 07:13:21

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

Link back to overview of underachieving metrics slide

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



Trust	Actuals Trend	Latest Month	Actuals	Plan	Latest Gap To Plan	YTD Value	YTD Plan	YTD Gap To Plan	End FY Plan	Variance Trend
N&WICB		Oct 24	61.2%	63.6%	13	57.5%	59.7%	79	70.8%	

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

Description of the metric

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

Description of performance

62-day performance at 61.2% against the trajectory of 63.6% for October 2024. All but the breast, sarcoma and haem pathways are challenged.

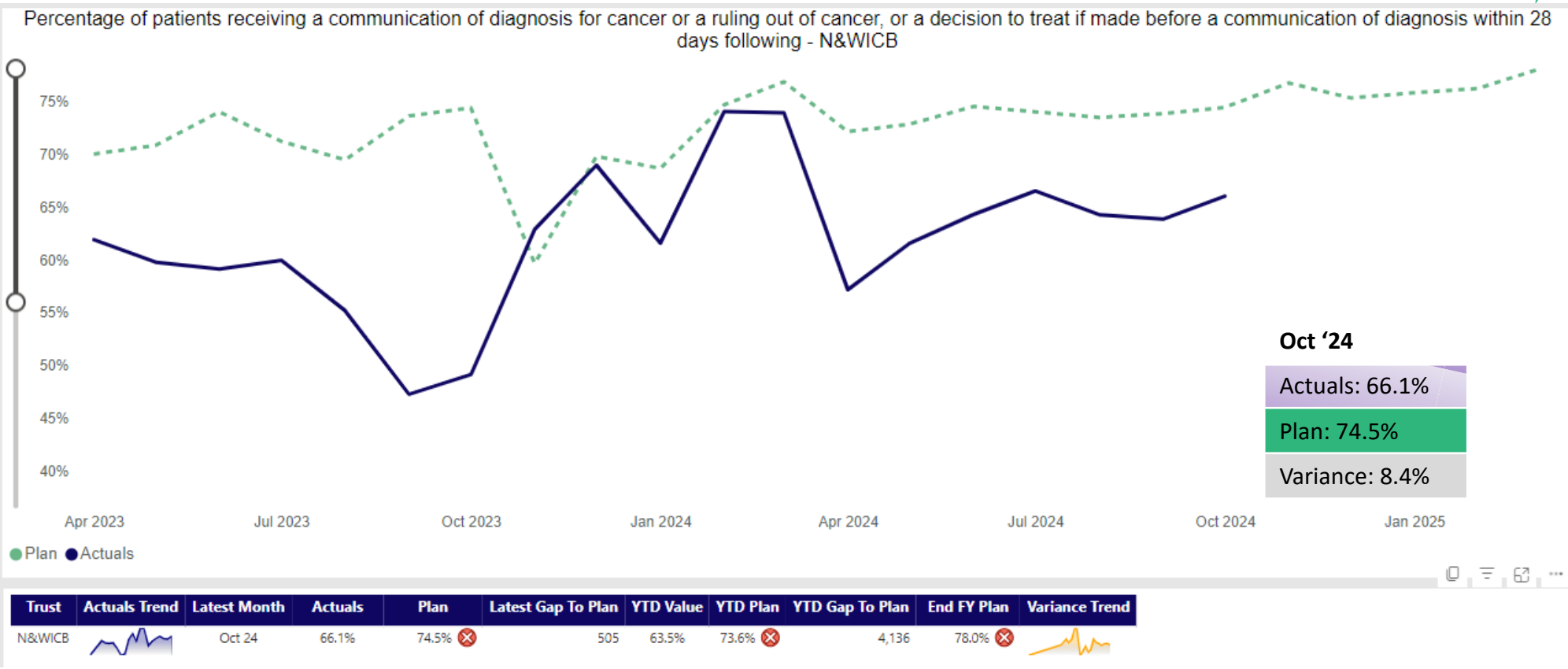
Is performance meeting national KPI?	No	If no above, is performance meeting recovery trajectory?	No	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
Backlogs, variation in demand. Capacity of the oncology medical workforce.	Regional and national tiering support meetings, allocation of additional NHS E funding to support backlog clearance, re-allocation of cancer SDF underspend in year. Workforce redesign steering group progressing medium to long term solutions. Oncology speciality network creating 5-year action plan which includes a hub and spoke model. Proposal to review capacity and demand within the system acutes.	Cancer Transformation Oversight Group and Cancer Alliance.	Acutes to work towards meeting their planned trajectories ending March 2025 when the standard is required to be met.	The continued surges in Urgent Suspected Cancer referral demand continue to provide a challenge for trusts to manage while clearing backlogs.

PMO
Project Management across Norfolk and Waveney

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

Improving lives together
Norfolk and Waveney Integrated Care System



Trust	Actuals Trend	Latest Month	Actuals	Plan	Latest Gap To Plan	YTD Value	YTD Plan	YTD Gap To Plan	End FY Plan	Variance Trend
N&WICB		Oct 24	66.1%	74.5%	505	63.5%	73.6%	4,136	78.0%	

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

Description of the metric

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

Description of performance

FDS is 66.1% against the trajectory of 74.5% for October 2024. With all but testicular, breast, upper GI, children's and head and neck being the most challenged pathways.

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

Root cause(s) identified:	**Corrective Action(s):**	**Action owner(s):**	**Delivery date for action(s):**	**Risk to delivery of corrective action(s):**
Diagnostic and treatment backlogs, variation in demand, particular issues with histopathology and imaging. Incomplete implementation of best practice timed pathways (BPTPs).	Regional and national tiering support meetings, allocation of additional NHS E funding to support backlog clearance, re allocation of cancer SDF underspend in year. Focus on FDS project with the Cancer Alliance. Monthly FDS workstream meetings in place and baselining of all BPTPs. Completion of pathway analysers and introduction of a more robust QI approach to BPTPs/capacity and demand analysis at the acutes. Histopathology contract for QEH moving from Addenbrookes to NNUH from April 2025.	Cancer Transformation Oversight Group and Cancer Alliance.	Acutes to work towards meeting their planned trajectories ending March 2025 when the standard is required to be met.	The continued surges in demand. Access to action / improvement plans for all providers where required. Fixed term funding for lower GI redirect (FIT negative) service ends March 2025. Resource to support Non-site-specific (NSS) pathway pending commissioning outputs from ICB.

PMO
Project Management across Norfolk and Waveney

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide

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

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

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

Regional view of stage 1 and 2 diagnosis by Cancer pathway

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

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

Description of the metric

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

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

Description of performance

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

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

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
There is variation in urgent suspected cancer (USC) referrals and a variable awareness of benefits of screening, signs and symptoms of cancer and NG12 guidance re early detection of cancer.	Local campaigns to raise awareness of signs and symptoms of benefits of screening in partnership with CRUK. Engagement with Core20+5 groups to gain insight into challenges. Review of USC referral forms and implementation of C the Signs decision support tool. Piloting Community Pharmacy Access for USC referrals. NSS cancer pathway in place. Early Diagnosis Primary Care education event in March 25. ED and Screening engagement event Jan 25.	Cancer Transformation Oversight Group.	Trajectories in place for March 2025.	Variable uptake of awareness raising, risk reducing and engagement activities. Fixed term funding for C the Signs, Community Pharmacy and NSS pathway.

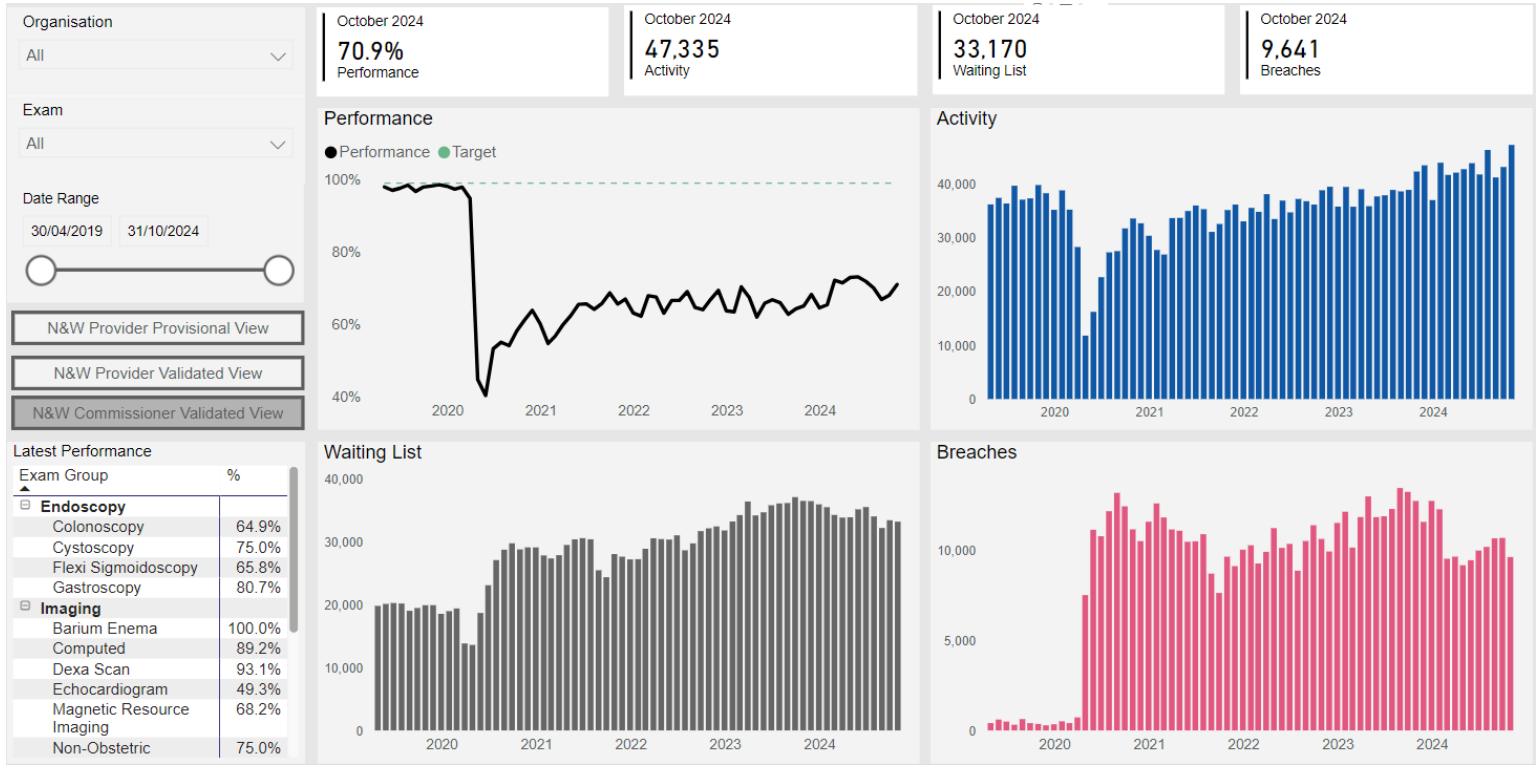
Diagnostics and Elective Care – summary

Metric Description	Target	Actual	Regularity of reporting	Reporting period (to)	Date report updated	Board with assurance oversight	Risk to escalate to Commissioning and Performance Committee?	Is there a related Board Assurance Framework risk? (provide reference)
Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	95%	70.9%	Monthly	Oct '24	15/01/24	Scheduled Care Board	No	BAF07 – Elective Recovery
Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest	1,050	1.086	Monthly	Oct '24	15/01/24		No	BAF07 – Elective Recovery
Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%	103.1%	117.5%	Monthly	Sept '24 (see slide 14)	15/01/24		No	BAF07 – Elective Recovery
Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25	46%	45.9%	Monthly	Oct '24	15/01/24		No	BAF07 – Elective Recovery
Improve patients' experience of choice at point of referral	-	-	See slide 16		15/01/24		No	BAF07 – Elective Recovery
Local Metrics as indicated by exception								

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

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

Improving lives together
Norfolk and Waveney Integrated Care System



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

Description of the metric

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

Description of performance

Activity has continued to underachieve plan at Month (October).

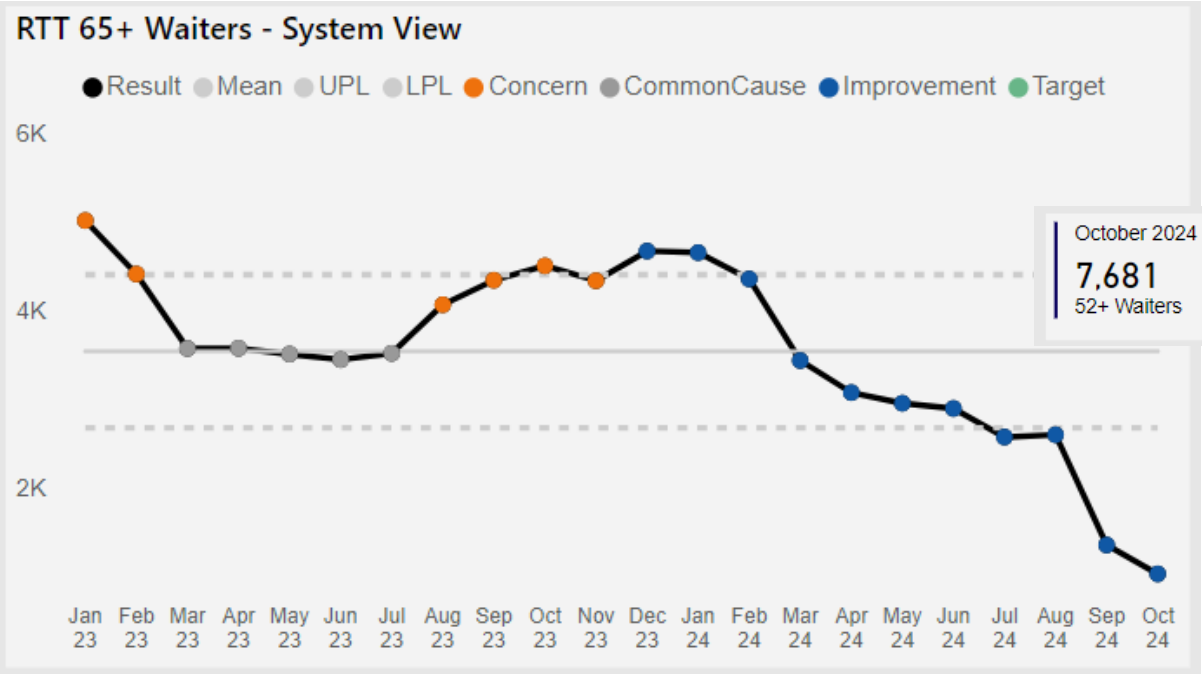
Is performance meeting national KPI?	no	If no above, is performance meeting recovery trajectory?	no	(if no to either/both, complete below)

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

PMO
Project Management across Norfolk and Waveney

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

Improving lives together
Norfolk and Waveney Integrated Care System



October 2024	October 2024	October 2024
54.1%	144,947	66,500
Performance	RTT Incomplete Pathways	RTT Breaches

October 2024	October 2024	October 2024	October 2024
7,681	1,086	165	1
52+ Waiters	65+ Waiters	78+ Waiters	104+ Waiters

Link back to overview of underachieving metrics slide

Description of the metric

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

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

Description of performance

Activity has continued to underachieve plan at Month 7 (October).

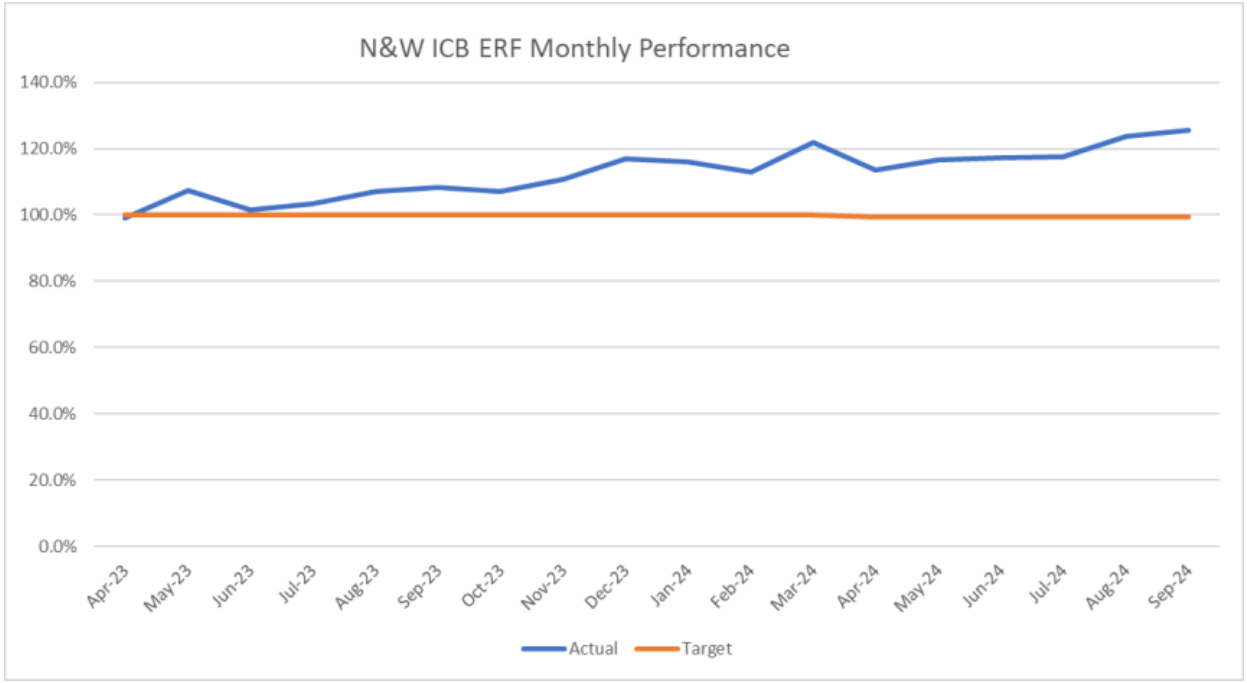
Is performance meeting national KPI?	no	If no above, is performance meeting recovery trajectory?	no	(if no to either/both, complete below)

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
• Wait list validation. • Grip & control. • Theatre utilisation. • UEC impact. • Workforce power is unsustainable. • Mutual Aid offering is limited due to patient complexities and financial flow. • Complexities of patients now breaching 65w.	• Patient Tracker List (PTL) non-clinical validation / data quality across system. • PTL oversight weekly / monthly including with Independent Sector Providers. Increasing oversight of ISP. • Super clinics (T&O and ENT) / additional outpatients all lists. Mutual Aid and Outsourcing/Insourcing. 7 day working implemented at JPUH and NNUH considering. Getting It Right First Time team support and system-wide best practice. • Provider Performance and Planning Oversight Group establishing working groups to cover productivity and demand management.	• Provider Performance and Planning Oversight Group. • Scheduled Care Board.	December '24: Overdue	• Collaborating with neighbouring Systems and across the Region for additional support. • Surgical Hubs being built to provide additional capacity.

PMO
Project Management across Norfolk and Waveney

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

Improving lives together
Norfolk and Waveney Integrated Care System



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

Description of the metric

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

Description of performance

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

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

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
• Current backlog excessed available capacity • Remaining patients who have been waiting over 52 weeks, have high acuity levels and high BMI ranges, making it difficult to utilise Independent Sector providers for additional capacity.	• Surgical Hubs and Community Diagnostic Centres are being built to provide additional capacity across the System to help treat patients more quickly • Super clinics (T&O and ENT) / additional outpatients all lists. Outsourcing/Insourcing. • Getting It Right First Time team support and system-wide best practice. • Provider Performance and Planning Oversight Group establishing working groups to cover productivity • Advice and Guidance to be increased between primary and secondary care, with connection to Jan '25 Reforming elective care guidance. • Implementation of Reforming elective care guidance (Jan '25)	• Provider Performance and Planning Oversight Group. • Scheduled Care Board.	31/03/2025	• Elective Recovery Funding stopping. • Patients being too complex safely to Independent Sector Providers • Not being unable to recruit for the Surgical Hubs and Community Diagnostic Centres.

PMO
Project Management across Norfolk and Waveney

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide

Proportion of all outpatient attendances that are for first appointments or for follow-u…

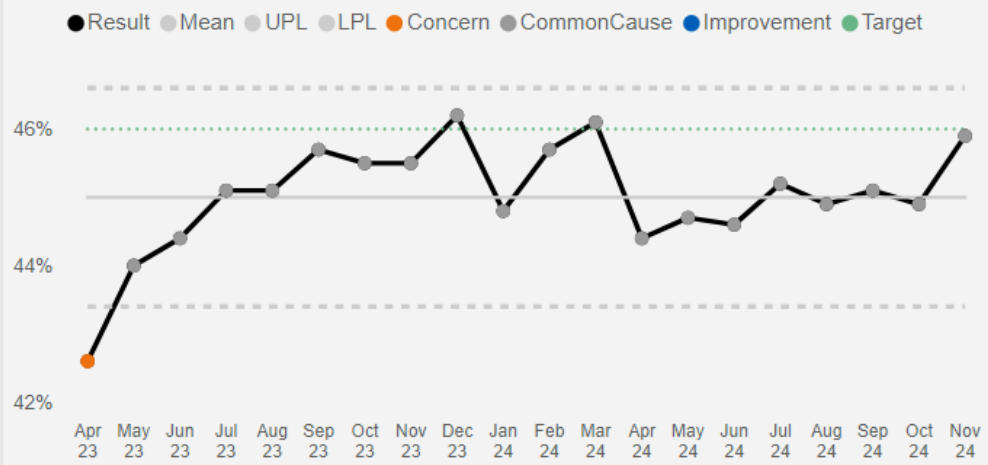
Nov 24

45.9%

Variation	Assurance
	

45.0% Mean	43.4% Lower PL
46.0% Target	46.6% Upper PL

Proportion of all outpatient attendances that are for first appointments or for follow-up appointments attracting a procedure tariff - ICB - System View



Analytical Commentary

Variation is Common Cause

System position reflects all expected providers

Provider	Position	Latest Data
N&WICB	Provided, up to date	Nov 24

Description of the metric

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

Description of performance

A continued increase in the number of episodes on an active PIFU pathway, however a slight flattening-out of episodes discharged to PIFU.
0.1% below target.

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

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

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

PMO
Project Management across Norfolk and Waveney

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide

The Office for National Statistics (ONS) Health Insights Survey data is expected, from October 2024, to inform this metric. Reporting on the metric will follow with development of new reporting.

Description of the metric
To be defined nationally.

Description of performance
Not available.

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

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

PMO
Project Management across Norfolk and Waveney

Maternity, Neonatal and Women's Health – summary

Improving lives together
Norfolk and Waveney Integrated Care System

Metric Description	Target	Actual	Regularity of reporting	Reporting period	Date report updated	Board with assurance oversight	Risk to escalate to Commissioning and Performance Committee?	Is there a related Board Assurance Framework risk? (provide reference)
Continue to implement the Three-year delivery plan for maternity and neonatal services	25/26	On track	Bi-annual	Sep 24	13/01/25	LMNS	No	No
Progress towards the national safety ambition	-	-	Bi-annual	-	13/01/25	LMNS	No	No
Increasing fill rates against funded establishment (less than 9% vacancies)	<9%	0.5%	Quarterly	Nov 24	13/01/25	LMNS	No	No
Establish and develop at least one women's health hub in every ICB by December 2024, working in partnership with local authorities	Dec '24	100%	Monthly	December 2024	10/01/25	Planned Care and Long-Term Conditions Clinical Transformation Oversight Group	No	No
Local Metrics as indicated by exception								

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

PMO
Project Management across Norfolk and Waveney

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

Improving lives together
Norfolk and Waveney Integrated Care System

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

Link back to overview of underachieving metrics slide

Description of the metric

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

Description of performance

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

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

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

PMO
Project Management across Norfolk and Waveney

National KPI: Progress towards the national safety ambition

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide

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

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

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

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

Description of performance

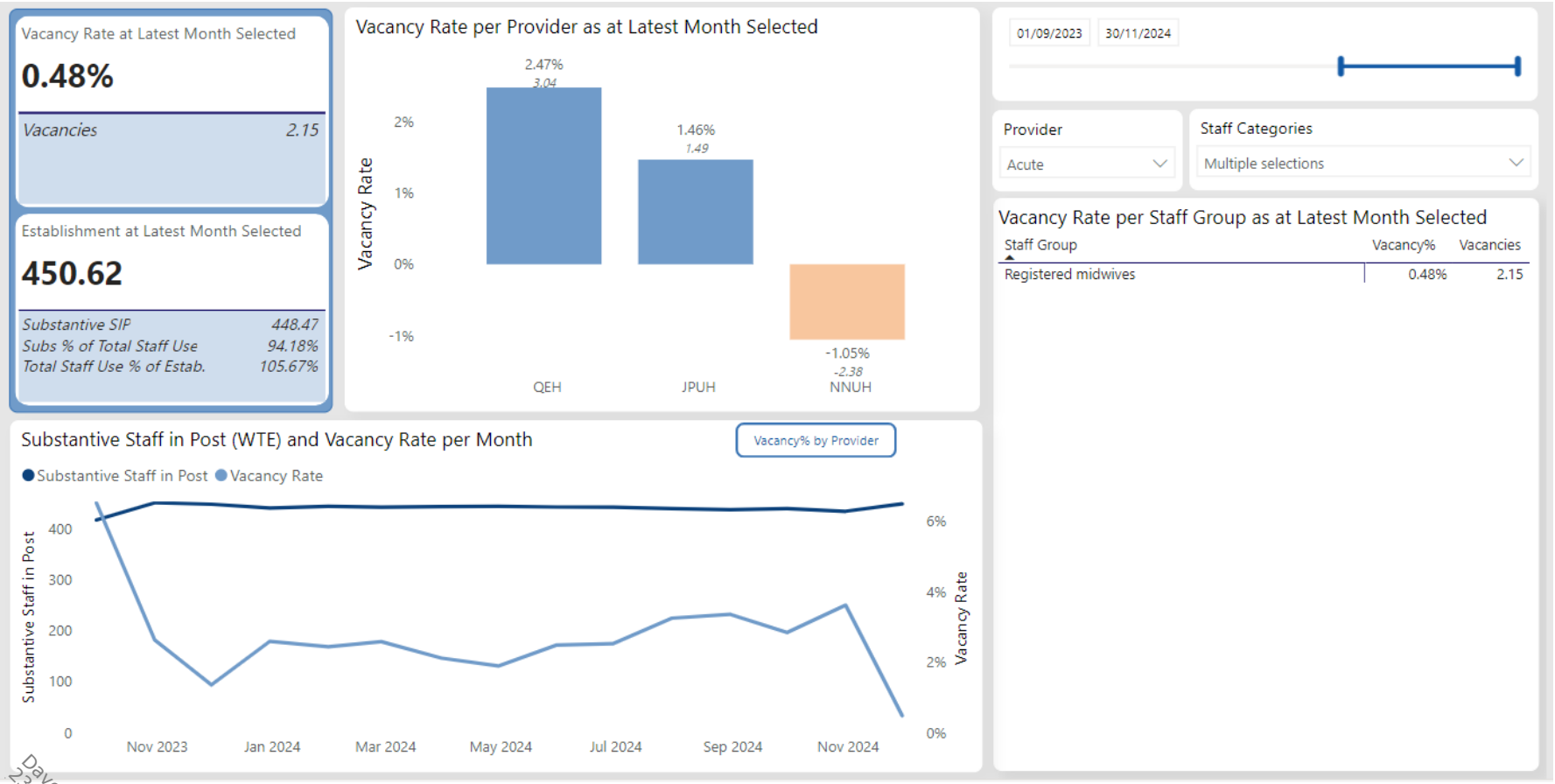
Is performance meeting national KPI?		N/A	If no above, is performance meeting recovery trajectory?	N/A	(if no to either/both, complete below)

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

PMO
Project Management across Norfolk and Waveney

National KPI: Increasing fill rates against funded establishment

Improving lives together
Norfolk and Waveney Integrated Care System



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

Description of the metric

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

Description of performance

ICB workforce dashboard; Midwifery Vacancies, reported to LMNS Board 22 January 2025

Vacancy rate 0.48%

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

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

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

PMO
Project Management across Norfolk and Waveney

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide

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

The women's health hub is now established according to 2024/25 planning guidance. Therefore, the implementation team propose this is removed from the reporting moving forwards.

Description of the metric

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

Description of performance

Delivery is on track.

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

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

PMO
Project Management across Norfolk and Waveney

Mental Health – summary

Improving lives together
Norfolk and Waveney Integrated Care System

Metric Description	Target	Delivery	Regularity of reporting	Reporting period	Date report updated	Board with assurance oversight	Risk to escalate to Commissioning and Performance Committee?	Is there a related Board Assurance Framework risk? (provide reference)
Improve patient flow and work towards eliminating inappropriate out of area placements	5	10	Monthly	Sept '24	14/01/24	Mental Health Integrated Delivery Group (Governance under review)	no	BAF04
Increase the number of people accessing perinatal mental health (to 66,000)	1,015	1,065	Monthly	Oct '24	14/01/24		no	BAF04
Work towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025	60%	63.8%	Quarterly	Q2 24/25	14/01/24		no	BAF04
Increase the dementia diagnosis rate to 66.7% by March 2025	63.4%	62.6%	Monthly	Nov '24	14/01/24		no	BAF04
Increase the number of people accessing transformed models of adult community mental health (to 400,000)	9,735	10,900	Monthly	Sept '24	14/01/24		no	BAF04
Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with • At least 48% of those achieving reliable recovery • At least 67% of those achieving reliable improvement	(14,000 annual) 1,259 48% 67%	1,485 50.2% 67.3%	Monthly	Oct '24 Oct '24 Oct '24	14/01/24		no	BAF04
Increase the number of people accessing children and young people services (345,000 additional CYP aged 0-25 compared to 2019)	13,127	14,690	Monthly	Oct '24	14/01/24		no	BAF03

Local Metrics as indicated by exception

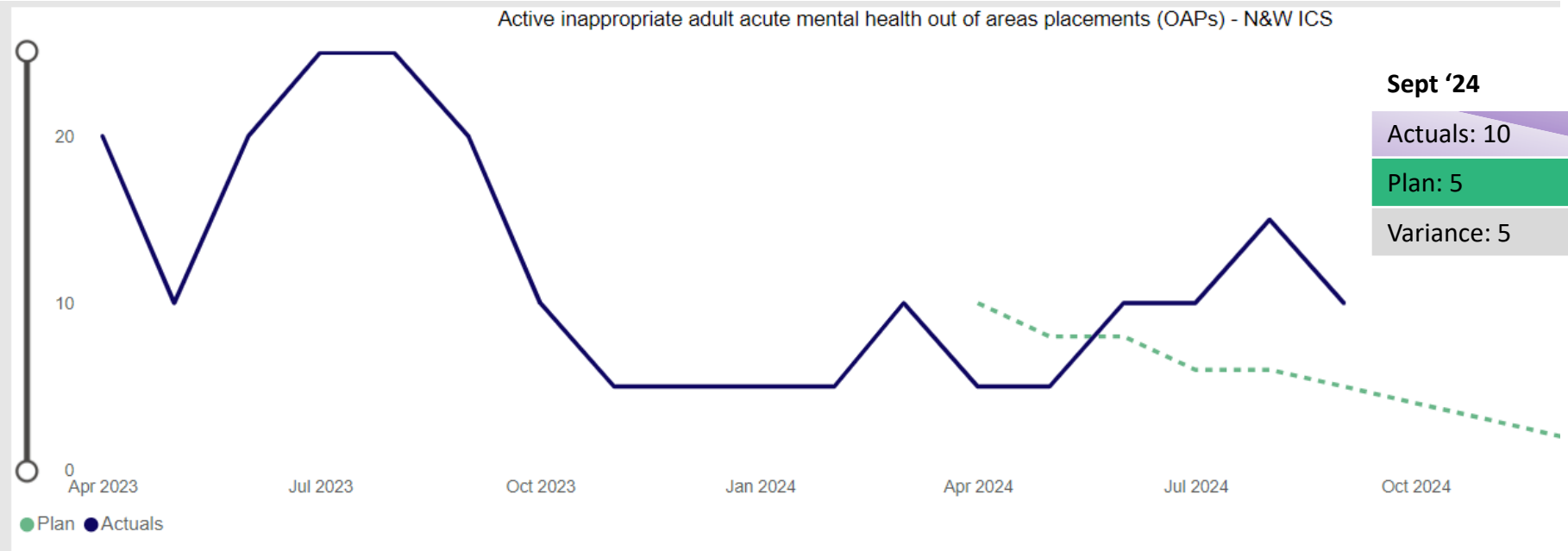
Green or red shading is used to identify where current delivery is on (green) or off (red) the plan or trajectory.

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

Improving lives together
Norfolk and Waveney Integrated Care System

PMO
Project Management across Norfolk and Waveney

Link back to overview of underachieving metrics slide



Trust	Actuals Trend	Latest Month	Actuals	Plan	Latest Gap To Plan	YTD Value	YTD Plan	YTD Gap To Plan	End FY Plan	Variance Trend
NSFT		Oct 24		4		55	47	8	0	

Description of the metric

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

Description of performance

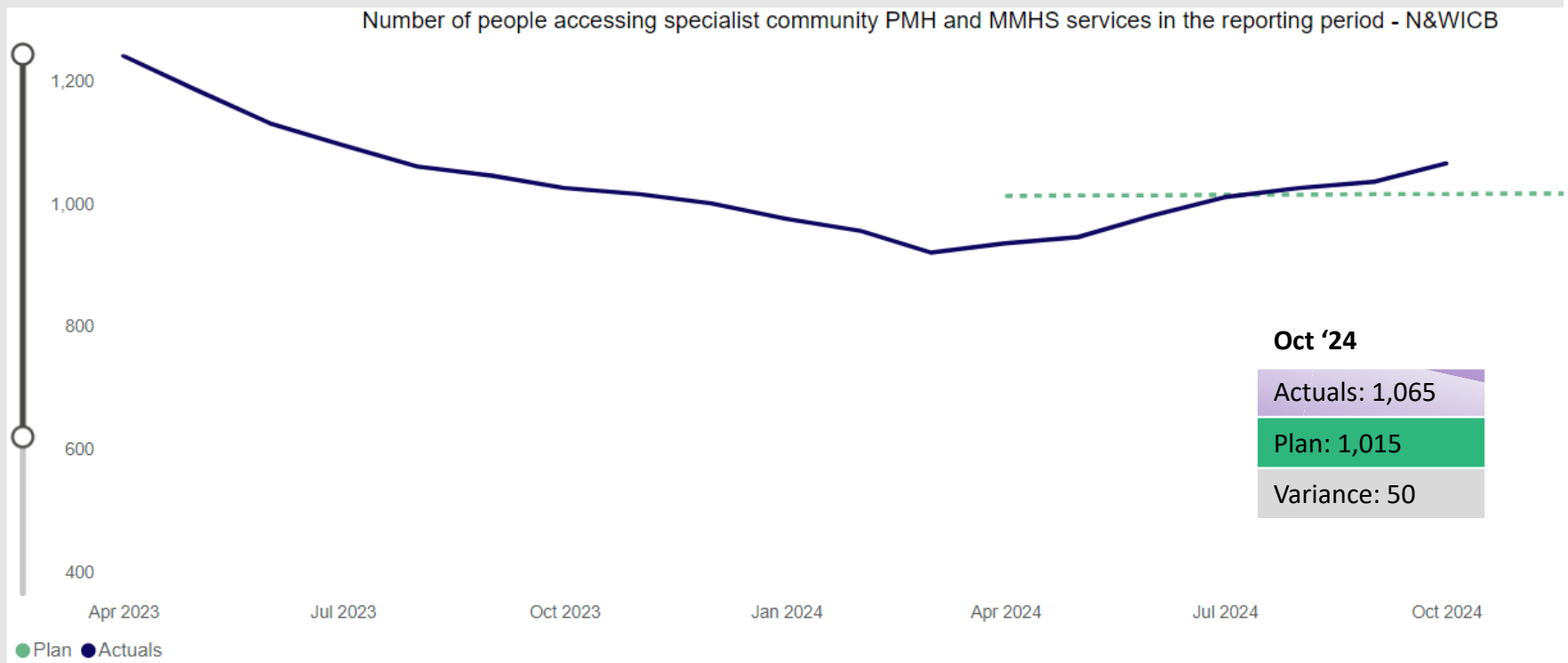
Target of 5 was exceeded but the trajectory is going in the right direction. Actual numbers of people in out of area placement: 10

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

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

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

Improving lives together
Norfolk and Waveney Integrated Care System



Trust	Actuals Trend	Latest Month	Actuals	Plan	Latest Gap To Plan	YTD Value	YTD Plan	YTD Gap To Plan	End FY Plan	Variance Trend
N&WICB		Oct 24	1,065	1,015	-	-	-	-	1,018	

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

Description of the metric

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

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

Description of performance

The service is currently meeting target.

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

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

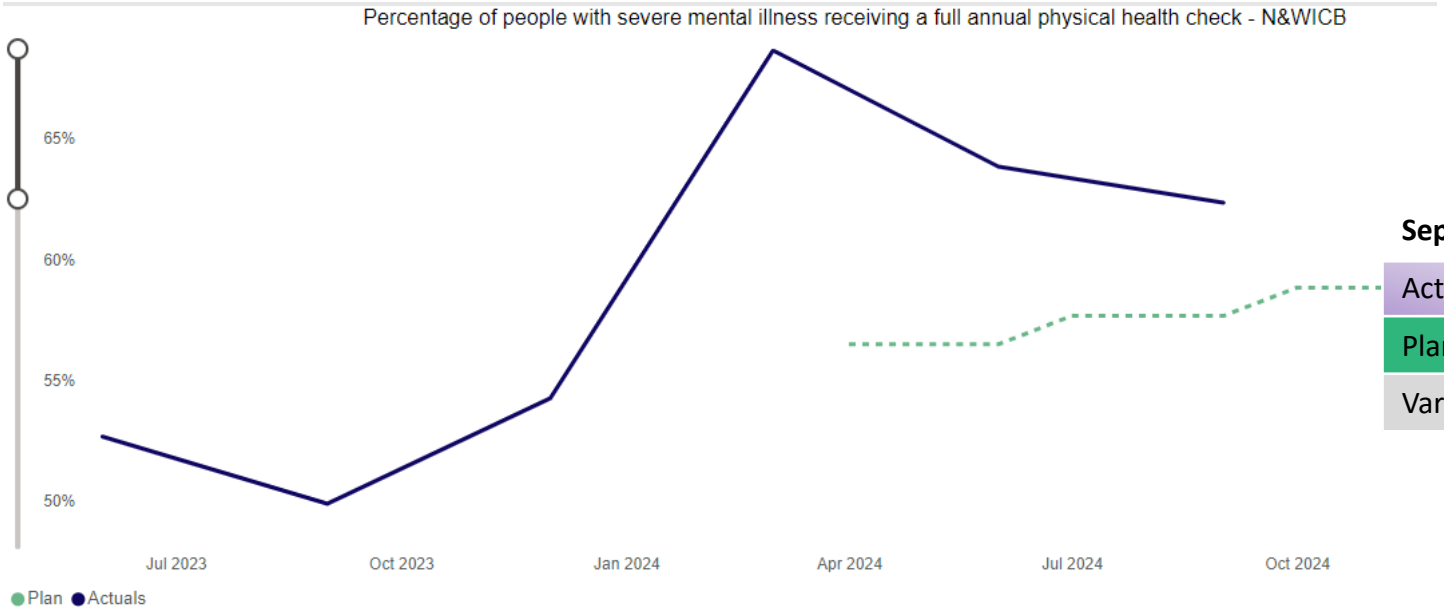
PMO
Project Management across Norfolk and Waveney

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

Improving lives together
Norfolk and Waveney Integrated Care System

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

Link back to overview of underachieving metrics slide



Sept '24

Actuals: 62.3%

Plan: 57.7%

Variance: 4.6%

Trust	Actuals Trend	Latest Month	Actuals	Plan	Latest Gap To Plan	YTD Value	YTD Plan	YTD Gap To Plan	End FY Plan	Variance Trend
N&WICB		Sep 24	62.3%	57.7%	-	-	-	-	60.0%	

Davey, Heidi 23/01/2025 09:13:21

Description of the metric

All GP Practices retain a register for their patients living with a severe mental illness. People on this register should have a full physical health check every year.

The ambition is that by March 2025 75% of eligible people have this check, with a national target of at least 60%.

Description of performance

The service is currently meeting target.

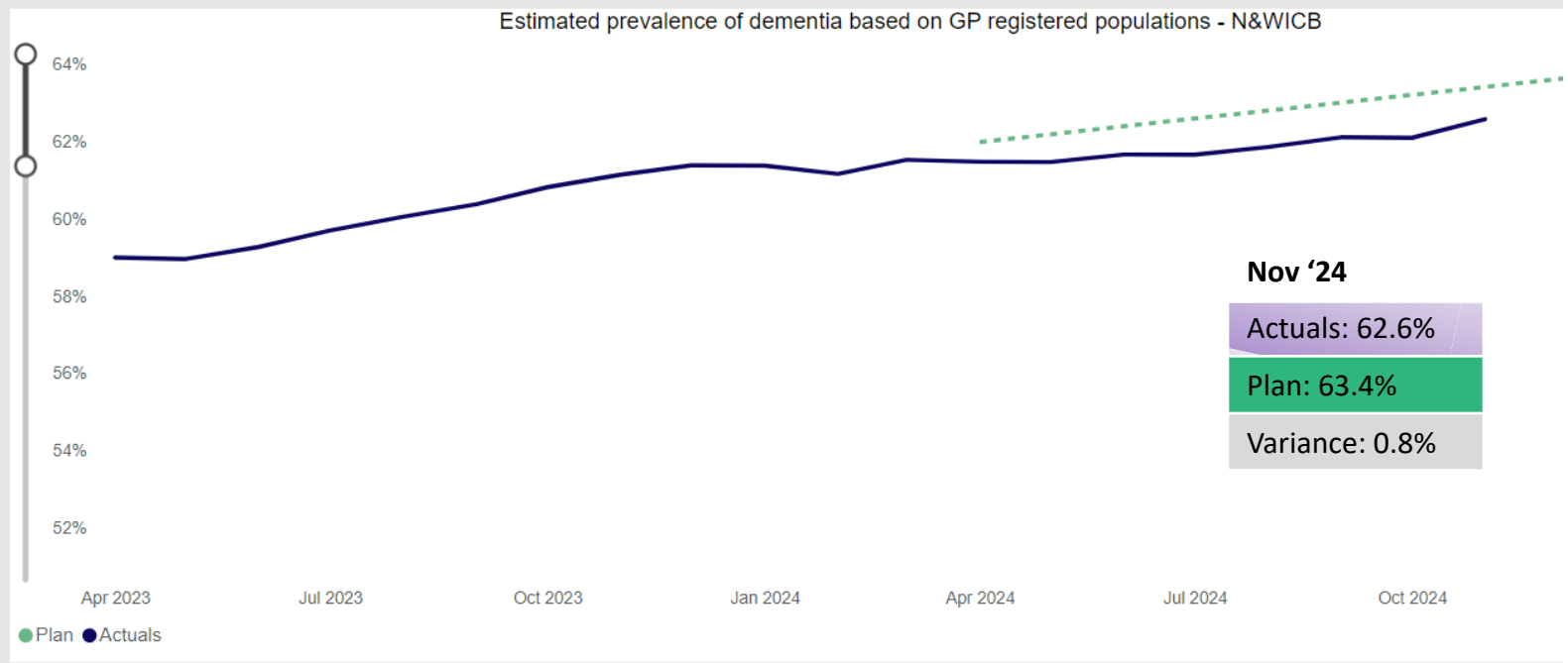
Is performance meeting national KPI?	Yes	If no above, is performance meeting recovery trajectory?	NA	(if no to either/both, complete below)

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

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide



Trust	Actuals Trend	Latest Month	Actuals	Plan	Latest Gap To Plan	YTD Value	YTD Plan	YTD Gap To Plan	End FY Plan	Variance Trend
N&WICB		Nov 24	62.6%	63.4%	151	-	-	-	64.2%	

Description of the metric

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

Description of performance

N&W ICS committed to achieving 64.2% by the end of the financial year (24/25) and 66.7% by end of 25/26. November plan to deliver 63.4% with 62.6% achieved and an upward trajectory continues to be achieved.

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

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
Significant Place variation, which is also replicated across Dementia Assessment Treatment Services (DATS).	Assessment session optimization to remove diagnosis inefficiencies and improve assessment-driven diagnosis; addressing demand and capacity issues, and Mild Cognitive Impairment (MCI) Workstream improvements	Mental Health Integrated Delivery Group		Delays to demand and capacity work and programme to address diagnosis inefficiencies impacts on delivery of plan to boost performance in line with agreed trajectory, in year.

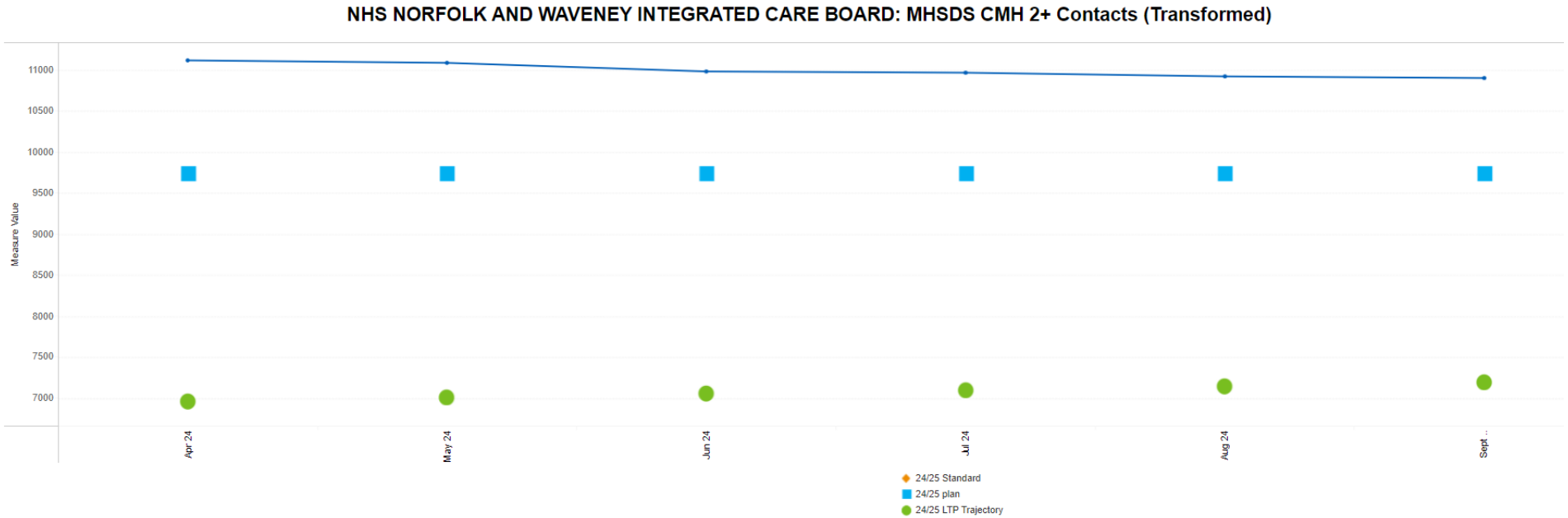
National KPI: Increase the number of people accessing transformed models of adult community mental health to 400,000

PMO
Project Management across Norfolk and Waveney

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide

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



Description of the metric

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

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

Description of performance

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

During Q1 performance is above national KPI.

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

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

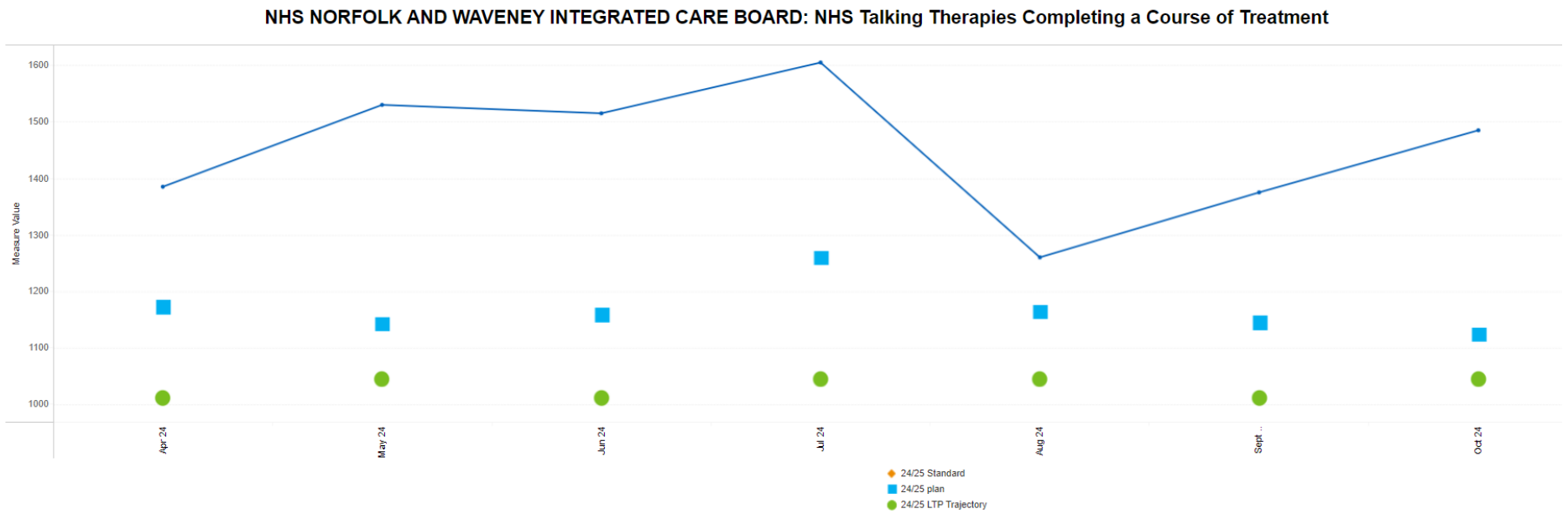
PMO
Project Management across Norfolk and Waveney

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

Improving lives **together**
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide

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



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

Description of performance
The service is currently meeting target

Davey, Heidi 23/01/2025 09:13:21

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

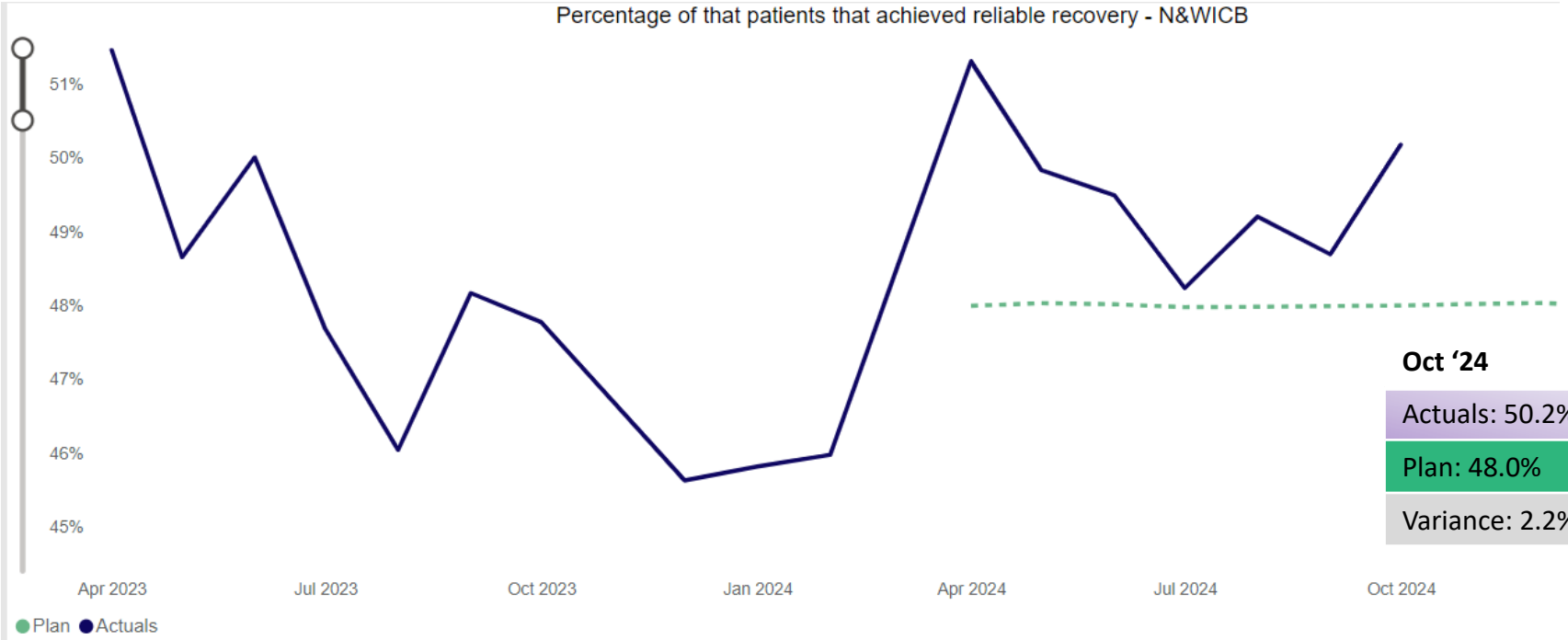
Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
NA	NA	NA	NA	NA

PMO
Project Management across Norfolk and Waveney

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide



Trust	Actuals Trend	Latest Month	Actuals	Plan	Latest Gap To Plan	YTD Value	YTD Plan	YTD Gap To Plan	End FY Plan	Variance Trend
N&WICB		Oct 24	50.2%	48.0%	-	49.5%	48.0%	-	48.0%	

Description of the metric

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

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

Description of performance

The service is currently meeting target

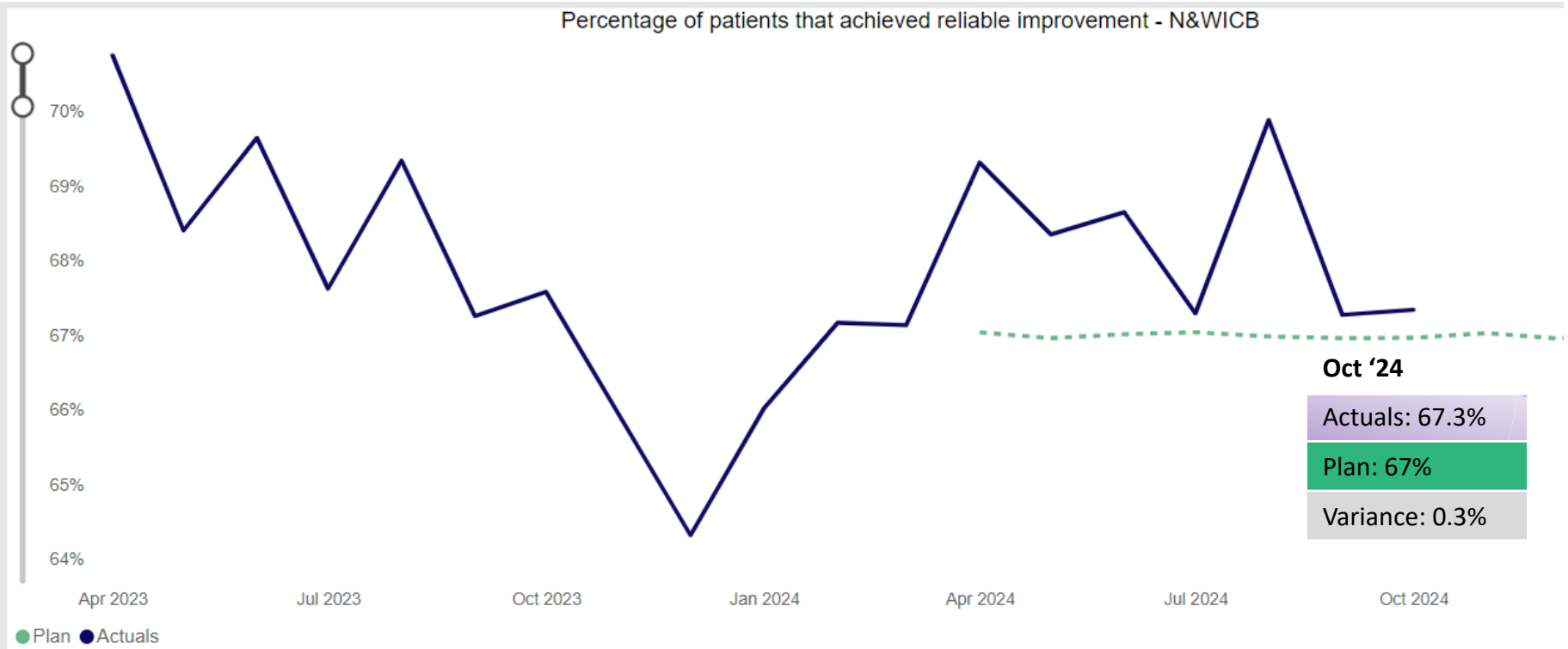
Is performance meeting national KPI?	Yes	If no above, is performance meeting recovery trajectory?	N/A	(if no to either/both, complete below)

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

PMO
Project Management across Norfolk and Waveney

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

Improving lives together
Norfolk and Waveney Integrated Care System



Trust	Actuals Trend	Latest Month	Actuals	Plan	Latest Gap To Plan	YTD Value	YTD Plan	YTD Gap To Plan	End FY Plan	Variance Trend
N&WICB		Oct 24	67.3%	67.0%	-	68.3%	67.0%	-	67.0%	

Davey Haidi 23/01/2025 09:13:21

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

Description of the metric

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

Description of performance

The service is currently meeting target

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

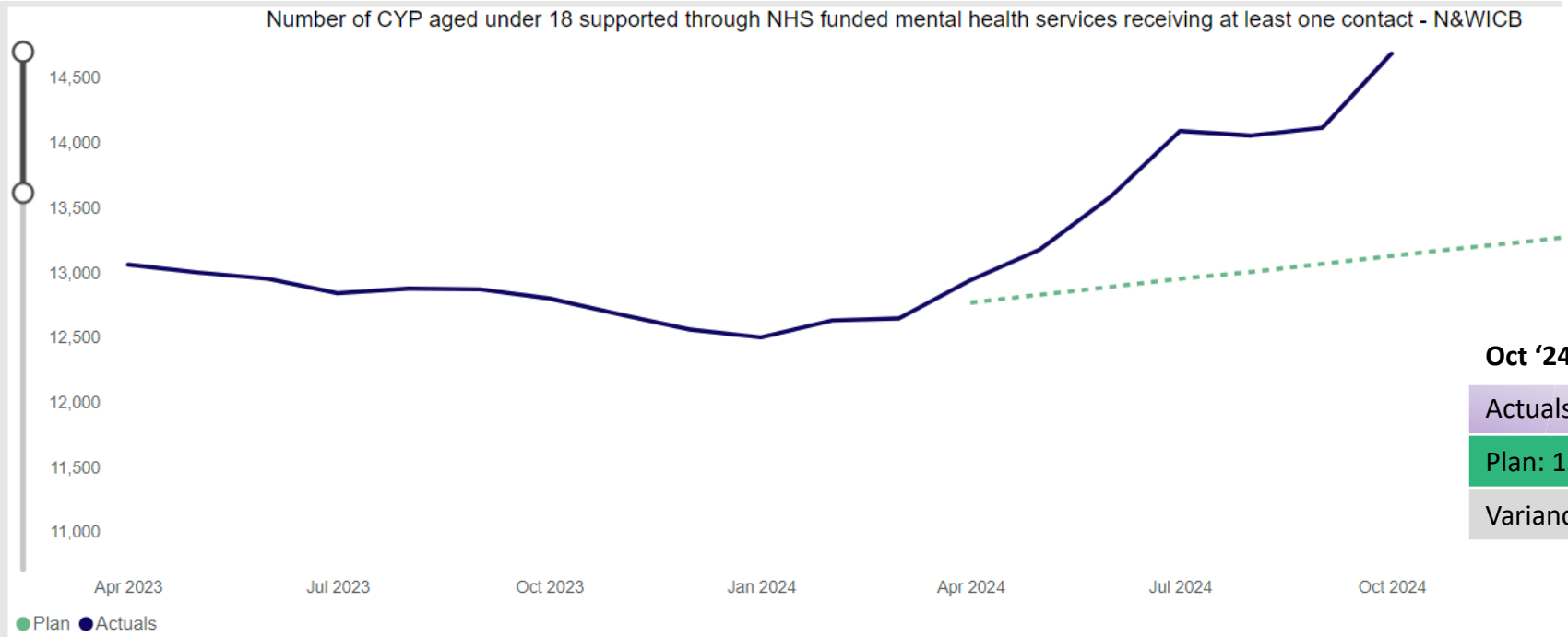
Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
N/A	N/A	N/A	N/A	N/A

PMO
Project Management across Norfolk and Waveney

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide



Oct '24

Actuals: 14,690
Plan: 13,127
Variance: 1,563

Trust	Actuals Trend	Latest Month	Actuals	Plan	Latest Gap To Plan	YTD Value	YTD Plan	YTD Gap To Plan	End FY Plan	Variance Trend
N&WICB		Oct 24	14,690	13,127	-	-	-	-	13,426	

Description of the metric

(345,000 is a national ambition)

In Norfolk and Waveney, the annual target for mental health access currently sits at 13,127 (see green dotted line to left)

Description of performance

October 2024 data shows continual over achievement of target with 14,690 CYP accessing mental health support, above a target of 13,127, during the rolling year.

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

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

People with a Learning Disability and Autistic people – summary

Metric Description	Target	Actual	Regularity of reporting	Reporting period	Date report updated	Board with assurance oversight	Risk to escalate to Commissioning and Performance Committee?	Is there a related Board Assurance Framework risk? (provide reference)
Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025	75%	42%	Monthly	Nov '24	14/01/25	Learning Disabilities and Autism Programme Board	no	
Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12-15 under 18s for every 1 million population	23	30	Monthly	December '24	14/01/25		no	

Local Metrics as indicated by exception

Davey Heidi 23/01/2025 07:13:21

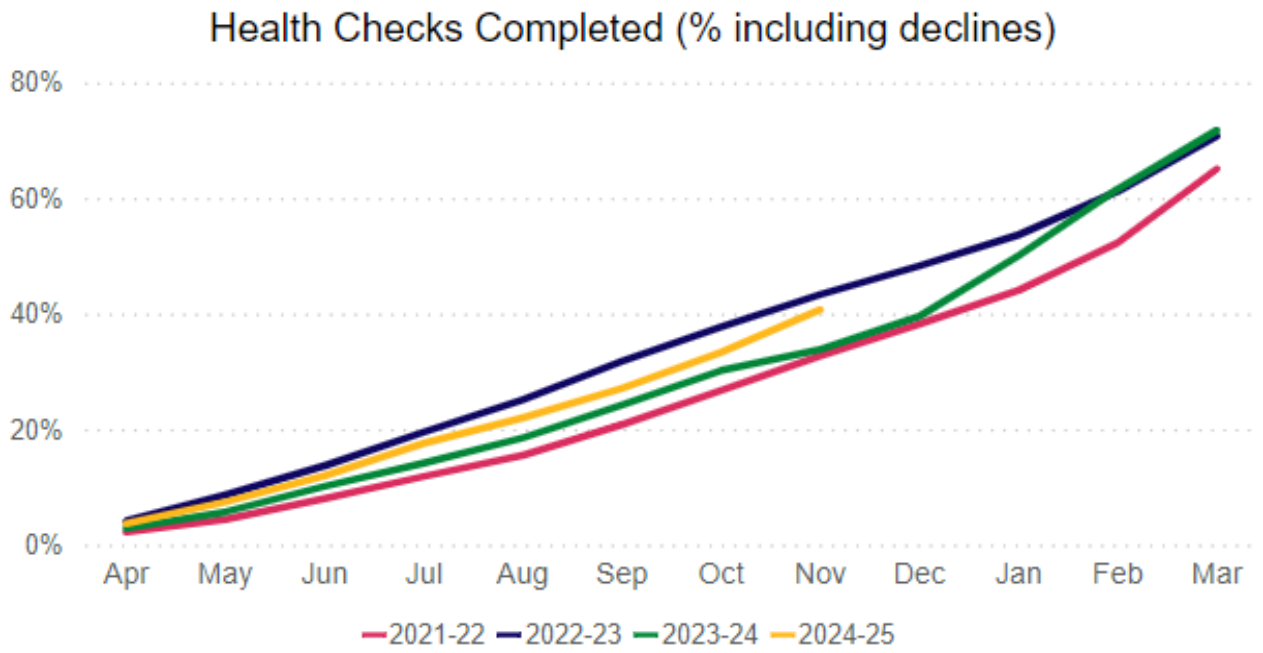
Green or red shading is used to identify where current delivery is on (green) or off (red) the plan or trajectory.

PMO
Project Management across Norfolk and Waveney

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide



As of the end of November 2024, 2,959 Learning Disabilities Health Checks have been delivered.

Description of the metric

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

Description of performance

This is year to date reporting, so delivery towards the full year ambition must be viewed. At November, delivery was 42% with indications that the full-year objective is on plan.

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

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

PMO
Project Management across Norfolk and Waveney

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

Improving lives together
Norfolk and Waveney Integrated Care System

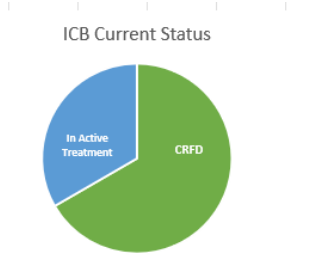
Link back to overview of underachieving metrics slide

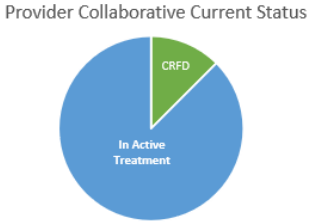
NWICB Adult Inpatients	2024								
	Q1			Q2			Q3		
Source Data	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Plan	12	12	12	12	12	12	12	12	12
Actual	12	13	14	14	14	14	20	17	15
Performance	0	1	2	2	2	2	8	5	3
Admissions	1	2	1	1	1	0	6	0	2
Discharges	4	1	0	1	1	0	0	3	4
Cumulative Admissions	1	3	4	5	6	6	12	12	14
Cumulative Discharges	4	5	5	6	7	7	7	10	14

NWICB Adult Inpatients	2024								
	Q1			Q2			Q3		
Source Data	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Plan	12	12	12	12	12	12	12	12	12
Actual	12	13	14	14	14	14	20	17	15
Performance	0	1	2	2	2	2	8	5	3
Admissions	1	2	1	1	1	0	6	0	2
Discharges	4	1	0	1	1	0	0	3	4
Cumulative Admissions	1	3	4	5	6	6	12	12	14
Cumulative Discharges	4	5	5	6	7	7	7	10	14

Tom Cahill, National Director of Learning Disability and Autism for NHS England has asked all regions for a push to ensure inpatient numbers are 10% less at end of year to 2023-24 totals.

This maximum figure is 29 for our ICB.





Description of the metric

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

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

Description of performance

Current position is 30, split to:

- ICB inpatient total: 15.
- Provider Collaborative inpatient total: 15

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

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

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

Prevention and Health Inequalities – summary

Metric Description	Target	Actual	Regularity of reporting	Reporting period	Date report updated	Board with assurance oversight	Risk to escalate to Commissioning and Performance Committee?	Is there a related Board Assurance Framework risk? (provide reference)
Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people	Maturity index	Foundation	TBC	Nov 2024	15/01/25	Health Inequalities Steering Group	no	BAF01
Increase the % of patients with hypertension treated according to NICE guidance to 80% by March 2025	80% by 31.3.25	69%	Quarterly	June 24	15/01/25	Cardio-Vascular Disease and Respiratory Board	no	BAF01
Increase the percentage of patients aged 25-84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 2025	65% by 31.3.25	59%	Quarterly	June 24	15/01/25		no	BAF01
Increase vaccination uptake for children and young people year on year towards WHO recommended levels	95%	89% - 96%	Quarterly	Q2 25/26	15/01/25	Norfolk and Waveney Health Protection Assurance Board (Public Health)	no	
Local Metrics as indicated by exception								

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

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

PMO
Project Management across Norfolk and Waveney

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide

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

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

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

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

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

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

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

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

PMO Project Management across Norfolk and Waveney

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide

Data for period: 12 months to June 2024

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

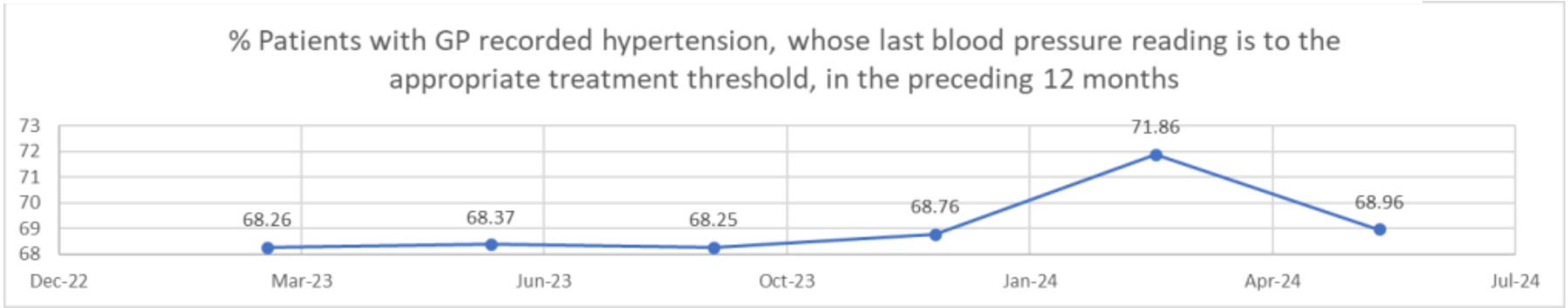
Explore Data | Data Extract | Metadata

Sex: Persons
Persons

68.96% ↓
Area value

67.17%
System median

Min: 58.79% Max: 73.73%



Description of the metric

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

Description of performance

For Hypertension Control N&W is ranked 2nd in East of England and 6th nationally.

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

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

PMO
Project Management across Norfolk and Waveney

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide

Data for period: 12 months to June 2024

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

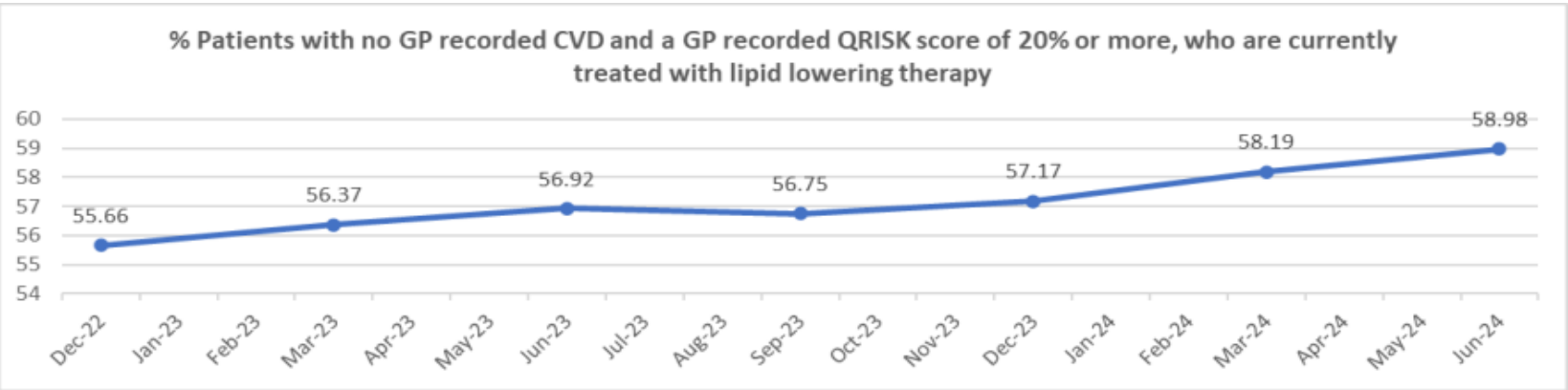
Explore Data | Data Extract | Metadata

Sex: Persons
Persons

58.98% ↑
Area value

62.14%
System median

Min: 53.85%
Max: 71.17%



Description of the metric

Proactively identifying patients who are at risk of Cardiovascular Disease and optimising their treatment through appropriate use of lipid lowering therapy (e.g. Statins) contributes to improving health outcomes for patients.
By March 2025, 65% of patients with a coronary risk score over 20% should be on lipid lowering therapy

Description of performance

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

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

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

PMO
Project Management across Norfolk and Waveney

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

Improving lives together
Norfolk and Waveney Integrated Care System

		23/24 Q2	23/24 Q3	23/24 Q4	24/25 Q1	24/25 Q2	Difference
12 months	DTaP / IPV / Hib	95.2%	94.7%	93.4%	94.4%	92.7%	↓
	Meningitis B	95.2%	94.5%	93.2%	94.1%	92.9%	↓
	Rotavirus	93.3%	91.4%	91.7%	91.2%	90.3%	↓
	Pneumococcal	96.9%	95.8%	95.3%	96.1%	94.2%	↓
24 months	DTaP / IPV / Hib	95.2%	95.6%	96.0%	95.3%	96.0%	↑
	Hib / Men C booster	93.6%	93.4%	94.4%	93.4%	93.7%	↓
	Men B booster	92.8%	91.6%	92.0%	90.8%	92.2%	↑
	MMR dose 1	93.8%	93.1%	94.1%	93.0%	93.5%	↑
	Pneumococcal booster	93.2%	92.5%	93.3%	92.1%	90.3%	↓
5 years	DTaP/IPV/Hib	96.2%	96.2%	95.8%	96.2%	95.8%	↓
	MMR dose 1	95.3%	95.8%	95.6%	96.0%	94.3%	↓
	MMR dose 2	89.7%	91.2%	90.4%	90.2%	88.8%	↓
	DTaP/IPV booster	88.1%	89.8%	89.1%	88.6%	87.3%	↓
	Hib / Men C booster	92.3%	93.6%	92.3%	92.9%	91.6%	↓

Link back to overview of underachieving metrics slide

Description of the metric

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

Delivery of these are with NHSE Regional team.

Q1 24/25 data is not yet available.

Description of performance

Performance varies between vaccination.
For all immunisations Norfolk and Waveney performance is higher than England performance and is higher than regional performance for all except 12m Rotavirus.

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

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
Practice level variation	Child Health Information Centre sending practice level dashboards with league tables. Regional team contact practices to offer support. Regional call-recall pilot evaluation to be reported on in Jan '25. Regional team mapping impact of local and national campaigns. Focus on Did Not Attend and time between immunisations.	Child Health Information Centre / NHSE Norfolk and Waveney Health Protection Assurance Board	March 2025	Primary Care capacity

Primary and Community Services – summary

Metric Description	Target	Actual	Regularity of reporting	Reporting period	Date report updated	Board with assurance oversight	Risk to escalate to Commissioning and Performance Committee?	Is there a related Board Assurance Framework risk? (provide reference)
Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are accessed the same or next day according to clinical need	Improve	81.4%	Monthly	Nov '24	15/01/25	Primary Care Commissioning Committee	No	
Improve community services waiting times, with a focus on reducing long waits	Improve	479	Monthly	Nov '24	15/01/25	Various dependent on service	No	
Increase dental activity by implementing the plan to recover and reform NHS dentistry, improving units of dental activity (UDAs) towards pre-pandemic levels*	Increase	Decrease	Quarterly	Dec '24	16/01/25	Primary Care Commissioning Committee		
Local Metrics as indicated by exception								

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

* Data to follow in future reporting.

PMO
Project Management across Norfolk and Waveney

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

Improving lives **together**
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide

Nov-24

81.4%

Variance

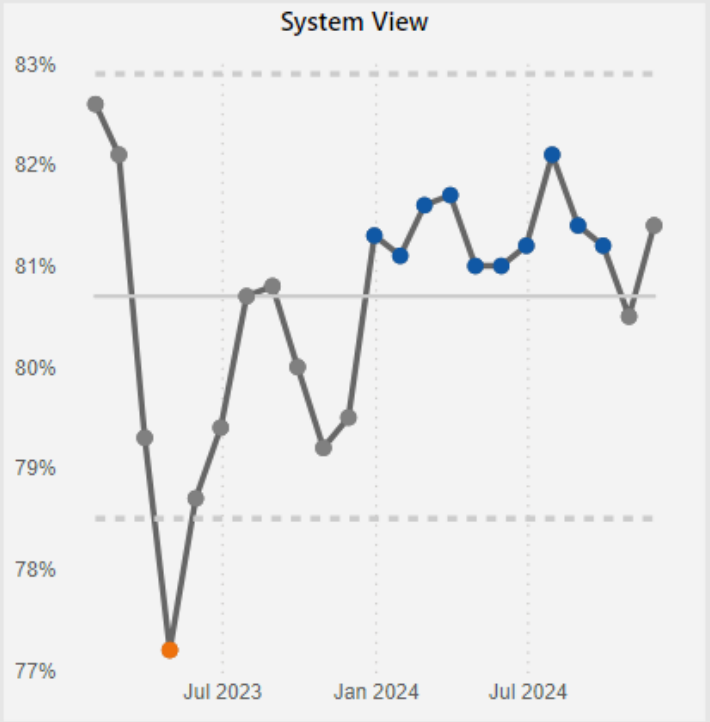
Common cause variation, NO SIGNIFICANT CHANGE.

Target

N/A

Assurance

Assurance cannot be given as there is no target.



Description of the metric

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

Description of performance

In November 2024, Norfolk and Waveney reported 81.4% of appointments within 2 weeks.

Note: Due to a delay in national reporting it is only possible to see the average % for East of England as of Sept'24.

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

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

PMO
Project Management across Norfolk and Waveney

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide

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

The two organisations provide data to the ICB in different formats and a standard community waiting time dashboard is in development by Norfolk & Waveney ICB Business Intelligence (BI) team. In the interim, performance is monitored through provider reports and ad-hoc reporting produced by the ICB BI team. There have been some data quality issues using this method, where commissioner and provider reports do not align, and this is being investigated by BI. Providers have also made us aware of some internal data quality issues they are investigating, for example on Musculoskeletal (MSK) waiting times. As part of the launch of the Getting It Right First Time MSK Community Delivery Programme, Norfolk & Waveney were identified as a recipient for funding. This will be used to reduce the waiting list for MSK services, through a combination of additional activity at clinical assessment days and data cleansing.

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

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

Description of performance
In November 2024 there were 479 patients waiting over 52 weeks, and we are working to reduce this.

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

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

PMO
Project Management across Norfolk and Waveney

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide

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

- Overall activity delivered as of 31 Dec 2024 is 52.6%. Forecast is that the ambition to restore activity to 2019 activity levels will not be met by year end however the trend indicates an improvement in activity achieved at year end.
- Access Improvement scheme started November 2024 aimed at improving access in areas of geographical need (South Norfolk and Norwich) and to reduce health inequalities. 11 Providers across ICB area with a recurrent investment of £1.5m
- Action plans for providers forecast to underachieve this year have been released to the ICB to assess and to agree contract renegotiations releasing funds for reinvestment in 2025/2026. Principles for renegotiation agreed by Dental Services Delivery Group (14 January 2025).

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

Description of performance
New patient data is unavailable pending validation of data with NHSBSA

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

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

PMO
Project Management across Norfolk and Waveney

Urgent and Emergency Care – summary

Improving lives together
Norfolk and Waveney Integrated Care System

Metric Description	Target	Actual	Regularity of reporting	Reporting period	Date report updated	Board with assurance oversight	Risk to escalate to Commissioning and Performance Committee?	Is there a related Board Assurance Framework risk? (provide reference)
Improve A&E Waiting Times, compared to 2023/24, with a minimum of 78% of Patients seen within 4 hours in March 2025	80%	72.8%	Monthly	Nov 2024	8/11/24	UEC Board	No	BAF06
Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25	30min	47.2min	Monthly	Nov 2024	8/11/24	UEC Board	No	BAF06
Local Metrics as indicated by exception								

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

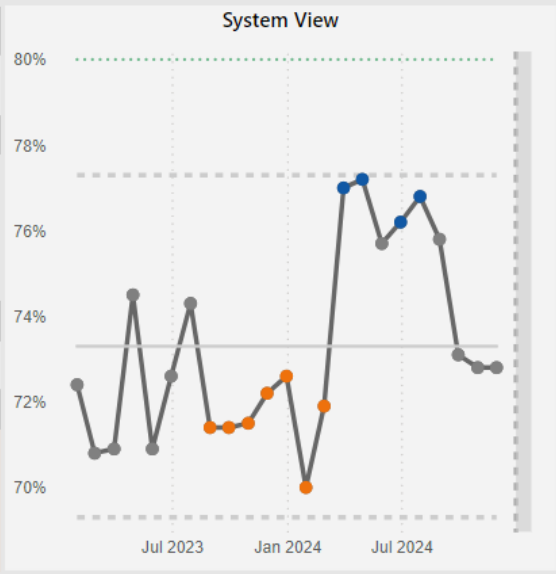
PMO
Project Management across Norfolk and Waveney

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

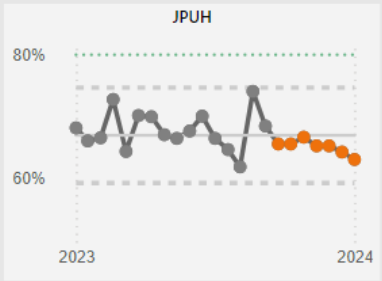
Improving lives together
Norfolk and Waveney Integrated Care System

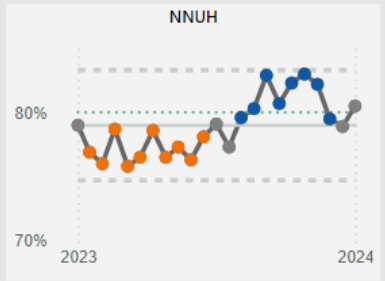
Link back to overview of underachieving metrics slide

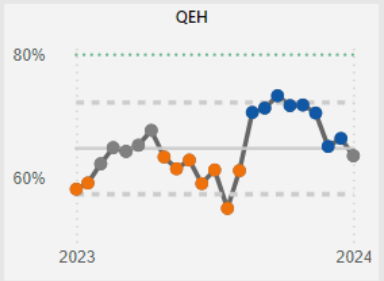
Nov-24
72.8%
Variance
Common cause variation, NO SIGNIFICANT CHANGE.
Target
80.0%
Assurance
This process is not capable and will FAIL the target without process redesign.



MetricName	View By Level	Latest Date	Result	Variance	Assurance	Target	Mean	LCL	UCL
Total A&E 4hr Performance	System View	Nov-24	72.8%			80.0%	73.3%	69.3%	77.3%
Total A&E 4hr Performance	JPUH	Nov-24	63.1%			80.0%	67.0%	59.3%	74.7%
Total A&E 4hr Performance	NNUH	Nov-24	80.5%			80.0%	79.0%	74.7%	83.3%
Total A&E 4hr Performance	QEH	Nov-24	63.7%			80.0%	64.9%	57.5%	72.3%







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

Description of the metric

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

Description of performance

System performance: 72.8%

JPUH performance: 63.1%
NNUH performance: 80.5%
QEH performance: 63.7%

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

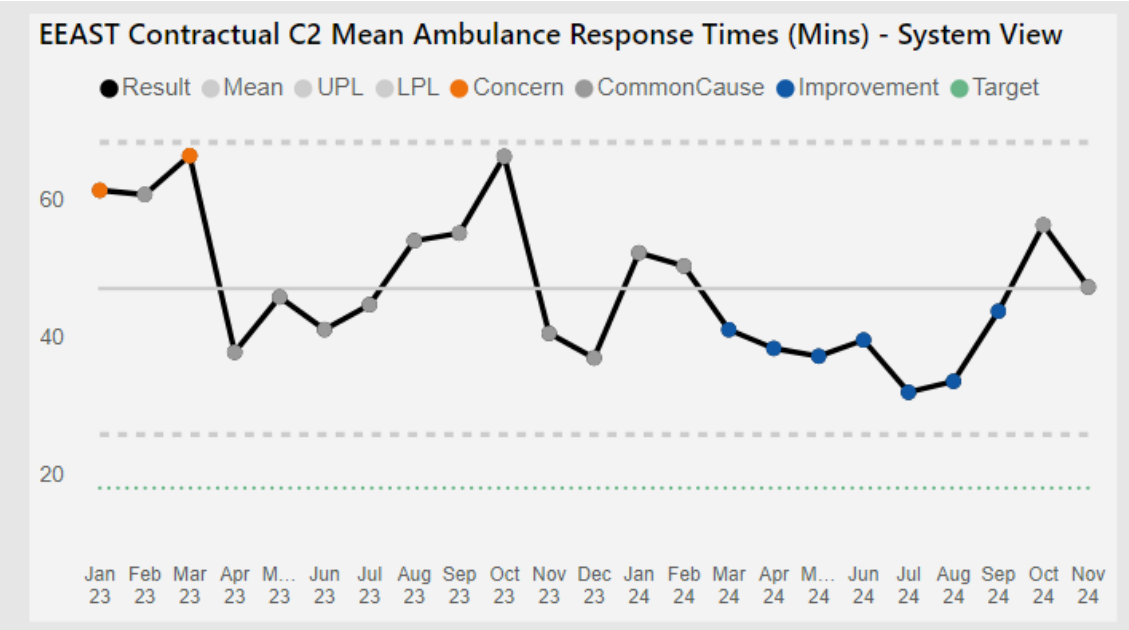
Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
Front Door model is sub-optimal as Norfolk & Waveney has no Urgent Treatment Centre provision. Exit block from A&E impedes flow and is due to high bed occupancy and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

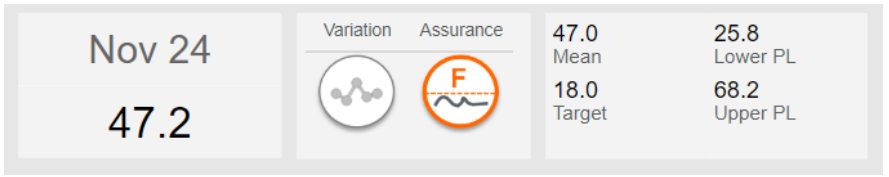
PMO
Project Management across Norfolk and Waveney

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide





Description of the metric

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

Description of performance

Ambulance C2 response times for N&W system 47.2 minutes.

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

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

PMO
Project Management across Norfolk and Waveney

Workforce, Use of Resources and Quality & Safety – summary

Improving lives together
Norfolk and Waveney Integrated Care System

Metric Description	Target	Actual	Regularity of reporting	Reporting period	Date report updated	Board with assurance oversight	Risk to escalate to Commissioning and Performance Committee?	Is there a related Board Assurance Framework risk? (provide reference)
Improve the working lives of all staff and increase staff retention and attendance through systematic implementation of all elements of People Promise retention interventions	<0	Stable	TBC	Oct '24	15/01/25	People Board	no	
Improve the working lives of doctors in training by increasing choice and flexibility in rotas, and reducing duplicative inductions and payroll errors	TBC	-	TBC	N/A	15/01/25	People Board	no	
Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the NHS Long Term Workforce Plan	TBC	-	TBC	N/A	7/1/25	People Board	no	
Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25	£44.1m	£48.4m (forecast FY)	Monthly	M (Nov 24)	15/01/25	People Board	no	
Deliver a balanced net system financial position for 2024/25	£0	+£37.6m	Monthly	M8 (Nov 24)	15/01/25	Finance Committee	no	
Implement the Patient Safety Incident Response Framework (PSIRF)	Implement	In place	Bi-annual	Nov '24	15/01/25	Quality and Safety Committee	no	
Local Metrics as indicated by exception								

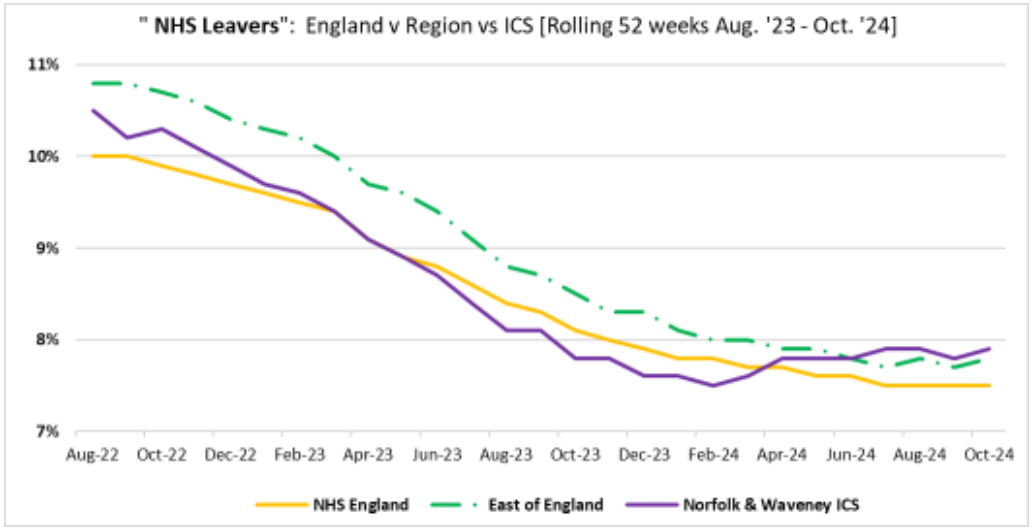
Green or red shading is used to identify where current delivery is on (green) or off (red) the plan or trajectory.

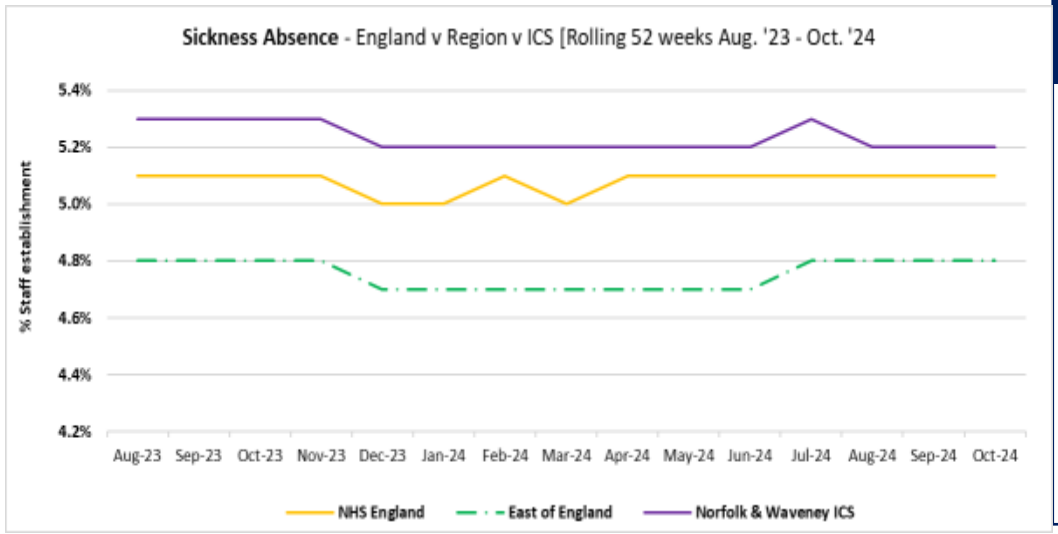
PMO
Project Management across Norfolk and Waveney

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide





Description of the metric

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

Attendance refers to employees showing up for work.

NHS leaver rates have been flat across the last quarter, nationally, regionally and across the ICS. At a trust level, leavers have reduced 0.5% at JPUH in the last quarter but have yet to show any improvement at the 3 trusts (ECCH, NCHC & NWICB) that drove the ICS increase in the first half of '24/'25 following restructures early in the year. HCSW leavers have continued to decline modestly, while AnC leavers continue to increase.

Across the ICS annual sickness rates have been consistent at 5.2% over the last 12 months, reflecting the national trend. Sickness absence for October was generally 0.5% above the ICS annual average, reflecting winter seasonality. The main exceptions were ECCH (+3%) and NCHC (+1%) but in both cases October sickness levels were in line with October last year.

Description of performance

Leavers rates have been flat for the last quarter. Sickness rates are above NHS averages by 0.1%.

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

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

PMO
Project Management across Norfolk and Waveney

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide

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

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

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

Description of performance
Nil available at this time.

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

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

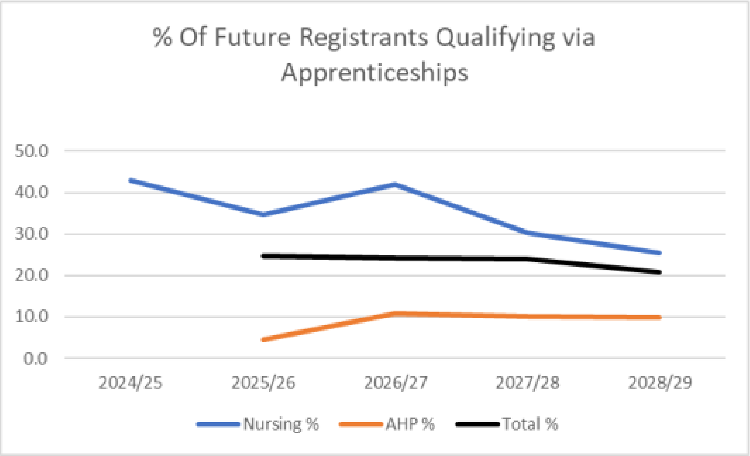
National KPI: Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the NHS Long Term Workforce Plan

Link back to overview of underachieving metrics slide

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

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

The graph to the right shows the planned trajectory for the next 5 years.



January 2025:
A digital placement system is in development which will allow baselining and tracking, alongside scoping with Trusts to establish current position. New approaches to learning opportunities for students is concurrently being explored.

Description of the metric

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

Description of performance

There is currently no route for measurement.

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

Root cause(s) identified:	**Corrective Action(s):**	**Action owner(s):**	**Delivery date for action(s):**	**Risk to delivery of corrective action(s):**
To have clear oversight of all clinical placement areas a digital placement system is required.	Scoping exercise for placement capacity modelling continues Digital placement system to identify all areas is under development. Increased supervisors and models to support learners and supervisors. Roll out of the Collaborative Learning in Practice model. Work with Apollo and Centre of Excellence, Academy to increase apprenticeship pipeline. Increase opportunities in new areas - Social Care and Voluntary, Community, Faith and Social Enterprise.	People Board	Q1 25/26	Expense of training route., financial pressures and current workforce pressures

PMO
Project Management across Norfolk and Waveney

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide

£m		Agency 2024/25					
		M8 YTD			Forecast Outturn		
Organisation		Plan	Actual	Variance	Plan	Actual	Variance
JPUH		3.9	6.4	(2.4)	5.7	8.7	(2.9)
NNUH		9.8	8.4	1.4	14.1	14.2	(0.1)
QEH		8.4	7.3	1.1	11.3	15.1	(3.8)
NSFT		6.3	6.5	(0.2)	8.4	8.7	(0.3)
NCH&C		1.2	1.2	0.0	1.8	1.7	0.1
N&W System Total		**29.5**	**29.6**	**(0.1)**	**41.4**	**48.4**	**(7.1)**

The system agency expenditure M8 Year To Date (YTD) excluding Capitalised Staff Costs (CSC) was £29.6m, £0.1m above plan.

£7.1m forecast overspend within agency (exc. CSC) is mainly due to the forecast total agency overspend at QEH of £3.8m (trainee grades £2.0m, other scientific, therapeutic and technical staff £1.0m, infrastructure support £0.8m) and JPUH of £2.9m (consultants £1.6m, registered nursing, midwifery & health visiting staff £0.7m).

The forecast agency spend of £48.4m is £4.3m above the agency cap.

Description of the metric

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

Description of performance

Plan is set to: £41.2m
Current FOT is: £48.4m

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

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

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

PMO
Project Management across Norfolk and Waveney

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

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide

The position M6 Year To Date (YTD) is a £45.5m deficit, which is £37.6m adverse against plan. This is a deterioration of £6.6m from M7 when the position was £31.0m off plan.

The forecast outturn (FOT) for the system is break even per the plan, although there is a reported £71m net risk to this position which needs careful mitigation if the plan is to be achieved.

The YTD QEH variance of £18.8m is mainly due to slippage within Cost Improvement Programme (CIP) delivery, bank spend and below plan activity levels. JPUH variance of £3.8m is mainly due to under delivery of CIP and the impact of industrial action. NNUH variance of £13.7m is mainly due to overspends on pay and under delivery of CIP.

Revenue surplus/(deficit) £m	Month 8 YTD			Forecast Outturn		
Organisation	Plan	Actual	Variance	Plan	Actual	Variance
JPUH	(0.8)	(4.6)	(3.8)	(1.1)	(1.1)	0.0
NNUH	(2.8)	(16.5)	(13.7)	0.0	0.0	0.0
QEH	(5.4)	(24.1)	(18.8)	(0.8)	(0.8)	0.0
NSFT	0.5	(0.9)	(1.5)	0.0	0.0	0.0
NCH&C	0.3	0.4	0.1	1.5	1.5	0.0
Provider Subtotal	**(8.2)**	**(45.7)**	(37.6)	**(0.4)**	**(0.4)**	0.0
ICB	0.3	0.3	0.0	0.4	0.4	0.0
N&W System Total	**(7.9)**	**(45.5)**	(37.6)	**0.0**	**0.0**	0.0

Description of the metric

Deliver a balanced financial position.

Description of performance

The position M8 YTD is a £45.5m deficit, which is £37.6m adverse against plan. The forecast outturn is per plan, although there is a reported £71m net risk to this.

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

Root cause(s) identified:	Corrective Action(s):	Action owner(s):	Delivery date for action(s):	Risk to delivery of corrective action(s):
Increased staff costs, resulting from sickness / vacancies. Cost Improvement Programme (CIP) slippage. Industrial action.	Workforce plan. Triple Lock process. CIP overview.	Finance Committee		At month 68 the system is forecasting to meet plan at year end. Finance Committee will oversee progress.

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

PMO
Project Management across Norfolk and Waveney

Improving lives together
Norfolk and Waveney Integrated Care System

Link back to overview of underachieving metrics slide

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

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

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

Description of the metric
Implementation of the PSIRF.

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

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

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

Additional performance areas that provide context and insights.

Link back to overview of underachieving metrics slide

Additional data which presents a wider view of system performance can be found here:

- Acute flow – includes length of stay and long stay, bed occupancy and readmissions.
- Cancelled electives –
- Discharge to Assess data – Acutes, Community, Social Care
- Outpatient activity – includes attendance, cancellation and DNA rates.
- Virtual ward – transfers in, length of 'stay' and readmission
- General Practice Appointments – views include time from booking to appointment.
- Cancer screening – Bowel, breast and cervical cancer

Access to the above is granted to Integrated Care Board staff and can be granted to those in organisations listed here: https://improvinglivesnw.org.uk/list-of-sub-licensees/

Norfolk and Waveney
Integrated Care Board

Agenda item: 16

Subject:	**Commissioning & Performance Committee (CPC) Report to Board**
Presented by:	**Hein van den Wildenberg, Non- Executive member and vice Chair**
Prepared by:	**Diane Smith, Head of Collaborative Commissioning and Performance**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**29 January 2025**

Purpose of paper:

To provide the Board with an update on the work of the Commissioning and Performance Committee (CPC) for the period since the last Board meeting in Public on November 27 2024.

Committee:	Commissioning and Performance Committee
Committee Chair:	Hein van den Wildenberg
Meetings since the previous update on 25th September 2024	Meeting held in private on 28th November 2024 0900 – 1130 via MS Teams. Meeting scheduled for 19th December 2024 0900 – 1200 via MS Teams was stood-down due to annual leave over the festive period and to allow staff to focus on any operational issues. A further CPC is scheduled for the 23rd of January 2024. This is after Board papers are published. Any key points will be raised verbally in 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. • To consider and make decisions on recommendations from the medicines optimisation programme board. • To oversee and gain assurance on the operational arrangements that support the commissioning of services. • Oversee the process of any further delegation of commissioning responsibilities from NHS to the ICB.

	• Provide oversight to the Individual Funding Request panel. • Conduct and lead the oversight of NHS system and commissioned provider performance, directing improvement resources and ensuring learning is implemented. This includes coordinating with regulators where formal improvement is required. • Ensure that innovation, best practice, evidence and evaluation and the impact on health inequalities consistently informs our commissioning decisions. • Approve the application of the Provider Selection Regime process for the procurement of any business cases that it approves under its delegation.
Main purpose of meeting:	The Committee exists to provide assurance and oversight and make decisions (within its delegations) on the commissioning and performance of services to ensure better outcomes for the population of Norfolk and Waveney. It will also consider the management of risk in all its work.
BAF and any significant Board Operational Risks relevant / aligned to this Committee:	The following risks are the responsibility of this Committee, which will be making commissioning decisions and managing performance: • BAF03 – Barriers to full delivery of the mental health transformation programme (Children and Young People) • BAF04 – Barriers to full delivery of the Mental Health Transformation Programme (Adults) • BAF06 – System Urgent & Emergency Care (UEC) pressures • BAF07 - Elective Recovery These are the risks that are part of the reviewed BAF, signed off by the ICB public Board in July, and aligned to the 8 ambitions in the Joint Forward Plan. The Committee continued to feed back to the risk owners to ensure accurate reflection of strategic risks and to ensure B/ORR risks reflect key operational elements. Board Operational Risks (BOR) • BORR10 - Neuro-Developmental Service (NDS) Children and Young People • BORR26 - ICB application of sustainable commissioning and compliance with procurement regulations Operational Risk Register (ORR) • ORR10 - Tier 3 and 4 weight management. A further risk was being reviewed at the point of the November meeting to reflect Cancer performance risks appropriately with the intention that a risk would be registered on the ORR.
Key items for Board to take note of:	**1.** The meeting welcomed Matt Dooley, Executive Director of Commissioning and Performance for the ICB. **2.** The committee noted that the transition to new structures of the Scheduled Care Board and sub-groups is being implemented through December ’24 and January ’25. The meeting reviewed and approved Terms of Reference (ToR) for sub-committee ‘Scheduled Care Board’ (SCB) and the

	working group 'Provider Performance and Planning Oversight Group' which feeds to SCB. **3.** There is now a clear process for sub-committees to outline and document any items for escalation to the Committee, including any new or transferred risks. **4.** The Performance Report was reviewed, with the same performance report being shared to the ICB Board for the first time in November 2024. The report in November highlighted the following key areas and summary discussion: ➢ **Elective**: - Focus remains on clearing 65 week waits. The expectation is that the NNUH and JPUH will still have people waiting in this timeframe outside of the target of end December 2024 – this is being monitored closely within the system and with NHS England. - James Paget has moved back to tier 1 level of support with NHS England, due to the proportion of waits of 65 weeks. NNUH remains in tier 1 support. - The committee has been considering plans to return to sustainable 18-week pathways incorporating future new ways of working and opportunities already in progress such as digital solutions and new hospital estates. Since the CPC meeting, national announcements in early January 2025 have provided further information on this expectation and outline the ambitions for elective care that by March 2026 the percentage of patients waiting less than 18 weeks for elective treatment will be 65% nationally, with every trust delivering a minimum 5 percentage point improvement. Norfolk and Waveney performance against the 18-week standard can be seen in the performance pack. ➢ **Cancer**: Cancer performance remains challenging. Delivery against targets is improving overall though there is variance across providers. The position is expected to remain challenging through the winter. ➢ **Diagnostics:** times remain challenging across the system – the November committee noted that performance stood at 66.8% (August position). Additional capacity is making an impact on waiting lists in various specialities with outsourcing. - Community Diagnostic Centres are open at JPUH and QEH, while the NNUH site and additional site associated with the JPUH are due to be open in late spring of 2025. ➢ **Mental health**: Key area off trajectory is the number of people in mental health beds which are inappropriately outside of our own geography of Norfolk and Waveney. Insights indicate this rise is due to the level of acuity and complexity of needs which also makes discharge challenging. There has been continued strengthening of the use of crisis services and to ward oversight from Matrons and use of Multi-Agency Discharge Events to engage all partners in improving discharges and flow. ➢ **Community**: work continues to ensure accurate and informative reporting of community performance position.

	➢ **Learning Disability and Autism:** Representation was not available. ➢ **Urgent & Emergency Care (UEC)**: Increased pressure at the 'front door' and demand for ambulance response has resulted in a slight deterioration in position. Work continues to implement nationally recommended '10 high impact' actions to effect long-term improvements that focus on demand and flow. ➢ **Children and Young People (CYP):** There are ongoing challenges in services for Neuro-Developmental Disorder (NDD) though work has brought waits for assessment to under 52-weeks. ➢ **Primary Care:** the committee noted the report on performance and recovery from the Primary Care Commissioning Committee and will not duplicate but consider this position within the overarching system performance view. ➢ **Specialised Commissioning:** Highlights include: o Thrombectomy service changes have seen an improvement in the numbers taking place. Additional funding has been secured for revenue costs to support further developments. o The Renal Network have presented papers outlining future plans. o An update on The Hyperbaric Oxygen Therapy went to the National Commissioning Group to review the model – a decision has not yet been made following consultation. o Aseptic service changes were discussed in relation to travel distances. o 2025 delegations of Specialised Commissioning will require sign off by ICB Board. ➢ Work is underway with reporting leads, Business Intelligence teams and the Commissioning and Performance team to develop a report which will include more automation and resilience for reporting from 2025/26. The intention being to streamline and focus each group, committee and the Board with a layered approach to views of performance which supports improvements. The timeline is for this to be in place for the 2025/26 financial year. **5. Report on Recovery Support Programme funding:** a report was received that identified all the funding is expected to be utilised as planned, and confirmation of satisfactory evidence by NHS England is expected. **6. Report on ADHD:** The position locally reflects nationally challenges with demand and the Right to Choose process. Locally a new set of providers have been contracted to add capacity while having more oversight and rigour in reducing the waits for people. There is a significant backlog to work through. **7. Report on community wheelchair waiting times:** the committee noted a letter has been received from NHSE, highlighting the waiting times data flowing nationally. Local data review has identified some data quality issues impacting

	on the view of the position, this is being addressed with an expectation that the national data flow will more accurately reflect the locally viewed position. Key areas noted were differences in waiting times for wheelchairs between community providers with ongoing impact from the COVID19 pandemic (e.g. staff redeployment which has left a backlog). Work is underway in providers and the ICB to support the reduction in waiting times in the short and long-term and ensure risk is appropriately managed. **8. Report on 'Tier 3' weight management services:** this report outlined the contractual position, current challenges and plans for future provision of this service. The report also outlined steps taken to support those currently waiting and mitigate risks, as well as the strategic view of the benefits of supporting management of weight in our population. **9. Planning** for any service changes from 1st April 2025 is underway and will be considered alongside national planning / financial planning information, which is still to be received for 2025/26. Impact Assessments have been completed or are underway for any proposed changes and also operate within the *Triple Lock* process. This included a report that highlighted process for contracts approaching end dates. **10.** There were several updates from feeder groups and some escalation: ➢ As part of Collective Action in General Practice some practices are not using the routine mechanism for prescribing in line with formulary. This may have a financial and quality impact. ➢ Equity of provision of community support with prescribed Oxygen is being escalated through providers. ➢ Audit of implementation of Robotic Process Automation (RPA) has identified pre-screening needs to be robust before RPA is rolled-out.
Items requiring formal approval of Board:	None
Confirmation that the meeting was quorate:	Yes.

Key Risks – of performance that falls short of expected national or local standards, constitutional requirements and/or plans	
Clinical and Quality:	The impact of commissioning decisions on Clinical and Quality are integral part of decision making, and a clear process of assessing this impact is in place. Performance which falls short of expected national or local standards, constitutional requirements and/or plans will frequently have an impact on the clinical care and/or quality of care that can be provided and risks negatively impacting experience and outcomes. Performance review includes the perspective of clinicians, quality leads and people with lived experience.

Finance and Performance:	Performance and Financial risk are inherently linked. Financial envelope impacts room for performance improvement initiatives. Most discretionary spend decision require sign-off through triple-lock process.
Impact Assessment (environmental and equalities):	Equalities and other relevant impact assessments are completed and reviewed at regular intervals and inform risk management processes.
Reputation:	If performance falls short of expected national or local standards, constitutional requirements and/or plans, this will have a negative impact on reputation of NHS Norfolk and Waveney.
Legal:	Legal risk in general may exist with commissioning decisions, and more broadly new Providers regime.
Information Governance:	None
Resource Required:	Not discussed
Reference document(s):	N/A
NHS Constitution:	Commissioning and Performance Committee seeks to assure we meet NHS Constitutional performance standards.
Conflicts of Interest:	Conflicts of interests is managed carefully, in view of the decision making authority of this committee.

Norfolk and Waveney
Integrated Care Board

Agenda item: 17

Subject:	**Delegation of 11 Specialised Services from NHS England to the six ICBs in the East of England**
Presented by:	**Andrew Palmer, Deputy CEO and Executive Director**
Prepared by:	**Lynelle Hales, Managing Director of Specialised Commissioning (East of England)** *(local amendments by Amanda Brown, ICB Associate Director of Corporate Governance)*
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**29 January 2025**

Purpose of paper:

To ask the Board to agree that the Chief Executive Officer can sign the revised delegation and collaboration agreements on behalf of ICB once finalised. This will delegate a further 11 specialised services to the ICB.

Executive Summary:

In March 2024, all six East of England ICB Boards ratified the Delegation and Collaboration Agreements paving the way for delegation of commissioning responsibilities for 59 specialised services to ICBs through the Joint Commissioning Consortium (JCC) and the regional specialised commissioning function, hosted by the Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK ICB). A further 11 specialised services will be delegated from April 2025.

The governance work required to expand the Specialised Services that are delegated to ICBs from April 2025 is underway. This includes amending the delegation and collaboration agreements, developing an East of England specialised commissioning strategy and a commissioning framework. The governance and oversight will continue to be through the JCC with the regional and specialised commissioning function hosted by BLMK ICB.

The revised Agreements need to be signed by each of the member organisations to the EoE JCC. That is the six ICBs and NHS England by the 21 March 2025.

The NHS England Board meeting 5 December 2024 approved the paper on delegation of Specialised Services. They agreed to:

a. Consider and reaffirm the ambition, intent and opportunities offered by the delegation of commissioning responsibility for suitable and ready specialised services to integrated care boards (ICBs).
b. Note that the list of services suitable and ready for delegation to ICBs has now been finalised with 70 services in scope (annex a).
c. Approve the delegation of commissioning responsibility for these 70 specialised services to all ICBs in the North East and Yorkshire, London, South East and South West regions from April 2025 (and the additional 11 services to those ICBs in the Midlands, North West and East of England regions that took on full delegated commissioning responsibilities this year).
d. Approve the template delegation agreement for signature ahead of 2025/26, at annex b.
e. Give delegated authority to regional directors to sign the final delegation agreements on behalf of NHS England

A EoE ICB Governance subgroup has been established to review the revised Delegation Agreement and consider any amendments to the current Collaboration Agreement and governance arrangements. The commissioning guidance for 2025/26, once released, will be reviewed in relation to the future governance requirements. Given the short timeframe to finalise the agreements by 21 March 2025, the process agreed is to:

1. Establish drop-in sessions in February for EoE ICB Board members to attend for a briefing on the updated governance and delegation arrangements from April 2025 and any amendments to the delegation and collaboration agreements.
2. Take the finalised versions to the JCC for agreement, and then
3. Signed by all parties.

It is recognised that not all Boards will meet in the short timeframe between documents being finalised in February and signed in March. As such, it is recommended that each Board give delegated authority to sign the Agreement on behalf of the ICB.

Background

Specialised Services support people with a range of complex conditions, they often relate to care given to people with rare cancers, genetic disorders or complex medical or surgical situations. They are provided by a relatively small number of hospitals to a small number of patients. The Roadmap for integrating specialised services within integrated care systems (2022) set out a change to the commissioning of prescribed specialised services which allows systems to operate a more integrated approach to enable the provision of high-quality equitable care. Legislative changes in 2022 to the Health and Social Care Act permits ICBs to take on delegated responsibility for some specialised services. Moving to ICB-led commissioning supports a focus on population health management across whole pathways of care, improving the quality of services, tackling health inequalities and ensuring best value.

At the NHS England (NHSE) Board meeting on the 7 December 2023 it was agreed that the delegation of specialised commissioning (spec comm) to ICBs in England would be supported. In March 2024, all six EoE ICB Boards ratified the Delegation and Collaboration Agreements paving the way for delegation of commissioning responsibilities for 59 specialised services to ICBs with governance and oversight through the Joint Commissioning Consortium (JCC) and the regional Specialised Commissioning function (across the six ICBs and NHS England), hosted by BLMK ICB. A further 11 specialised services will be delegated from April 2024.

Although the specialised commissioning team remain employed by NHS England until the planned transfer of the team to BLMK in July 2025, the Specialised Commissioning function

is now managed by BLMK ICB. Lynelle Hales has been appointed as Managing Director to undertake leadership of the hosted delegated service, started in May 2024.

The specialised commissioning team (SCT) which currently sits within NHS England (EoE), from 1 April 2024, work on behalf of the six ICBs and NHS England for both the retained and delegated specialised services. From 1st July 2025 the SCT will be hosted (employed) by BLMK ICB and will continue to work for the six ICBs and NHS England reporting through the JCC and its subcommittees.

Recommendation to the Board:

That the Board agrees that the Chief Executive Officer can sign the revised delegation and collaboration agreements on behalf of ICB once finalised.

Key Risks	
Clinical and Quality:	This is a transfer of specialised commissioning functions from NHS England to the ICB.
Finance and Performance:	Not applicable
Impact Assessment (environmental and equalities):	Not applicable
Reputation:	
Legal:	Statutory delegation pursuant to section 65Z5 of the NHS Act
Information Governance:	Not applicable
Resource Required:	Not applicable
Reference document(s):	
NHS Constitution:	Not applicable
Conflicts of Interest:	Not applicable
Reference to relevant risk on the Board Assurance Framework	Not applicable

Governance

Process/Committee approval with date(s) (as appropriate)	Board to agree CEO can sign revised documents on behalf of the ICB

Norfolk and Waveney
Integrated Care Board

Agenda item: 18

Subject:	**Primary Care Commissioning Committee Report to Board**
Presented by:	**Ian Wake, Local Authority Member and Chair of PCCC** **Hein van den Wildenberg, Non-Executive Member and Deputy Chair of PCCC**
Prepared by:	**Sadie Parker, Director of Primary Care**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**29 January 2025**

Purpose of paper:

To provide the Board with an update on the work of the Primary Care Commissioning Committee from the December 2024 committee meeting.

Committee:	Primary Care Commissioning Committee
Committee Chair:	Ian Wake, Local Authority Member
Meetings since the previous update on 27 November 2024	10 December 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 relevant / aligned to this Committee:	**BAF02 – Primary Care Resilience and Transformation** **Current mitigated score – 5x4=20** 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. **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). • 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 December 2024** Members received reports on the following areas: • **Complaints and contacts** – a review of complaints and contacts was presented, with access to dentistry and general practice continuing to be among the main themes, although the number of complaints for dentistry had reduced. It was thought the reduction was attributable to the new urgent treatment service which was providing around 1900 additional appointments per month. • **National Patient Safety Strategy** – the aim of the National Patient Safety Strategy is to develop a supportive environment where patient and staff well-being is paramount, and patients are involved in identifying improvement opportunities. It is supported by an incident response framework (PSIRF) which is not mandatory for practices but has received positive feedback in a recent pilot of 4 PCNs. It was hoped the use of PSIRF would reduce the burden of analysis and reporting for practices and release capacity. • **Norwich Health Centre procurement** – members noted and ratified the abandonment of the APMS contract procurement at Norwich Health Centre and the decision to place a 1-year contract from 1st April 2025. The existing contract covered the Walk-In Centre, the registered practice and the Vulnerable Adults Service. The proposal for abandonment was based on grounds of affordability. • **Delivery group reports** for the Dental Services, Dental Delivery and General Practice and Community Pharmacy Delivery Groups were noted. • **A strategic finance report** was noted. Month 9 would provide a more accurate forecast of the year end position and the pressures in the budget due to increased activity such as complex dressings and prescribing were explained. • **Terms of Reference review** – due to the operational effectiveness of scheduling meetings and managing business, it was agreed to return to alternate committee and delivery group meetings from April.

	• **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. • **Prescribing strategic reports** was noted, along with acknowledgement of the breadth of work being undertaken.
Items for escalation to Board:	No items for escalation outside of the risks reported to ICB Board.
Items requiring approval:	• The **Risk Register** was approved which included the latest updates to BAF and BORR. The impact of Collective Action by general practice continued to be monitored through the resilience risk. • **Toftwood Medical Centre** – members considered at length and approved a report which recommended the closure of Toftwood Medical Centre when the contract expires on 31 March 2025. Several members of the public attended the meeting and provided questions and comments in relation to the proposal. These have been summarised and will be published along with the minutes. It was noted Norfolk Health Overview and Scrutiny Committee intended to request the Secretary of State for Health and Social Care to call in the decision. In the meantime, work would continue with the three Dereham practices (including Toftwood Medical Centre) to plan and mobilise the transition. • **Pharmaceutical Services Regulations Committee Memorandum of Understanding and Terms of Reference** – members approved revised ToRs and MOU documents, for the service delivered on our behalf by Hertfordshire and West Essex ICB for the eastern region.
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 December 2024** Hein van den Wildenberg, ICB Board non-executive member, Deputy Chair Karen Watts, Director of Nursing and Quality (deputising for Patricia D'Orsi, executive director of nursing, ICB) James Grainger, Head of Finance – Primary Care and Corporate (deputising for Steven Course, executive director of finance, ICB).

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
Resource Required:	Primary care commissioning, quality, finance, primary care estates, primary care workforce, primary care digital, prescribing, locality and BI teams
Reference document(s):	Primary care services regulations, statement of financial entitlements, premises directions and policy guidance manual, delegation agreement with NHS England
NHS Constitution:	N/A
Conflicts of Interest:	Arrangements are in place to manage conflicts of interest

Norfolk and Waveney
Integrated Care Board

Agenda item: 19

Subject:	**Norfolk Local Health Resilience Partnership (LHRP) NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR) annual assurance process for 2024/25**
Presented by:	**Steven Course, Executive Director of Finance, Accountable Emergency Officer (AEO) NHS Norfolk and Waveney ICB**
Prepared by:	**Grant Rundle, EPRR NHS Norfolk and Waveney ICB**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**29 January 2025**

Purpose of paper:

Approval

Executive Summary

NHS Core Standards for EPRR annual assurance process 2024/25

NHS England has an annual statutory requirement to formally assure its own and the NHS in England's readiness to respond to emergencies. To do this, NHS England asks commissioners and providers of NHS-funded care to complete an EPRR annual assurance process.

This paper provides a summary of the core standards annual assurance process for Norfolk Local Health Resilience Partnership (LHRP).

Recommendation to the Board:

The Board is asked to approve the contents of this paper.

Key Risks	
Clinical and Quality:	Risk to the safety of patients and public if statutory civil protection duties are not fulfilled. Failure to fulfil duties could have an impact on the quality of clinical services.
Finance and Performance:	Risk of failure to comply with ICB statutory duties, with the Civil Contingencies Act 2004 and with NHS England's EPRR requirements.
Impact Assessment (environmental and equalities):	None
Reputation:	Risk to organisational reputation resulting from failure to respond in an emergency and to recover business as usual functions.
Legal:	As a ICB we must comply with relevant legislation and guidance. (see reference documents)
Information Governance:	Failure to ensure all actions are taken with regards to IG during an incident could result in legal challenge.
Resource Required:	EPRR Lead and EPRR Support Officer
Reference document(s):	Civil Contingencies Act 2004 (legislation.gov.uk) NHS Act 2006 NHSE Emergency preparedness resilience and response EPRR annual assurance process for 2024-/25 letter July 2024.
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Governing Body Assurance Framework	N/A

GOVERNANCE

Process/Committee approval with date(s) *(as appropriate)*	N/A

1. NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR) annual assurance process for 2024/25.

1.1 Introduction

NHS England has a statutory requirement to formally assure its own and the NHS in England's readiness to respond to emergencies. The NHS core standards for EPRR provide a common reference point for all organisations and they are the basis of the EPRR annual assurance process.

The Civil Contingencies Act 2004, Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, NHS Act 2006 and Health and Care Act 2022 underpin EPRR within health service. All acts place EPRR duties on NHS England and the NHS in England.

1.2 Process

Norfolk Local Health Resilience Partnership (LHRP) organisations were asked to undertake a self-assessment against individual core standards relevant to their organisation type and rate their compliance for each. This was then used to inform the organisation's overall EPRR annual assurance rating.

An LHRP peer review workshop was conducted with the aim of providing an environment that promoted the sharing of learning and to gain confidence with core standard organisational ratings. This workshop delivered a safe space for EPRR leads to discuss core standards, provided supportive challenges of self-assessment ratings, ensured robustness of action plans, and enabled an opportunity to discuss areas of best practice and challenges encountered during the core standards process.

Organisations were required to submit their completed self-assessment to NHS Norfolk and Waveney ICB and to take part in a dedicated 1:1 confirm and challenge session. This sought to gain any further clarification and supporting evidence required to obtain confidence with the assurance ratings. Additionally, NHS England regional EPRR conducted a similar confirm and challenge session with NHS Norfolk and Waveney ICB's self-assessment.

A collated Norfolk LHRP assurance return was submitted to the NHS England regional EPRR team on 2 December 2024.

1.3 NHS Core Standards for EPRR

The applicability of each core standard is dependent on the organisation's function and statutory requirements. Each organisation type has a different number of core standards to assure itself against:

- Acute Provider - 62 core standards.
- Community Service Providers - 58 core standards.
- Mental Health provider - 58 core standards.
- Ambulance service - 58 core standards.
- ICB - 47 core standards.
- NHS111 - 43 core standards.
- Non-Emergency Patient Transport services - 42 core standards.

The NHS core standards for EPRR cover 10 core domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans

4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Co-operation
9. Business continuity
10. Chemical biological radiological nuclear (CBRN) and hazardous material (HAZMAT)

1.4 EPRR Core Standards 2024/25

The compliance level for each standard is defined as:

Compliance Level	Compliance definition
Fully Compliant	Fully compliant with core standard.
Partially Compliant	Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan is in place to achieve full compliance within the next 12 months
Non-compliant	Not compliant with the core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months

An overall assurance rating is assigned based on the percentage of NHS Core Standards for EPRR which the organisation is assessed as being 'Fully Compliant' with. The thresholds for each assurance rating are:

Overall EPRR assurance rating	Criteria
Fully Compliant	The organisation if fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial Compliance	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial Compliance	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards.
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards.

1.5 Assurance levels summary

The submitted outcomes of the Norfolk LHRP overall assurance ratings for EPRR Core Standards 2024/25 were:

Organisation	2024/25
NHS Norfolk & Waveney ICB	Partial Compliance
JPUH NHS Foundation Trust	Substantial Compliance
NNUH NHS Foundation Trust	Partial Compliance

Organisation	2024/25
QEHKL NHS Foundation Trust	Substantial Compliance
Norfolk Community Health and Care NHS Trust	Non-Compliance
Norfolk and Suffolk NHS Foundation Trust	Partial Compliance
East Coast Community Healthcare CIC	Substantial Compliance

All Norfolk LHRP providers recognise where there are core standards for which they are not fully compliant. Actions have been identified with the aim of achieving a fully compliant status. The LHRP working group will continue to provide a collaborative and safe environment whereby organisations are supported in undertaking and completing these actions.

Note - As a regional service, the East of England Ambulance Service Trust submit their annual assurance return through the Suffolk LHRP. Additionally, IC24 and HTG patient transport service submit their return through Essex LHRP and Cambridgeshire Community Services NHS Trust through Cambridgeshire LHRP. Similarly, these organisations have action plans for those core standards which are not fully compliant. These organisations are included here for completeness as they contribute to the work of Norfolk LHRP.

East of England Ambulance Service Trust	Substantial Compliance
Integrated Care 24	Substantial Compliance
HTG Non-Emergency Patient Transport Service	Partial Compliance
Cambridgeshire Community Services NHS Trust	Substantial Compliance

1.6 Deep Dive

Each year, alongside the core standards annual assurance process, a ‘deep dive’ is conducted to gain valuable additional insight into a specific area. The 2024/25 annual deep dive focused on cyber security. The outcome of the deep dive will be used to identify areas of good practice and to guide organisations in the development of local arrangements.

The deep dive process does not contribute to the overall assurance ratings for organisations. However, each organisation was assessed as either Fully Compliant or Partially Compliant with each of the deep dive standards.

1.7 Areas of good practice

During the core standards process for 24/25 organisations had the opportunity to raise and discuss areas of good practice they had encountered.

- The LHRP EPRR peer review session was an extended session for 24/25 and conducted over a full day, as opposed to an afternoon session during last year. This was welcomed by EPRR representatives and seen as a positive process to explore the core standards assurance requirements, along with capturing best practice and challenges encountered. This was an open and honest forum for all attendees.
- NHSE Regional EPRR team were cognizant of the input required by organisations of the LHRP in undertaking the range of work necessary in adhering to the core standards

process. As such, the final submission to NHSE by the ICB was not required until 2 Dec 24. This gave additional time for the completion of all aspects of the assurance return while still undertaking business as usual tasks by relatively small EPRR teams. The recommendation would be for this to be replicated in future years.

- The good working relationships between EPRR reps and the subject matter experts within organisations assisted facilitating the needs of the core standard work.

- Core standards affords the opportunity for organisations to review internal procedures and policies. This has led to instances of improved governance processes.

1.8 Common challenges/issues

During the core standards process for 24/25 organisations had the opportunity to raise and discuss areas of challenge and any issues they had encountered.

- Despite the national team indication of an early release of the core standards process for 24/25 the final confirmed details were not distributed until 16 Jul 24. This compressed the initial timeline for all organisations.

- The core standards spreadsheet created by the national team for the collation of self-assessment returns had access/formatting errors. These necessitated further versions being distributed, creating additional workloads on organisations in transferring data. Furthermore, updated versions still displayed 'DRAFT' which indicated there would be a confirmed 'FINAL' version. This did not materialise. Notwithstanding the fact that sufficient time exists each year for the national team to create and test spreadsheets required for core standards, the importance of version control processes must be expressed to the national team to avoid confusion and unnecessary delays in the completion of self-assessments.

- Concurrency of EPRR activities continues to be a risk and when combined with core standards and limited EPRR resources necessitates a re-prioritisation of proactive workstreams within organisations.

- EPRR resourcing continues to be a factor within organisations and there are different interpretations of what is appropriate. This item was raised during last year's core standards process and a national/regional piece of work is required to benchmark and map fully the resources/workstreams necessary to adhere to organisational, ICS, LRF, NHSE Regional & National needs.

1.9 Norfolk LHRP considerations for EPRR improvement/development

To enhance the collaborative processes and engagement within the LHRP, a recommendation was put forward by EPPR representatives to conduct an initial workshop style meeting at the start of future core standard processes. The intent would be for this meeting to outline the proposed core standards process for the year, and to discuss any specific areas of change indicated by national and regional teams for that year. This will be a particularly useful addition to the LHRP process due to the national tri-annual review of core standards taking place currently.

The LHRP is to explore the possibility of having combined joint plans between similar trusts where there is some commonality in process and procedures. This would allow an integrated approach to those plans and embed a degree of interoperability where practical.

1.10 Next Steps

Norfolk LHRP organisations will build upon the close working relationships of the EPRR leads in supporting organisations in attaining a Fully Compliant status. A review of the organisational core standard actions will be conducted within the regular LHRP working group meetings. A summary update report will be provided to the Norfolk LHRP Executive at the 6-month point. This process will enable the LHRP to continue to share good practice and maintain a consistent approach across the system.

Agenda item: 20

Norfolk and Waveney
Integrated Care Board

Subject:	**Risk Management**
Presented by:	**Karen Barker, Executive Director of Corporate Affairs and ICS Development**
Prepared by:	**Agnes Earl, Corporate Governance & Risk Management Senior Officer**
Submitted to:	**Norfolk and Waveney Integrated Care Board – Board Meeting**
Date:	**29 January 2025**

Purpose of paper:

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

Executive Summary:

Effective risk management is an essential part of the ICB's system of internal controls and supports the provision of a fair and well-illustrated Annual Governance Statement.

The Board Assurance Framework (BAF) sets out the key risks that may impact on achievement of the ICB's strategic objectives by mapping out the key controls that are in place to manage each risk and assurance that has been gained about the effectiveness of these controls.

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

Please find attached a copy of the following (as at 16 January 2025):

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

Attention is directed towards the following notable changes:

Board Assurance Framework (BAF)

Risk	Changes
BAF04: Barriers to delivering equitable, safe and consistent care	• Unmitigated and Mitigated score have both decreased from 16 to 12. • Title changed from 'Barriers to Full Delivery of the Mental Health Transformation Programme (Adult)'

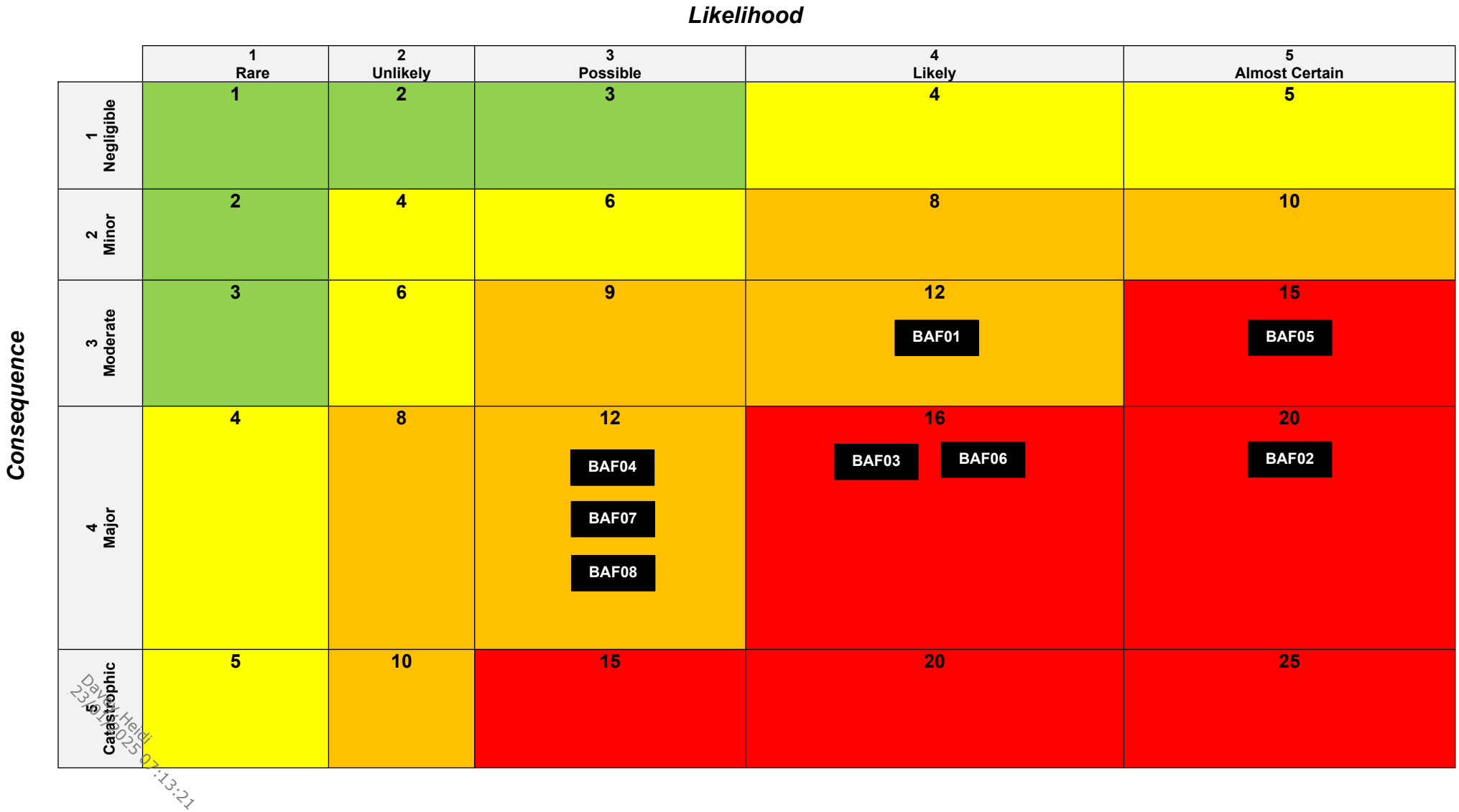
Recommendation to the Board:

The Board are asked to note the contents of this paper and approve the change in score and title for BAF04.

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

Appendix 2: Risk visual

Board Assurance Framework risks
Board Operational Risk Register risks



Norfolk and Waveney Integrated Care Board

NHS Norfolk and Waveney ICB – Board Assurance Framework

Version	V5	Date last updated:	20.01.2025

Board Assurance Framework – Summary Page

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

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

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

<table>
<tr><th colspan="9">BAF01 (Inphase ref 00000008)</th></tr>
<tr><td>Risk Title</td><td colspan="8">Health inequalities and Population Health Management</td></tr>
<tr><td>Risk Description

Please include any collaboration and partnership aspects of the risk.</td><td colspan="8">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.</td></tr>
<tr><td>Risk Owner</td><td colspan="3">Responsible Committee</td><td colspan="2">Operational Lead</td><td>Date Risk Identified</td><td colspan="2">Target Delivery Date</td></tr>
<tr><td>Mark Burgis / Dr Frankie Swords</td><td colspan="3">Patients and Communities</td><td colspan="2">Suzanne Meredith/ Tracy Williams/ Shelley Ames</td><td>01/07/2022</td><td colspan="2">31/03/2025</td></tr>
<tr><th colspan="9">Risk Scores</th></tr>
<tr><th colspan="3">Unmitigated</th><th colspan="3">Mitigated</th><th colspan="3">Target</th></tr>
<tr><td>Likelihood</td><td>Consequence</td><td>Total</td><td>Likelihood</td><td>Consequence</td><td>Total</td><td>Likelihood</td><td>Consequence</td><td>Total</td></tr>
<tr><td>4</td><td>4</td><td>16</td><td>3</td><td>4</td><td>12</td><td>1</td><td>4</td><td>4</td></tr>
<tr><td colspan="2">Risk appetite:</td><td colspan="3"></td><td colspan="2">Risk tolerance:</td><td colspan="2"></td></tr>
</table>

Controls	Assurances on controls
• The HI Strategic Framework for action and the PHM strategy have been published. Implementation plans developed, with supporting programme management. • Specialty advisors are leading on HI, PHM and the Core20Plus5 clinical areas. • ICP supported proposals for a strategic group and co-ordination group to formally oversee delivery of the Health Inequalities Framework for action. Co-ordinating multi-partner health inequalities group now in place. .SROs established for Lifestyle factors and Healthcare Inequalities • Health Inequalities & VCSE Partnering team appointed to lead health inequalities work programme development. • The Health Improvement Transformation Group (HITG) focusses on Primary Prevention: smoking, physical activity and Healthy weight, report to ICP. • Community Voices gathering insights into HI and connecting with local communities to help address. • ICS groups set up for Inclusion health groups, vaccines inequalities, Core20plus5 programme group, NHS Anchors group, access and support programme group, reporting to HIOG • Datahub Population Health dashboards in place to support reporting and population health management approaches. • 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	**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. Equality Health Impact Assessment (EHIA) process established, overseen by a QEAP (panel). **External**: Integrated Care Partnership Board Health Inequalities governance structure including a strategic steering group and co-ordination group.

seekers which impacts on the services they receive) are raised by the HI team to be managed across the ICP. • Refresh of the VCSE Assembly and partnership working reporting into the PH&I Board. New Assembly Chair appointed.	

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.
- 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
06/12/24	ICS Health inequalities commitment sign-up underway and Organisations' baseline assessments to inform ICS improvement plan. The ICB Senior leadership Team workshop on HIs and PHM took place to inform the ICB's baseline assessment. Presentation to CDs on PHM awareness and accessing the new datahub , supporting clinicians to self-serve information.		**31/1/25**

Visual Risk Score Tracker – 2024/25

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

Ambition 2: Primary care resilience and transformation

BAF02 (Inphase ref 00000032)

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

Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Mark Burgis	Primary Care	Sadie Parker	**31/08/2024**	**31/03/2027**

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

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

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

Gaps in controls or assurances
• Lack of in-depth knowledge about the resilience and stability of **all** primary care services across Norfolk and Waveney. • Lack of awareness and understanding across the system about the impact struggling primary care services will have in the longer term on other system partners and services. • Unknowns associated with the ongoing collective action associated with the BMA's 'Save General Practice' campaign in respect of pressure on primary medical care and other system partners and impact on access to healthcare for our population. • Significant gaps in ICB teams remain following restructure and reliance on wider teams (eg Quality and Workforce) to address the issues – there is a reduction in vacancies in the primary care team but building knowledge and relationships will take time, with operational readiness work in progress. • ICB's financial position is impacting on our ability to support resilience and transformation in primary care leading to temporary and more expensive solutions being put in place, particularly across dental and primary medical contractors. • Primary care dashboard/ delivery report remains in development, leading to a lack of integrated performance oversight. • Lack of access to NHS dentistry services is an area of quality and safeguarding concern - this impacts some of our most vulnerable patient groups. • Significant workforce shortfalls across general dental services, Level 2 services and secondary care dental services and a lack of comprehensive workforce data to support planning. • CQC activity is currently focused on private dental practice, rather than NHS practices. • General practice visit programme has been tested but not launched due to vacancies impacting capacity, CQC inspections focused on where there is a significant risk or concern. • Data to capture inappropriate transfers of workload and general practice pressures is incomplete - planning resources may be less effective if based on an incomplete picture. • Workforce and capacity shortages across general practice, community pharmacy and dental practices, together with the ongoing drug shortages, are having an impact on access to robust and effective primary care provision. • Resilience policy in development, which will link into any bids for section 96 support for general practice. • Five-year Primary Care Strategy has expired, new strategic framework/long term plans in development for integrated neighbourhood working, general practice and community pharmacy, however capacity and long term absence is affecting progress.

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

	• National workforce data received with analysis underway. A reduction in workforce is noted, and the staff groups collected are limited. Medical • Close monitoring of the impact of GP collective action continues, feeding into regional monitoring. • The team has started planning for a programme of work to develop a long-term plan for general practice. • The ICB is currently out to consultation on a proposal to close the Toftwood Medical practice in Dereham and transfer patients to neighbouring practices. Public drop-in sessions and a public meeting are due to take place in November, with the final decision at Primary Care Commissioning Committee in December. Community Pharmacy • Materials being developed to support general practice in referring to Pharmacy First. • Relaunch of Pharmacy First coming on line in early November. • NWICB performance on Pharmacy First is strong when compared to regional colleagues however there is more opportunity to increase referrals		
Nov/ Dec 2024	Dental • Continuing to work on priority areas set out in Long Term Plan with a focus on health inequalities. • Significant ongoing political interest, which impacts on capacity of the team. • Clinical advisor has commenced in role and is already making an impact in the work we do and the support to the team. Medical • Ongoing close monitoring of GP collective action. Referring by letter rather than form is increasing across practices, as reported by providers. • Lack of winter resilience funding for general practice is causing concern with practices already reporting increased activity. At the same time, EDs are reporting a significant increase in minors activity. • Vision and principles document has been approved, and a PCARP report has been noted by the ICB Board at its meeting in November. Community pharmacy • Pharmacy First activity continues to grow, however there remains much potential and referrals from general practice and NHS111 are relatively low. The likelihood of collection action by community pharmacy is increasing, following support to a national ballot by The National Pharmacy Association. Potential impact being modelled.	**A**	**28/02/25**
Jan 2025	Primary Care Contractors remain concerned about the potential impact of National Insurance Employers Contributions and the lack of clarity to date on any financial support being provided nationally. An uplift to GP contracts has been confirmed, however there is no news yet on the other contractor groups. NHS operational planning guidance has not yet been published, and this is expected in the New Year. Work has commenced on refreshing our commitments in the Joint Forward Plan. The focus for the remainder of the current financial year will be on developing a strategic framework for primary care. This will be set	**A**	**31/03/25**

	against the backdrop of uncertainty and unrest for many primary care providers in terms of national contracts and funding and at a time when national policy drivers are expected to come into play which support and accelerate opportunities for transformation. The document will seek to underpin long-term plans for each pillar and accommodate the forthcoming 10-year plan and operational guidance. The framework will seek to provide contractors and system partners with clarity on local priorities for primary care commissioning and support available for them to be confident and effective system partners. The framework will also reflect the opportunities associated with the significant levels of capital investment planed in N&W together with the collective focus across the ICS on addressing health inequalities. Dental • The national DDRB uplift for dental contractors has yet to be confirmed and applied adding to the concerns about the impact on practice incomes in April 2025. There may be an increased risk of contract terminations. • Long Term Plan 24/25 individual pathways will be fully mobilised by end March 2025. Planning for implementing 2025/26 plans has commenced to agree project plans, resources and financial impact (where relevant) for approval. Medical • Ongoing ICB monitoring of GP collection action with regional oversight. Increases being seen in primary care activity across emergency departments and general practice. • 7.2% cash growth to GMS has been announced, equivalent to 4.8% real growth. National contract negotiations are ongoing. Community Pharmacy • Community Pharmacy Contract negotiations due to commence January 2025, likelihood of collective action is heavily dependent on the result of these negotiations. • Norfolk and Waveney General Practice Referral Toolkit launched to support Pharmacy First which still shows steady growth. Workforce Risk incorporated into overall Community Risk PC20.		

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					**NEW**	➡	➡	➡	➡	➡		

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

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

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

Controls	**Assurances on controls**
• Dedicated CYP strategic commissioning team in place • Effective System wide governance framework • Collaboration with system partners to understand demand and capacity has begun and the shared resource is better understood. • Development of robust understanding of the financial envelope available to drive the transformation, and investment necessary, including appropriate measures to reconcile these is still in process. • System approach to increasing knowledge skills and expertise across agencies and developing additional capacity through use of digital. Greatly assisted by digital appointing a digital lead. Digital workstream initiated. • Financial slippage is being mitigated against protecting our ability to maintain MHIS investment. • Implementation of system wide transformation programme • Commitment from system partners to adopting Thrive approach – mental health needs being considered and addressed in wider health and social care settings. • Additional partnership working with VCSE. • All age Eating Disorder Strategy • Established Children and Young Peoples System Collaboratives in Norfolk and Suffolk • Working in partnership with Norfolk and Suffolk Constabularies to implement a system wide collaborative approach to Right Care Right Person • Intensive day support unit now open for eating disorders and parent support offer in place. • Professional Therapeutic Pathway in place • Integrated Front Door phase one and two in place • Enhanced support offers for 18–25-year-olds in wellbeing hubs. • Gender Identity Service in place • Additional capacity within Professional Therapeutic Pathway in place	**Internal:** EMT, Integrated Care Board Board, Finance Committee, Quality and Safety 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 historical backlog, ongoing quality concerns and frequent changes in leadership and care model. • System financial position is impacting on the ability to support resilience and transformation. • Conflicting priorities across complex system transformation agenda. • Intra-system Electronic Patient Record connectivity, especially at the interface of primary/secondary/social care and third sector provision, remains a challenge and priority to address. • Lack of clarity regarding workforce capacity to deliver support at required levels. • Ability to recruit, retain and train a viable number of staff to enable service expansion and meet the MH and well-being needs of the N&W population. • Lack of clarity about leadership for CYP within new structures across system. • Lack of alignment in age bands with model in Suffolk footprint.

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**
06/11/22	Recruitment remains challenging in core secondary care services. New staff in post but staff leavers nullifying effect. Requirement to address urgent presentations and increased community acuity reducing routine capacity to reduce waiting times. Update 02/01/2024. Recruitment remains problematic. Workforce information requested from NSFT through newly re-established SPQRG Update 28.08.24 Workforce information outstanding. Further discussion has taken place regarding information format. Update 31.10.24 Meeting has taken place with NSFT staff to agree information needed, remains outstanding. Requested again through SPQRG. Update 03.01.25 New place teams confirmed within partnership structures and new leads for transformation. Meetings arranged for January 2025 to re-establish key working relationships.	**R**	**31/03/25**
25/08/23	Waiting list size within main provider continues to increase. Staff vacancies within central youth team critical. Proposal from provider to declare business continuity. Trust undergoing organisational restructure so delays to replacing key leadership roles. Plan to escalate to NSFT Executive. Update 19/06/24 referrals to NSFT reducing following introduction of Integrated Front Door. No corresponding reduction in waiting list to date. NSFT have developed a recovery plan for referral to assessment and are developing a similar plan for referral treatment. Exploring opportunities to utilise additional capacity. Update 28.08.24 significant work within main provider to reduce waits. All CYP waiting longer than 52 weeks for assessment have been addressed – plan now to look at those waiting >48 weeks. Corresponding work to reduce referral to treatment waits. Some concerns regarding sustainability raised at SPQRG Update 31.10.24 Delays to treatment still significant despite significant reduction in demand. Request to provider to review productivity. Some referrals still being rejected despite IFD in place and triage at referral. Update 03.01.25 New place teams confirmed within partnership structures and new leads for transformation. Meetings arranged for January 2025 to re-establish key working relationships.	**R**	**31.03.25**
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 Update 03.01.25 NHSE have confirmed support for utilisation of capital funding on a range of proposed estates projects. Paper to EMT in January.	**A**	**31/03/25**
08/11/23	CYP Collaborative continues to develop. System workshop scheduled for 15/12/23 to progress system working and opportunities for stakeholders to align resource. Workshop completed 15/12/2023. Priorities for workstreams proposed and will be established within January 2024 Update 19/06/24 workstreams established and scoping vision for priority areas. Update 28.08.24 Case for change in development. For presentation to Executive team in October 2024 Update 31.10.2024 case for change agreed. Further work required to develop screening tools and develop business case to be taken through prioritisation process Update 03.01.25 Progress continues on business case for prioritisation review in March	**A**	**31/03/25**
02/01/24	Integrated Front Door further role out to include NSFT direct referrals scheduled to commence April 2024	**B**	**Complete**

02/01/24	Recruitment to mental health care navigator team commenced. Some delays due to organisational restructure – Project Manager in post, recruiting to programme lead role.	**B**	**Complete**

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

Ambition 4: Transforming Mental Health Services

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

Risk Scores

Unmitigated			Mitigated			Target		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
3	**4**	**12**	**3**	**4**	**12**	**2**	**4**	**8**
Risk appetite:					**Risk tolerance:**			

Controls	Assurances on controls
• System wide governance framework in situ • Finance & planning working group regularly to drive robust financial arrangements and deliver planned MHIS investment. • NSFT lead CMHT, CRHT and Inpatient plan transformation programmes.	**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

- **Wait lists:**
  - 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
- **System:**
  - Organisational development required to drive forward 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.
  - Development and true integration of care pathways is at an early stage. Organisational capacity potentially limited to meet the needs of this area of work while wider NSFT internal CMHT, CRHT, Inpatients transformation plans take effect.
- **Operational:** collaboration to enable access and easily navigable mental health services, is at an early stage of development.
- **Digital:** 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.
- **Workforce:** 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.
- **Financial:** Living wage and national insurance uplifts impact on VCSFE providers and resulting in potential financial instability or reduced operational capacity
- **Restructure:**
  - ICB restructure commenced July 2023 impacting on team capacity until March 2024.
  - NSFT Restructures underway impacting on delivery until April 2025

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**
25/11/24	**Inpatient -** NHSE launched the national inpatient programme in April 2024. NSFT have now developed their transformation plan to support the delivery of this programme of work. NSFT, SNEE and N&W ICB will agree this plan and embed into the NHS contract Service Development Improvement Plan (SDIP) with oversight of delivery at Service Performance Review group (SPRG)	**A**	**31/03/2025**
25/11/24	**Community -** NSFT have now developed their transformation plan to support the delivery of this programme of work. NSFT, SNEE and N&W ICB will agree this plan and embed into the NHS contract Service Development Improvement Plan (SDIP) with oversight of delivery at Service Performance Review group (SPRG)	**A**	**31/03/2025**
25/11/24	**Crisis and UEC** - NSFT have now developed their transformation plan to support the delivery of this programme of work. NSFT, SNEE and N&W ICB will agree this plan and embed into the NHS contract Service Development Improvement Plan (SDIP) with oversight of delivery at Service Performance Review group (SPRG) • 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 (currently meeting trajectory) • Improving Dementia Diagnosis • Reducing Out of Area Placement (OoAP). (Currently meeting trajectory)	**A**	**31/03/2025**
25/11/24	**Primary Care** - Mental health Practitioners in Primary Care: NSFT are currently leading on the redesign of the MHPPM model, Additional funding of circa 650K has been redirected to support the shortfall in funding identified following the CT Stocktake in April 2024. NSFT currently engaging with Primary care and the ICB to deliver an agreed plan prior to roll out. Concerns raised by primary care concerning: • Clarity and responsiveness of NSFT crisis/community pathways • Rejected referrals for CRHT and CMHT • 111 Mental Health Option Clinical Line	**A**	**31/03/2025**
25/11/24	**Access Pathways** - Single point of Access NSFT have stopped operating a N&W Single Point of Referral across N&W locality as per commissioned service. N&W ICB issued a Contract Performance Notice on 24/10/24, re. failure to effectively deliver Single Point of Access and Crisis Resolution Home Treatment Team services. Work is currently ongoing to support NSFT to implement the required service improvement plans.	**A**	**31/03/2025**

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

Objective 5: Transforming care in later life

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

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

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

Gaps in controls or assurances

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

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

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
01/07/24	Frailty Attuned Acute Care workstream agreed unified frailty scoring for use across system.	**B**	**19/07/24**
01/07/24	Dementia Awareness education sessions delivered for Primary Care staff.	**B**	**08/07/24**
01/07/24	Population data analysis complete; social isolation and loneliness and falls prevention Joint Strategic Needs Assessment (JSNA) groups established.	**B**	**19/07/24**
01/07/24	Frailty Attuned Acute Care workstream agreed unified scoring tool for use across the ICS in July 24 with pilot of Clinical Frailty Scoring tool to start Sept 2024.	**B**	**02/09/24**
01/07/24	Joint Care home support group established including wider stakeholders.	**B**	**06/09/24**
01/07/24	Facilitating an ICS Dementia Round Table event with findings to be shared with stakeholders to identify priority areas.	**B**	**25/09/24**
04/11/24	Dementia Charter to be signed by all statutory organisations and self-assessments completed by all providers to understand gaps in service	**A**	**31/03/25**

	delivery and what organisations must improve. 6/7 signatures received although executive leads have been nominated.		
04/11/24	Winter Communications Plan for developed and finalised ahead of implementation.	**B**	**Complete**
04/11/24	Joint Strategic Needs Assessment for Social Isolation and Loneliness completed to inform systemwide work and NCC commissioning for 2025.	**G**	**31/03/25**
04/11/24	Ageing Well Programme Blueprint developed to establish priorities and align workstreams	**A**	**31/01/25**
04/11/24	Develop appropriate system Dashboard with all core workstream metrics	**A**	**31/03/25**

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

Objective 6: Improving urgent and emergency care

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

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

Controls	Assurances on controls
• **Strategic Oversight:** UEC Programme Board oversees non-elective flow and monitors a system wide transformation programme to improve the responsiveness of our Urgent and Emergency Care pathways to ensure patients receive the right treatment in the right place at the right time; that timely discharge for non-elective patients from inpatient hospital and community beds takes place and that appropriate discharge capacity is available to meet the discharge demand from health settings. Associated clinical risks are reviewed monthly by the ICS Clinical Risk Review Panel (CRRP). The panel monitors and through SCC puts in place control measures to mitigate risks and issues, this risk and issues log is shared with the UEC Programme for assurance purposes. • **Business Continuity:** ○ All Trusts, including community, 111 and primary care have business continuity plans in place to manage the operational response to in-year peaks in demand and periods where demand exceeds 'business as usual' levels. ○ A seven-day System Control Centre (SCC) and East of England Ambulance Service (EEAST) System Oversight Cell (SOC) are in place. The SCC and SOC work alongside Providers to coordinate operational responsiveness when individual or multiple providers are unable to meet demand in a timely and safe way and to escalate to appropriate levels of management when decisions to mobilise additional resources are needed. **Specific controls to appropriately manage urgent and emergency care demand ensuring patient's needs are met:** • **Hospital 'Admissions Avoidance':** A range of 'Admissions Avoidance' schemes are in place across N&W to ensure that	**Internal:** ICB Executive Management Team; Norfolk and Waveney UEC Programme Board; Three UEC Alliances aligned to each acute hospital system; System Control Centre (SCC); Clinical Risk Review Panel (CRRP) **External**: ICS Executive Management Team (CEOs Group); Trust Boards; NHSE Regional Strategic Oversight

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 temporary escalation spaces / surge beds through internal operational changes. 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. ○ **Winter 24/25 plans for peak period of demand:** The Director of Resilience working through SCC has developed a plan to seek assurance from all providers that there is sufficient resource, grip and control over the peak period of demand to maintain flow thus reducing the potential for harm from any delays in receiving treatment as a result of high demand. The Director of UEC has set up a specific initiative using the Urgent Care Coordination Hub (UCCH) and Virtual Ward. It provides additional support to our care homes and their residents to prevent avoidable conveyance and admissions to hospital which in turn reduces the risk of spreading infection by moving patients from one institution to another when not necessary. • **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 April 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 a Director of Resilience on a fixed term basis until the end of March 2025 when we expect system pressure due to winter peak of respiratory infection to have reduced. This post is responsible for coordinating and supporting operational response and escalation to system pressures. There is currently no funding to support this role from April 2025, therefore this function will need to be provided through the existing ICB UEC Team structure.
- 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**

Jan 25 update	The system continues to fall below the 78% threshold set within the national recovery strategy and current trend suggests this will not be met by the end of March 2025. UCCH has now been recurrently funded which will ensure the admissions avoidance work that it has been undertaking will continue and the overall activity trend over time of ambulance dispatch in Norfolk and Waveney will continue to be flat. In addition, the UCCH has launched a specific initiative to support care homes and their residents to prevent unnecessary conveyance and admission to hospital as part of the winter 24/25 plans.		
16/03/23 **Jan 25 update**	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. As above – and in addition the uptake of support from UCCH for ambulance crews on scene is increasing which in turn releases crews significantly faster to return to a "ready state" to attend further calls.	**A**	**31/03/25**
16/03/23 **Jan 25 update**	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. Nationally and regionally the target has been revised down to 20 beds per 100,000 and Norfolk and Waveney is performing well in terms occupancy and capacity with a focus for our virtual ward (VW) on admissions avoidance. For the peak of winter VW is also prioritising support to care homes and their residents recognising they are some of most vulnerable in the population who are at greater risk of avoidable conveyance and admission to hospital.	**A**	**31/03/25**
29/8/24 **Jan 25 update**	The ICB has committed to recurrently supporting the Unscheduled Care Coordination Hub – this is a core deliverable in the Joint Forward Plan (JFP). The Unscheduled Care Coordination Hub will better coordinate admission avoidance activity and deliver right care, right place, whenever the need arises which has demonstrated a reduction 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. With the commitment to recurrent funding in place plans are now progressing to increase the substantive workforce in the UCCH from April 2025 with recruitment underway.	**A**	**31/03/25**

Visual Risk Score Tracker – 2024/25

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

Objective 7: Elective recovery and improvement

BAF07 (Inphase ref 00000010)				
Risk Title	**Elective Recovery**			
Risk Description Please include any collaboration and partnership aspects of the risk.	The number of patients waiting for elective treatment in Norfolk and Waveney grew significantly during the pandemic. There is a risk that this cannot be reduced quickly enough to a level that meets NHS Constitutional commitments. This would also contribute to poor patient experience and may lead to an increased clinical harm for individual patients resulting from prolonged waits for treatment, including waits for diagnostic tests and for cancer care.			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Andrew Palmer	Commissioning & Performance	Andrew Palmer	**01/12/2022**	**31/03/2025**

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

Controls	Assurances on controls
• The Elective Recovery Board meets bi-weekly to oversee all workstreams to improve performance and reduce harm. • As of December 2024, the Elective Recovery Board is transitioning into the Provider Performance and Planning Oversight Group (PPPOG), which will report into the Scheduled Care Board (SCB). • Each Provider has completed waiting list validation, all patients clinically prioritised. Each Provider is expected undertake a cycle of waiting list validation every 12 weeks. • Unified process of clinical harm review and prioritisation in line with national guidance. • Workstreams in place to expand capacity, share learning, maximise efficiency and reduce variation in waiting times, including through mutual aid, and to transform care pathways to accelerate elective recovery, each led by a chief operating officer or medical director. • EoE funding secured for mutual aid administrative support to contact long wait patients to confirm availability, signpost to While You Wait website and confirm if transfer to alternative provider via mutual aid. • EMT agreement to commission elective capacity through independent sector providers. • Introduction of national PIDMAS system to assist with offering alternative choice of provider to long wait patients with non-recurrent funding allocated to assist with travel costs. • Extending the use of insourcing and outsourcing opportunities to create capacity. • New theatre capacity opened at NNUH in January 2024 for Paediatrics. • Additional orthopaedic capacity at NNUH (NaNOC) opened in July 2024 and JPUH is due to open spring 2025. • Cancer: Local engagement to raise awareness of signs/ symptoms of cancer and to encourage early presentation to Primary Care/linking with health inclusion groups and areas of deprivation. Non-Specific symptoms (NSS) pathway is in place via the system cancer Rapid Diagnostic Service and the “C the Signs” Primary Care Clinical Decision support tool to improve	<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-from Tier 2 to Tier 1 in November 2024. NNUH remains in Tier 1 Internal: Weekly and monthly performance metrics for each workstream monitored through the monthly Provider Performance and Planning Oversight Group from December 2024. Additional oversight and monitoring for impact on cancer pathways via the EOE Cancer Alliance Programme Board. External: Trust Board Governance processes and returns to NHSEI, National contract monitoring by NHSEI and Scheduled Care Board. Weekly Tiering KLOE return from Trusts to system, region, and national teams, monitored through fortnightly Tiering meetings.

quality and reduce variation in urgent suspected cancer referrals. • There is also insufficient oncology medical staffing across all providers to meet current demand. Additional transformation resource provided to support short-term locum capacity and mutual aid arrangements in place. Duty of candour letters sent where appropriate. Progression of non-medical multi-professional skill mix redesign projects, international recruitment and redesign of the system oncology services via the Speciality Oncology Network. Escalated to People Board. ICB Quality team supporting trusts to prioritise patients approaching the end of adjuvant treatment window to prevent harm occurring/provide appropriate support while waiting.	

Gaps in controls or assurances

- Cessation/ reduction of elective activity due to RAAC plank works at JPUH and QEH.
- Impact of industrial action in the acute and primary care sectors on elective recovery and administrative resources to support validation and booking processes.
- Critical incidents declared at trusts due to intense pressure on emergency capacity.
- Staffing challenges at the Trusts with consultant sickness and vacancies.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
19/11/24	• All trusts submitted zero 104-week waits for end of March 2024 • As of 11th November 2024: o NNUH have 146 65ww who will not be treated by 22nd Dec 2024. o JPUH have 37 65ww who will not be treated by 22nd Dec 2024. o QEH have 1 65ww who will not be treated by 22nd Dec 2024.	**A**	**31/03/25**
22/04/24	• New elective orthopaedic theatre capacity will come onstream at the JPUH in Spring 2025. • The NNUH orthopaedic centre (NaNOC) opened in July 2024 Recommend maintain risk rating due to steady decrease in number of 52-week breaches, clearance plans in place and opportunities for new capacity coming on stream over the summer.	**A**	**01/06/25**
22/04/24	• Trusts continuing to use ICB staff to contact patients and make arrangements to transfer patients to alternative providers including ISPs.	**A**	**31/03/25**
20/11/24	• Additional detail added re associated cancer risk and mitigations.	**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	12	12	12	12			
Change	↓	→	→	→	→	→	→	→	→			

Objective 8: Improving productivity and efficiency

BAF08 (Inphase ref 00000027)				
Risk Title	**Achieve the 2024/25 financial plan**			
Risk Description Please include any collaboration and partnership aspects of the risk.	IF the ICB does not deliver the 2024/25 Financial Plan of a break-even position, THEN the ICB may not be able to maintain spending on current levels of service, or to continue with plans for further investment. This may lead to a reduction in the levels of services available to patients.			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Steven Course	Finance	Emma Kriehn Morris	**10/05/2022**	**31/03/2025**

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

Controls	Assurances on controls
• Monthly monitoring of risks and mitigations, reported to NHSE/I. • Detailed plan for 2024/25 approved by Board and submitted to NHSE/I as part of the wider ICS plan. • Monthly Finance Report presented to Finance Committee and Board. • Analysis and understanding of underlying recurrent position, including drivers of the deficit on a monthly basis. • ICS Medium Term Financial Model has been developed on consistent assumptions. • Key lines of Inquiries (KLOEs) have been reviewed and provide assurances as to strong financial governance and best practice adoption. The ICB is part of the Triple Lock process with self-imposed reduced limits of £25k.	**Internal:** Board Reports and Minutes, Audit Committee reports and Internal Audit work plan, Finance Committee reports, Executive Management Dashboards, Delegated Budget manager review, Internal monthly review of Risks & Mitigations. **External**: ICB assurance process, early flagging of risk with NHSE/I and Protocol conditions.

Gaps in controls or assurances

Financial Plan Delivery:

- No contingency reserve in plan;
- £51m of unmitigated risks against the plan at the point of final submission; As at M08 (November 2024) the £51m planning risks have been re-assessed to £12m (M07 £16.3m) on a probability basis.
- In addition to the revised £12m Planning Assumption Risks, a further £2m (M07 £0.1m) of Net Mitigations have been noted resulting in a Total net risk of £14m (M07 £16.2m).
- The financial position assumes full delivery of the unidentified Efficiencies equating to £8.1m (M07 £8.1m). Whilst this remains a significant risk to the delivery of the in-year financial plan, work is ongoing to address mitigations arising from potential over-performance income from the Elective Recovery Fund for Independent Sector activity.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
01/04/24	Review of monthly and year to date performance and assess forecast out-turn evaluated risks and mitigations.	G	**Monthly to 31/03/25**
31/07/24	Review of all mitigations and recovery actions to support the financial delivery to plan.	A	**Monthly to 31/03/25**

Visual Risk Score Tracker – 2024/25

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

Norfolk and Waveney
Integrated Care Board

Agenda item: 21

Subject:	**Audit and Risk Committee Report**
Presented by:	**David Holt, Audit and Risk Committee Chair**
Prepared by:	**Amanda Brown, Associate Director of Corporate Governance**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**29 January 2025**

Purpose of paper:

To provide the Board with an update on the work of the Audit and Risk Committee for the period September 2024 to December 2024.

Committee:	Audit and Risk Committee
Committee Chair:	David Holt, Non-executive Member
Meetings since the previous update on 17 July 2024:	*Bullet pointed details of each committee meeting held since the last report to Board, including dates and times.* • ***10 December 2024***
Overall objectives of the committee:	This Committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.
Main purpose of meeting:	Main purpose of this meeting was to report on key areas to the Committee providing information and assurance. The main issue the Committee would like to highlight to Board was the presentation by HR as below: **HR Briefing on potential risks to the organisation post restructure** This presentation discussed from a HR perspective the impact on some of the key risks on the BAF following the restructure. Key issues noted included staff workload and capacity concerns as well as how risks are managed and time frames for addressing. An action plan to address risks, how these are managed and the time frame for completion

	needs to be appropriately considered to ensure and evidence a clear response to risks. The role of place within the organisation was also discussed and it was agreed that it needed to be better understood both internally and within the voluntary sector and providers of place-based approach. **Cyber Security** The meeting discussed cyber security and the increased risk faced across all sectors. The Committee has asked for this to be an item for discussion on a future meeting agenda. It was flagged that this was a key issue for all sectors and need to raise the profile of cyber security across the organisation. The Committee asked that these items be highlighted to Board. In addition, the Committee discussed the following items: *Briefing by Executive Director of Finance* *Internal Audit Progress Report* *Counter Fraud Service Progress Report* *External Auditor's Report* *Losses & Special Payments* *Information Governance Senior Information Risk Officer Report* *Board Assurance Framework* *Committee Self-assessment part 1* *Committee Terms of Reference* Committee Annual Plan *Draft Annual Report and Accounts – timetable and themes* The following items were presented to the Committee for information: o Conflicts of Interest Committee Update o Internal Audit Reports with reasonable assurance or above and advisory reports o Procurement update and Tender Waiver Briefing o Report on any urgent Board decisions and non-compliance with the Standing Orders o TIAA Client Briefing Notes
BAF and any Board Operational risks relevant / aligned to this Committee:	BAF reference numbers and detail of any Board Operational Risks (BORR) set out here. None
Key items for assurance/noting:	See HR presentation to Committee above
Items for escalation to Board:	N/A
Items requiring approval:	N/A
Confirmation that the meeting was quorate:	The meeting was quorate

Norfolk and Waveney
Integrated Care Board

Agenda item: 25

Subject:	**Health and Wellbeing Board and Integrated Care Partnership Committee Report**
Presented by:	**From ICP/HWB to note**
Prepared by:	**Steph Butcher, Communities Business Lead Central, Norfolk County Council**
Submitted to:	**Integrated Care Board – Board Meeting**
Date:	**29 January 2025**

Purpose of paper:

A report 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 5th December 2024.

Committee:	Health and Wellbeing Board and Integrated Care Partnership
Committee Chair:	TBC
Meetings since the previous update on	5th December 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.

Main purpose of meeting:	The meeting held on 5th December 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** **New members** We welcomed new members to the HWB/ICP meeting - Ian Wake who has been appointed as the new Executive Director for Adult Social Care at Norfolk County Council, Assistant Chief Constable Chris Balmer who is the new representative from Norfolk Constabulary, Tim Gardiner who has been appointed as the new Chair of the Voluntary Sector Assembly and Nicholas Pryke who is the new representative from Suffolk County Council **Urgent Matters Arising** None **Annual Report of the Norfolk Drug and Alcohol Partnership (NDAP)** This item updated members on the NDAP Board priorities, progress and work underway and gave a brief overview of the equivalent Suffolk Combating Drugs Partnership (SCDP) The positive, collaborative work of the partnership was highlighted in a report from the Local Government Association on progress against the national drug strategy. The partnership has been extended to cover further areas of work including setting up a new group to focus on children and young people. A joint needs assessment has been undertaken and new priorities considered. There has been progress on a number of workstreams. A new delivery plan was developed and signed off by the NDAP Strategic Group. Outcomes from the Joint Needs Assessment were considered by the NDAP Strategic Group in October 2024 and new priorities until March 2026 agreed, while maintaining three existing priorities, with all of the priorities covering children and young people as well as adults: ▪ Embedding the voice of lived experience across the partnership. ▪ Developing a multiagency response to improving outcomes for those with complex needs.

	▪ Responding to the emerging risks of changing drug trends in the county (e.g. from ketamine and synthetic opioids). ▪ Joint priority with SVD: tackling exploitation, e.g. from County Lines and cuckooing. ▪ Continuing work on dual diagnosis pathways. ▪ Continuing to improve rates of continuity of care from prison to community. ▪ Continued workforce development. Some of the following points and comments were discussed: Norfolk had previously had a high rate of alcohol and drug-related deaths; this had improved but was beginning to increase again. Members heard that the Drug and Alcohol Panel identified physical ill health as a link to the increase. People were accessing support later when they already had physical ill health. The only change to the funding was the supplementary funding; drug and alcohol funding would remain as it was. Alternative options have been discussed with services if the supplementary funding was not available. Following a member's question, it was said that the voluntary sector input was important, and that additional information would be shared with members on the voluntary sector members of the NDAP. There was a ketamine clinic at the Norfolk and Norwich University Hospital Trust that had seen over one hundred people. The provision was increased to include children under sixteen and people who fall into other catchment areas. **Better Care Fund 2023-25 Q2 Report** The Health and Wellbeing Board (HWB) holds the responsibility for overseeing and signing off the Better Care Fund (BCF), plans each year and for signing of each of the quarterly reports requested by the national Better Care Team. The report presented included Q1 report and Q2 reports for sign-off. The quarter one report can be found here and was attached for sign-off by the Board focussed on our Additional Discharge Fund spend and activity. The report is formed of three tabs: **1. Guidance:** This tab offers guidance on completing the report. **2. Cover:** This tab shows who is submitting the report, when it is going to Health and Wellbeing Board, and has validation boxes, which are green when the report is completed. **3. Spend and Activity:** This tab focusses on the thirteen schemes that we fund via the Additional Discharge Fund. It asks for the actual expenditure to date, the outputs delivered to date where required, and whether there have been any implementation issues.

	The quarter two report, which can be found here, looks at the National Conditions, our Capacity and Demand figures, our performance against metrics and our spend and output activity across all four income elements of the BCF. The report confirmed that we are meeting our National Conditions, and that our outputs and spend are on track. The report is formed of six tabs: **1.Guidance:** This tab offers guidance on completing the report. **2. Cover:** This tab shows who is submitting the report, when it is going to Health and Wellbeing Board, and has validation boxes, which are green when the report is completed. **3. National Conditions:** This tab asks us to verify that we have met the BCF National Conditions, which we confirm. **4. Metrics:** This tab looks at the four national metrics, and our performance against them. **5.1 C&D Guidance and Assumptions:** This tab offers guidance on completing the next. **5.2 C&D H1 Actual Activity:** This tab looks at our actual Capacity and Demand activity for across intermediate care services, both for hospital discharge and step up from the community. **6a Expenditure Guidance:** This tab offers guidance on completing the next. **6b Expenditure:** This tab looks at all of our BCF spend. It asks for the actual expenditure to date, the outputs delivered to date where required, and whether there have been any implementation issues. Activity and expenditure profiles are in line with original profiles submitted in the 2024-25 planning return that was approved by HWB in June 2024. This report confirms that we have met all four National Conditions, and three of the key metrics. **Becoming a 'Marmot Place': West Norfolk's work with the Institute of Health Equity** The Board received an update on the commissioning of the University of College London (UCL) Institute of Health Equity (IHE) led by Professor Sir Michael Marmot for the Borough Council of King's Lynn and West Norfolk to become a Marmot Place. Usually, the work to become a Marmot place is led by public health teams in unitary and two-tier settings. However, it has been agreed between the three parties that the Borough Council of Kings Lynn and West Norfolk will be the lead authority for this work, with the strong partnership support from the public health team and the ICB. This arrangement recognises the two-tier arrangements in Norfolk and the role of the West as a distinct place in delivering health equity in its area. The Borough Council of King's Lynn and West Norfolk (BCKLWN) have identified that long standing and persistent health inequalities within the Borough must be a priority. There have been and continue to be efforts to reduce these inequalities but there is a need to accelerate actions, prioritise the major drivers of poor health and inequalities and strengthen partnerships for health equity.

	The Marmot review 2010 and the 10-year on review identified eight principles to reduce health inequalities, they are: • Give every child the best start in life. • Enable all children, young people, and adults to maximise their capabilities and have control over their lives. • Create fair employment and good work for all. • Ensure a healthy standard of living for all. • Create and develop healthy and sustainable places and communities. • Strengthen the role and impact of ill health prevention. • Tackle racism, discrimination, and their outcomes. Pursue environmental sustainability and health equity together. The work with the IHE will take place over two years and will comprise of four areas: 1. Assessment of the health equity system and data on health inequalities and key social determinants of health. 2. Development of recommendations, action plans and monitoring systems. 3. Exploring and collaborating with partners across the whole system. 4. Advocacy and commitments across the whole system. The IHE will initially be involved with this work for two years, but this is a long-term piece of work that aims to provide systemic change in the West of Norfolk to improve health equity across all sectors, including housing, education, early years, health care, business and the economic sector. Reducing deprivation and mitigating its impacts is the central theme for all Marmot Places. By focussing on the eight Marmot principles, the outcomes of the work in the West of Norfolk will include system change and culture shifts - via strong governance, accountability, leadership, partnerships, networks, training/capacity building and advocacy. • A member shared their experience of being part of Marmot Place, noting the difference that it made and the value that came out of the deep dive. • It was requested that the ask to join the advisory board was sent to the Norfolk Care Association, the governors of the QEH, and the youth council that had recently launched. • Learning from the programme would be brought to the Health and Wellbeing partnerships, Place Boards and would be shared with the community more generally. Part of the commitment to the programme was to share what had been learned. • Members expressed their support towards Kings Lynn and West Norfolk becoming a Marmot Place. • East Suffolk Council was expected to become a Marmot Place next year.

- Volunteer sector members would likely be drawn from the Health and Wellbeing partnership, and involvement in the advisory board was welcomed from across the system.

Integrated Care Partnership

Launching the Norfolk & Waveney Health Inequalities Commitment

This is a standing item to update on progress being made to implement the actions detailed in the Integrated Care System (ICS) Health Inequalities Strategic Framework for Action and to ask the Integrated Care Partnership (ICP) members to pledge their organisation's commitment to implementation and to provide oversight on the uptake.

At the ICS Conference in October 2024 a 'Health Inequalities Commitment' was launched which asked organisations and partners from across the system to commit to a number of actions to further strengthen system action on addressing health inequalities

This asked organisations to commit to four key actions, as highlighted below:

1. To lead your organisations to act and address inequalities by developing a network of health inequalities advocates and identifying **a Health Inequalities Lead** in your organisation.
2. To **connect with communities** by prioritising listening to seldom-heard voices and meaningfully engaging with underserved groups.
3. To equip your teams and services to be accessible for all by undertaking a **self-assessment** (so that we may develop a useful Resource Hub based on what the system needs), addressing data gaps and undertaking a workforce training needs analysis.
4. By **embedding** addressing health inequalities in all you do and report progress on your actions, share best practice and become a 'Health Literacy Friendly' organisation.

To support organisations to fulfil these commitments the ICS Health Inequalities Steering Group, via its Coordination Group, will develop a number of practical tools and resources.

A temperature check was undertaken and positively, many organisations have indicated that they are already taking action around the Commitments, suggesting there is much we can learn from each other if we can establish the forums and mechanisms to communicate and collaborate.

Members generally endorsed the Norfolk & Waveney Health Inequalities Commitment

Update on driving integration through system wide training opportunities

This is a standing item presenting an update to the Integrated Care Partnership (ICP) on integration opportunities through system wide training, education, and leadership opportunities.

Norfolk Economic Strategy and Norfolk Employment & Skills Board

The new (draft) economic growth strategy for Norfolk (which will be known as the "Local Growth Plan" builds on the Norfolk & Suffolk Economic Strategy and other local strategies. The strategy will be an overarching document for Norfolk, to encompass thematic, place based and sector strategies to help grow the local economy and support the people who live and work in Norfolk.

Among the key priorities within the strategy is the focus on People and Skills

The Norfolk Employment & Skills Board will be responsible for the delivery of the strategic objectives outlined in the local growth plan and Strategic Skills plan.

An update will be provided to the ICP in early 2025 on the progress of these discussions.

NHS Digital Skills passport

Conversations continue to take 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 NHS Digital Staff Passport service is currently piloting the service with a limited number of NHS trusts, carefully selected based on critical eligibility criteria. The pilot focuses on two specific staff groups:

- Temporary movers, who remain employed by their current NHS employer and will work at another NHS trust for an agreed period.
- Postgraduate doctors in training, who rotate between trusts as part of their training programme.

NHS Trusts in the East of England region are not included in the pilot at this time.

Volunteering for Health Programme: Digital Learning Academy Initiative

The Integrated Care Board (ICB), Norfolk County Council (NCC), and other partners have successfully secured funding from NHS England,

NHS Charities Together and CW+ for the 'Volunteering for Health' programme across Norfolk and Waveney.

This programme encompasses several objectives, one of which is the establishment of a 'Digital Learning Academy' for volunteers and volunteer managers.
The Digital Learning Academy will serve as an online portal providing accessible training for all volunteers and volunteer managers.
It is anticipated that once the platform is operational, there will be opportunities to incorporate additional modules to meet further training requirements.

Social Care Institute for Practice Excellence Board

Following a review in early 2024, the purpose of the SCIPE Board has been revised. The Board has been renamed to the "Norfolk Strategic Social Care Network" and will now focus on the following key areas:

- Sharing Key Service Updates: Providing regular updates on social care services.
- Discussing Opportunities for Collaboration: Identifying and exploring opportunities for joint working.
- Agreeing on Actions to Address Service Barriers: Formulating and agreeing on actions to overcome barriers within services.

The meeting was in November 2024, and an update will be provided to the ICP on joint learning opportunities and development across both adult and children's social care where identified.

Norfolk & Waveney Learning Opportunities: Fortnightly Online Learning Sessions

Norfolk & Waveney Learning Opportunities provide a complimentary fortnightly online learning hour, accessible to all staff, including clinical and non-clinical personnel, social care workers, healthcare professionals, and students.

Digital Placement System: Educators Update

Currently, the ICB lacks comprehensive oversight regarding NHS student placement capacity. To address this issue, the development of a Digital Placement System is underway.

Norfolk Initiative for Coastal and rural Health Equalities (NICHE)

The Norfolk Initiative for Coastal and rural Health Equalities (NICHE), Anchor Institute, is a co-ordinated programme of activity to establish effective workforce intelligence networks across the Norfolk and Waveney Integrated Care System
NICHE will provide a coordinated approach to evidencing the value, benefits, outcomes and impacts of research, evaluation, and innovation for the East of England, and beyond.

Driving Integration through Digital, Data and Technology

This report provides an update on the work that has progressed on the Shared Care Record (ShCR) since the last update in September and also a proposed roadmap of area's that would be helpful to share with the partnership.

The roadmap below has been updated:

Cloud telephony has been installed in the majority of GP Practices in Norfolk & Waveney, giving the opportunity for patients to opt for a call back from the practice rather than waiting in a queue. Practices have more lines and more reporting via dashboards, so they can see call volumes, numbers waiting and other information that allows them to manage their staff resources.

The first step of an ICS wide intranet will go live by the end of October. The intranet will be live first in primary care – GP Practices, Pharmacy, Optometry and Dentists, and in Care Homes before being rolled out across the ICS.

The campaign to encourage sign up to the NHS App continues with many events taking place across the area. The NHS App uptake in Norfolk and Waveney is 55% which is lower than the East of England average of 58% and the national average of 61%.

40 Care Homes have the remote monitoring technology deployed, and staff are confident in taking observations. Linked GP Practices have access to the observations on a dashboard.

A project is underway with James Paget Hospital and a number of care homes to electronically track Red Bags when care home residents are admitted to hospital. The Red Bag scheme is designed to ensure that care home residents have all notes and personal belongings with them when they go to hospital, and that they return to the home with the same belongings.

A bot to process repeat prescription requests has been developed and is working in around twenty practices across Norfolk and Waveney. The bot is trained to follow the protocols devised by the Medicines Management Team in the processing of repeat prescription requests and will manage all compliant requests, leaving more complicated requests for controlled drugs or patients requiring review to the practice staff.

Phases 1 and 2 of the Norfolk & Waveney Shared Care Record (NWShCR) Project are complete and the record is accessible in Norfolk County Council, all three Acute Hospitals, the community providers, Norfolk & Suffolk Foundation Trust (NSFT), NHS 111, GP Practices, and the Out of Hours Service. Work is in progress for Voluntary, Community and Social Enterprise (VCSE) access via the Social Prescribing system.

An evaluation of the Norfolk & Waveney Shared Care Record Project has been completed, as well as two surveys by Healthwatch, one for staff and one for patients.

Phase 3 of the project will begin soon, the focus of which will include work on compliance with the NHS England minimum viable standard for Shared Care Records version 2, for delivery by March 2025, and ensuring the Professional Records Standards Board core information standards are met.

To ensure the partnership is aware of all of the digital activities being carried out across the ICS they are proposing that the items below are considered at each meeting over the next 12 months:

- Overall Digital Roadmap - All meetings
- Generative AI including Ethics and Phase 3 of the Falls Prevention Work and the impact on the ICP. - March 2025
- Information Governance and sharing of data across the system – June 2025
- Assistive Technology and Virtual Wards - September 2025
- Data Hub and Population Health Management - December 2025

Preparing for Seasonal Pressures: ICS Framework for 2024/25

This report informed the ICP of significant steps to ensure preparedness this winter. In developing the plan for the winter period, there is engagement with a wide range of teams and key external partners.

As with last year, our ICS has not experienced a summer where pressures have abated. We also face the additional challenge this winter of pressures on budgets, with the combination of additional demands and unit prices meaning we are experiencing financial pressure in the 2024/25 financial year and beyond.

	Priorities for Winter 2024/25: Publication of national expectations on social care during winter, by the Department of Health and Social Care (DHSC), was received on 17th September 2024. The letter outlines short-term priorities for the winter period, including: • A 'home first' approach to support independence for as long as possible. • A focus on ensuring high-quality care. • Involvement of people receiving care and their families and carers. NHS England (NHSE) have also set national expectations for the winter period (16th September 2024) that will have ramifications for NHS organisations and wider ICS partners, in both the planning and delivery of support. These cover: • Providing safe care over winter. • Supporting people to stay well. • Maintaining safety and patient experience. • Using evidence-based practice. The NHS remains in a period of pressure around urgent and emergency care (UEC) and planned care provision. Alongside continued delivery of existing priorities, such as elective care including for those who have experienced a longer wait for treatment, the NHS is focussed on delivering year two of the UEC Care Recovery Plan (part of a submitted annual operating planning). As we enter the second half of the year the focus remains on: • Delivering a 30min response for category two ambulance patients. • Delivering an emergency department standard of 78% of patients being admitted, transferred, or discharged within 4hrs of arrival, with a stretch to 80%. Framework for action (ASSD): ASSD has developed a winter framework, building on previous years successful approaches. This framework reflects the following increasing priorities: • Additional focus on intermediate care – given its vital importance to supporting people to remain at home, and return home after crisis, during winter. • Managing demand and capacity within limited resource. • Prioritising proactive intervention to support people to remain independent in winter. With these refinements, the key strategic priorities for ASSD winter framework are: • Meeting people's needs (to remain at, or return to, home). • Resilient communities. • Supporting our workforce, and • Working together in winter conditions. Framework for Action (NHS): For the NHS, and wider ICS partners involved in urgent and emergency care, delivery plans over the last 12 months have been developed to support this winter, leading to alternative access to healthcare, and alternatives to the emergency department if hospital care is required. Planning has also looked to

	increase capacity for patients on discharge pathways. Three key areas of winter planning are in place: • 9 winter focus areas. • UEC Board Priorities. • Ten high impact interventions. Since last winter, partners have been implementing plans that have placed our services in a strong position ahead of seasonal pressures this year, including: • Improvements and investment in the community-based intermediate care offer that will support residents this winter, including a forecast increase in the number of people Adult Social Services will support back to their own home of c.5-10%, on top of a c.6% increase last year. • Continued steady decrease in the number of cases on the Interim Care List to one of its lowest points since the COVID-19 pandemic, which indicates there is good capacity within the local Home Care sector. • In advance of this winter, we have contacted over one thousand residents at high risk of a fall and offered interventions to reduce the likelihood of a serious fall. • Continue to deliver our unscheduled care coordination hub, supporting the ambulance service to enable the right care in the right place. • Improving processes that support patient flow, timely access and transfer or care. • Ensure the annual vaccination programme of COVID and seasonal flu is delivered across Norfolk and Waveney. • Improving flow within our acute and community hospitals to maximise longer term outcomes and support with improvement in patient flow. Some of the following points and comments that were discussed are: • Following a member's question, it was noted that vaccinations remained a key part of the winter planning programme, and the Health Protection Assurance Board looked at vaccination uptake rates. • A member shared that areas across the system were already feeling pressurised and highlighted the importance of implementing plans before the winter peak. • A member asked if Norfolk Care Association could be involved in communication and engagement with the decisions made in acute hospitals. In response, it was noted there was a commitment to make sure there was engagement at a variety of levels. • Resilience of services was important but raising awareness of likely events was also useful to reduce the pressure on the system.

The Chair noted the importance of this work and how it had developed over the years. This year would be especially challenging as there was no winter funding being made available.

2023/2024 Learning from Lives and Deaths: People with a Learning Disability and Autistic People (LeDeR) Annual Report

This report covers the reporting period from 1st April 2023 to 31st March 2024. It is the responsibility of all Integrated Care Boards (ICBs) to have an established LeDeR programme within their system.

Sadly, people with learning disabilities and/or autistic people continue to have a much shorter life expectancy, with the average being over 20 years younger than the general population.

Mortality data presented in the LeDer annual report, which can be found here, shows that the leading single cause of death of those reviewed was aspiration pneumonia and pneumonia, followed by cancer. The median age of death is 62 years old, which reflects the current national picture.

This has informed targeted work around early diagnosis of bladder cancer, including a review of referral pathways and a plan for a programme of clinical training. Wider work around addressing barriers for cervical and breast screening also continues and we must work towards better equity of access to interventions that helps catch cancers early and improve outcomes and survival rates.
It is positive to note that COVID-19 and Flu vaccination uptake is performing well and that we have plans to further improve access to the pneumonia vaccine.

The team works to achieve the national target of 95% of reviews completed within 6 months of notification. The team completed 77% (43 out of 56 reviews) of reviews within 6 months of notification in the 2023/2024 year. However, in the subsequent 6 months, due to capacity and a continued increase in notification, this has slipped considerably.

- A member raised engagement in services and how we could support this as a collective. It was confirmed that the services that people were involved with, and/or had accessed were looked at but this was not tracked post review. It was noted that this could be an area of work that could be explored further in the future.

- A member asked how the review that fell short of good practice informed actions. It was noted in response, the partnership heard that these reviews would feed into the learning from action work. There was a robust process and collaboration to ensure that issues are dealt with as they are identified in the review. It was acknowledged that general quality issues could be more difficult to resolve.

- The Health Inequalities Team had a process to support primary care to maintain learning disability registers. The team supports

	the decision around the Mental Capacity Act and training primary care and care providers to inform and educate on what a good quality health check looks like. The partnership heard that a nurse within the team had recently won an award for their work in addressing health inequalities for people with learning disabilities and autistic people. • Concerning cervical screening and the lessons learned from reduced uptake, it was noted that work was being done to improve the uptake of cervical screening. Communication was occurring with primary care and care providers to remind them of the importance of the checks as part of the health check. There were attempts to mitigate the barriers that may prevent someone from attending. • It was confirmed that reporting structures were strong , and that learning was fed into the Learning from Deaths Forum and End of Life Board regarding deaths in acute environments. The partnership heard that end of life was sometimes not identified early enough and thus, not planned for. However, more people were being supported to die at home. A member shared that it would be important to ensure that people with a learning disability and autistic people were reflected in the Marmot Place programme. **All Age Carers Strategy for Norfolk and Waveney 2024** The Health and Wellbeing Board (HWB) and Integrated Care Partnership (ICP) have championed the development of an All-Age Carers Strategy for Norfolk and Waveney It has been coproduced with Carers of all ages, including Young Carers and Parent Carers and builds on research and coproduction with practitioners systemwide across Norfolk and Waveney. Carers will be part of a monitoring group with representatives from the members of the ICP. The All-Age Carers Strategy for Norfolk and Waveney has identified key focus areas with specific recommended actions for the first stage of delivery which encompass, for example, access to and maintenance of education, employment, and training for Carers of all ages. The Key Focus Areas together with recommended actions in the All-Age Carers Strategy concentrate on the importance of: • Identifying and raising awareness of all ages of Carers, their rights and their value (including hidden Carers). • Improving access to good quality information and services including a single point of contact. • Recognising and involving Carers as equal partners in the care of those they care for.

	• Undertaking to coproduce services with Carers wherever possible recognising their expertise and ability to influence and shape services that they need and want to support their health and wellbeing. • Having a framework and knowledge of commissioned services for all age Carers. • Recognising the importance of peer support and access to services which enable Carers to have a break from their caring role. • Developing a Carers pathway. The Strategy has ensured a strong foundation which has been led by Carers to support future planning. Key to tangible outcomes for people will be the establishment of a Monitoring Board with agreed actions and outcomes from partners within the ICP which can be tracked and measured and against which individual partners can be held to account. Members acknowledge the work that had gone into producing the Age Carers Strategy for Norfolk and Waveney 2024 – 2029 which can be found here **Full copies of the all the Papers and Minutes can be found here** **Dates for your diaries: -** The next formal meeting of the Norfolk Health and Wellbeing Board and Integrated Care Partnership will be at **09:30 am Wednesday 5th March 2025**, 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